

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

**Montana**

**FY 2017 Application/  
FY 2015 Annual Report**

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## I. General Requirements

### I.A. Letter of Transmittal



## Department of Public Health and Human Services

Public Health & Safety Division ♦ Family & Community Health Bureau ♦ 1400 East Broadway Rm A116 ♦  
Helena, MT 59602-2953 ♦ Voice:406-444-4572 ♦ Fax: 406-444-2750

**Steve Bullock, Governor**

**Richard H. Opper, Director**

July 12, 2016

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

Dear Ms. Lawler:

Enclosed is Montana's application for the 2017 Title V Maternal and Child Health Block Grant (MCHBG) and 2015 Annual Report. MCHBG funding supports state and community-based programs and efforts aimed at improving the health of the maternal child health population.

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

We look forward to continuing to improve the health of the MCH population in Montana.

Sincerely,



Denise Higgins, Bureau Chief  
Family & Community Health Bureau

## **I.B. Face Sheet**

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

## **I.C. Assurances and Certifications**

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

## **I.D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

## **I.E. Application/Annual Report Executive Summary**

**The following narrative is an update on information initially submitted for the July 2015 application and report:**

### Executive Summary Update

Two recent state-level accomplishments will have a widespread effect on the MCH population:

- In March 2016, Mary Lynne Billy-Old Coyote, began as the Director of the Office of American Indian Health housed in DPHHS. The position was created at the request of tribal health directors to address health disparities. Billy-Old Coyote coordinates work with tribal health stakeholders and DPHHS staff, identifies key health-related issues and develops strategies and identifies existing state resources to address the disparities.
- The 2015 MT legislature passed the Montana Health and Economic Livelihood Plan (HELP), which expanded Medicaid to adults up to age 64 earning up to 138% of the federal poverty level effective January 2016.

### **Women & Maternal: *Low-Risk Cesarean Deliveries (NPM 2)***

In 2014, MT Medicaid instituted an elective deliveries policy for birthing facilities and reduced reimbursement rates for any non-medically necessary induction or C-section prior to 37 weeks. In February 2016, the rate went from 4.6% in 2012 to 0.5%. In 2014, 30 births fit the criteria for low-risk cesarean delivery and the percentage for the whole population was 26.4%. The FCHB will continue educating statewide partners about these policies.

MT will use the 2015 Health Survey of MT Mother and Babies (HSMB), to provide baseline data on low-risk mothers having cesarean deliveries and inform subsequent strategies, is the ESM for NPM 2. In May 2016, the FCHB received a CDC PRAMS grant, which will provide continued data collection and analysis needed to measure the effectiveness of future activities.

### **Infant & Perinatal: *Breastfeeding (NPM 4), Safe Sleep (NPM 5)***

#### Breastfeeding

A new WIC Breastfeeding Peer Counselor site was added in FFY 2017, bringing the total number of programs to 12. Due to the large geographic area lacking direct access, all WIC programs have been encouraged to expand

services through distance delivery: phone, texting, iPad FaceTime, or WebEx. USDA Breastfeeding Infrastructure Grants are funding local and state WIC staffs' attendance at regional and CLC certification trainings.

In 2014, MT's percent of infants who are ever breastfed is fairly high, 91.2%, but the percent drops significantly for infants' breastfed exclusively at six months, 19.3%. For the ESM, the FCHB is contracting with seven County Public Health Departments (CPHDs) interested in increasing the rate of breastfeeding in their areas. The CPHDs will implement and evaluate at least two community-level activities during SFY 2017.

The MCH Staff will support MT's 4 Baby-Friendly designated facilities, 6 in the Designation Phase, 4 in the Dissemination Phase, and 1 in the Development Phase.

### Safe Sleep

DPHHS has an Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN) team that develops and maintains public and private partnerships. The team has planned the Promising Pregnancy Care training geared for prenatal care providers, which includes safe sleep education, and blending Coming of the Blessing and group pregnancy care approaches.

NPM 5's ESM will be a surveillance report on the knowledge level and behaviors of caregivers, using data from the HSMB and data entered into the Child Death Review (CDR) Reporting System. The HSMB and CDR analysis will provide specific data related to the number of infants placed to sleep on their backs and forms the foundation for future ESMs. Five CPHDs, comprising 28% of the MCH population, offered safe sleep education and training in their communities.

**Children:** *Child Injuries (NPM 7 for ages 1-10), Immunization (SPM 3A)*

### Child Injuries

During SFY 2016, CPHD had numerous and diverse activities addressing child injury prevention: establishing a crisis nursery, where families in crisis situations can have a safe place to drop off their children for the day; creating a mental health coalition after two teen suicides; placing warning signs on unstable river banks and building a life-preserver station; sponsoring an interactive distracted driving prevention campaign at the local high school; and providing gift certificates to low-income families to purchase bike helmets.

According to hospital discharge data, the 2014 state rate of non-fatal injuries in children ages 0-9 years was 100.5 per 100,000, down from 200.7 in 2009. The ESM for NPM 7 involves assessing and identifying county-level trends for the primary causes of injury-related hospital admissions for children ages 0 – 19. This information provides the basis for CPHDs to implement targeted injury-prevention activities in subsequent years.

### Immunization

SPM 3, Part A addresses the 19 to 35 months age group. According to the 2014 National Immunization Survey, 67.1% of children ages 19-35 months completed a combined seven-vaccine series. This is a significant increase over the 2010 rate of 50%. Eleven vaccines are being tracked for SPM 3A.

The 19 CPHDs, who selected SPM 3 are required to submit quarterly reports and provide details on two activities addressing their immunization levels. Data on the county's baseline immunization levels was determined prior to the start of and will be re-calculated at the end SFY 17 using the state's imMTrax system.

The IZ Program continues to work with partners across the state to improve rates and supports ongoing activities. A series of trainings via WebEx for IZ partners are being offered, which included "Immunizations - Building Trust During

the Time of Twitter” featuring pediatrician Dr. Wendy Sue Swanson, Executive Director of Digital Health at Seattle Children’s Hospital.

**Adolescent:** *Child Injuries (NPM 7 for ages 11-19), Adolescent Preventive Care (NPM 10), Immunization (SPM 3B), Teen Pregnancy Prevention (SPM 5)*

### Child Injuries

According to hospital discharge data, the 2014 statewide rate of non-fatal injuries in children ages 10-19 years was 262.7 per 100,000, a decrease from 411.9 per 100,000 in 2009. Much of the information for the adolescent age range on NPM 7 is the same as in the Children’s section, but some CPHD activities are specifically directed at teenagers. These include: suicide prevention, alcohol use, distracted driving, drug abuse, and intimate partner violence.

Motor vehicle deaths and injuries continue to be high in MT, which was a featured topic at the March 2016 FICMMR Regional Trainings. National trainers delivered a presentation on motor vehicle crashes which included: webcams showing kids texting and driving while going off the road; the additional risks of young drivers; the importance of parent engagement; and the fact that technology such as cell phones should be shut down before a vehicle is started.

### Adolescent Preventive Care

Directly addressing adolescent preventive care is a new endeavor for DPHHS. Adolescent health is addressed by multiple PHSD programs whose funding targets specific adolescent health areas.

The ESM for NPM 10 is an environmental scan identifying state organizations and programs with an interest in adolescent health. The FCHB will then conduct an outreach and information gathering survey to identify those interested in partnering with messaging and promotion on the importance and benefits of preventive care for adolescents.

### Immunization

The general information for immunization is covered in the Children’s section. SPM 3B specifically addresses age appropriate vaccinations for ages 13-17 years.

The 2015 MT Legislature passed HB 158 that revised school immunization requirements. HB 158 requires a 4<sup>th</sup> tetanus, diphtheria, and pertussis (Tdap) vaccine for students entering 7th grade; and requires kindergarten through 12th grade students to have two doses of varicella (chickenpox) vaccine. Prior to HB 158, MT was the only state not requiring the varicella series and one of five not requiring a pertussis booster for school attendance.

HB 158 requirements have generated new work processes for IZ staff and contractors. The work includes: reviewing school records and sending letters to parents regarding required school attendance immunizations; working with partners, i.e. the Blue Cross Blue Shield Care Van, to provide vaccines in remote areas where it is difficult to transport vaccines; using advertising campaigns and social media posts; offering incentives as part of adolescent outreach; and holding additional school immunizations clinics. The passage of HB 158 also provides an opportunity to offer other adolescent specific vaccinations, i.e. meningococcal and Human Papillomavirus.

### Teen Pregnancy Prevention

In 2014 the rate of birth to adolescent ages 15-17 years was 13 per 1,000. A Title X goal for SFY 2017 is for 85% of female patients < 19 years to use a highly or moderately effective method of contraception, defined as Implant, IUD,

OCPs, patch, ring or Depo. WMH is providing these contraceptive methods to adolescents, based on their income, as an approach to reduce barriers to care.

Providing information about Teen Pregnancy Prevention Month, HIV, Domestic Violence/Teen Dating Violence, and STI/STD were identified as WMH priorities for SFY 2016. Information is disseminated through outreach campaigns, community presentations, training, newsletter articles, and toolkits. The March 2016 Family Planning Training Conference included STD Prevention and the MT HELP Plan sessions.

**CYSHCN:** *Access to Care & Public Health Services, Transition Services (NPM 12), Medical Home (SPM 4)*

#### Transition Services

In 2012, CSHS began a transitions project with the University of Montana Rural Institute for Inclusive Communities (RII) which focused on: Outreach and Education, Resource Development, and Family Engagement. Because of the success of the project and the mutually beneficial partnership, CSHS is continuing the RII Transition Project into FFY 2017 using MCHBG funds.

Effective SFY 2017, CSHS altered their requests for proposals and contracts with service providers to include CYSHCN outcome measures, ensuring that providers have the services needed to transition to all aspects of adult life.

The ESM for NPM 12 involves CSHS completing a comprehensive program assessment which includes questions regarding transition services for families of CYSHCN. The results will provide a baseline and be used to plan strategies to improve how CSHS supports those services.

#### Medical Home

In SFY 2016, CSHS changed the way multidisciplinary clinics are managed. CSHS now contracts with hospitals to provide the clinical services and to coordinate patient care. The new structure allows the hospitals to play an active role in care coordination and quality improvement.

Montana's TCM State Plan Amendment included changes allowing more agencies the capacity to bill Medicaid for CYSHCN care coordination and the freedom of choice of selecting a provider.

CSHS contracts with RII for administration of the MT Medical Home Web Portal, which provides current and reliable information to families and providers of CYSCHN about diagnosis and services available to them locally. During this reporting period RII conducted a statewide survey of providers to address the need for mental health services on the portal.

**Life Course / Cross-Cutting:** *Oral Health (NPM 13), Smoking in Pregnancy & Households (NPM 14), Access to Care & Public Health Services (SPM 1), Family Support & Health Education (SPM 2)*

#### Oral Health

A pilot project with the Oral Health Program (OHP) and Flathead County's Public Health Department and Community Health Center, to increase dental visits to pregnant clients is the NPM 13 ESM. The CPHD is co-located with the CHC, which has a full-time dentist. Pregnant CPHD clients will be assessed for dental care utilization during their prenatal care visits. If they have not had a dental visit during their pregnancy, an attempt will be made to have them seen by the dentist before they leave that day.

The OHP continues to support alternate and community-based models of care. The OHP is assisting two American

Indian clinic sites to alleviate staffing challenges through UW/SoD dental student rotations; and is focused on increasing the number of primary care providers who assess and provide preventive care during well-child visits. A proposal for continued OHP resources was submitted in February 2016. If funded, it will offer an opportunity for community-based preventive care programming and build on the relationships that have been established.

#### Smoking in Pregnancy & Households

Home visitors continue to assess primary caregivers and pregnant enrollees for tobacco use at enrollment and provide referrals to the MT Tobacco Use Prevention Program (MTUPP) for tobacco cessation. During FFY16, MTUPP a Quit-Line Program specifically for pregnant and postpartum smokers, who may call or visit the website to enroll. Enrollment services include a dedicated female coach, extended coaching calls with cash incentives, a personalized quit plan, and Nicotine Replacement Therapy support. MTUPP also added an American Indian tobacco users program which connects them with Native Coaches.

The ESM for NPM 14 is a trial project with Park County Health Department (PCHD) to support targeted tobacco cessation activities. PCHD will plan, implement and evaluate at least 2 community-level activities during the fiscal year. Information on the outcome of their efforts will be distributed to all the CPHDs receiving MCHBG funds.

#### Access to Care and Public Health Services

SPM 1 was developed to address the unique challenges faced by counties with very small populations to allow CPHDs the flexibility to offer their MCH services and the activities to their MCH population. Six frontier-level population CPHDs collaborated with the FCHB on implementing SPM1 in SFY 2016, which retained an additional CPHD to provide MCH services. For SFY 2017, ten counties are implementing SPM 1.

#### Family Support and Health Education

The results of the 5-Year Statewide Needs Assessment identified a strong emerging trend: family support and parental education were essential services, but increasingly unmet. SPM 2 was created to support CPHDs with providing referrals and follow-up to community services and health education to their MCH clients. The MCH staff assisted the CPHDs by creating standardized documents: 1) a simple and non-invasive family needs survey, 2) an informed-consent form, 3) a more in-depth interview assessment tool, and 4) a data collection and tracking form. Six counties of differing sizes chose SPM 2 in SFY16, and nine in SFY17.

SPM 2 recognized the necessity of addressing the social determinants of health so as to have a positive impact on the health of MT's MCH population, especially ages 0 to 19 years.

## II. Components of the Application/Annual Report

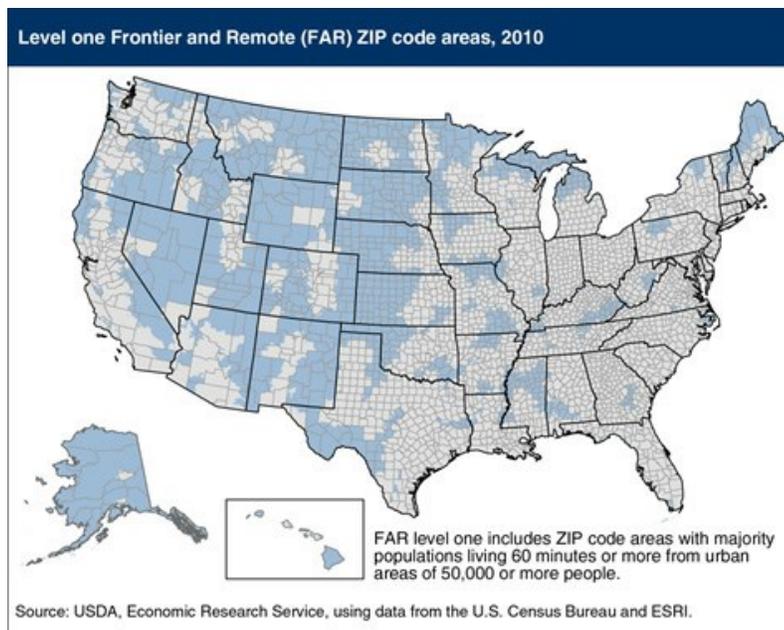
### II.A. Overview of the State

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

Montana is the fourth largest state in size, at 145,546 square miles. It is larger than Germany, and the ten smallest-sized states combined do not have as much area. Conversely, the *city* of Dallas, Texas has a significantly higher population.

Western Montana is mountainous and heavily forested, while the eastern two-thirds are semi-arid rolling plains. More than half of the population lives in rural or frontier areas, characterized by limited access to health care in local communities. Agriculture, tourism, logging and natural resource extraction are major industries.

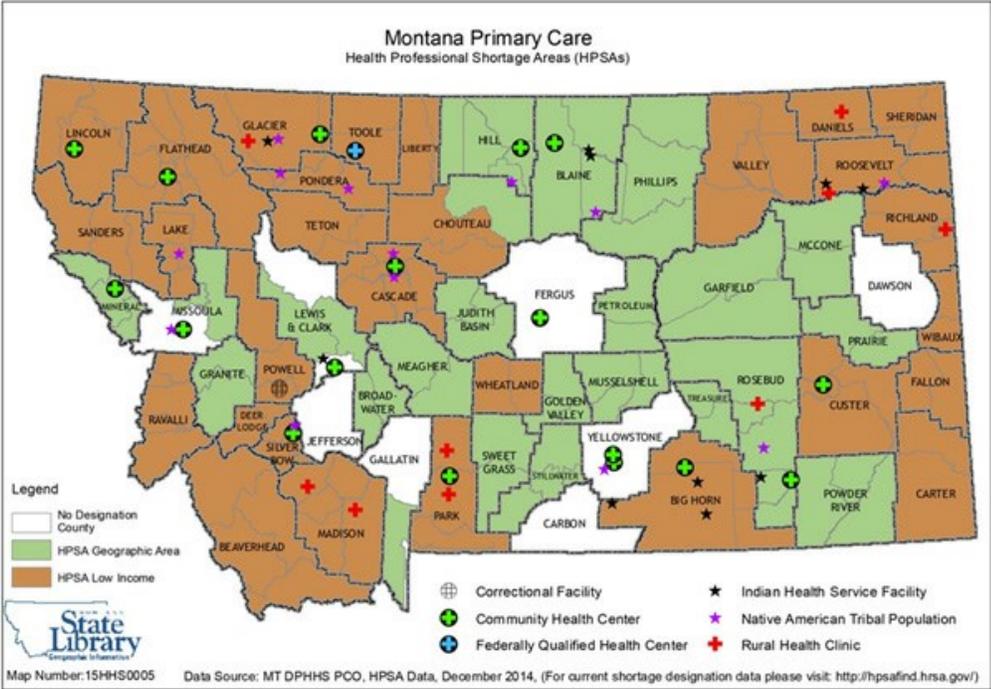
The definition of a Level 1 Frontier and Remote Area is that residents must have to travel at least 60 minutes to reach an urban area of 50,000 or more people. *Although 52 percent of the land area of the United States is in these areas, only 4 percent of Americans live there.* The map below shows the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



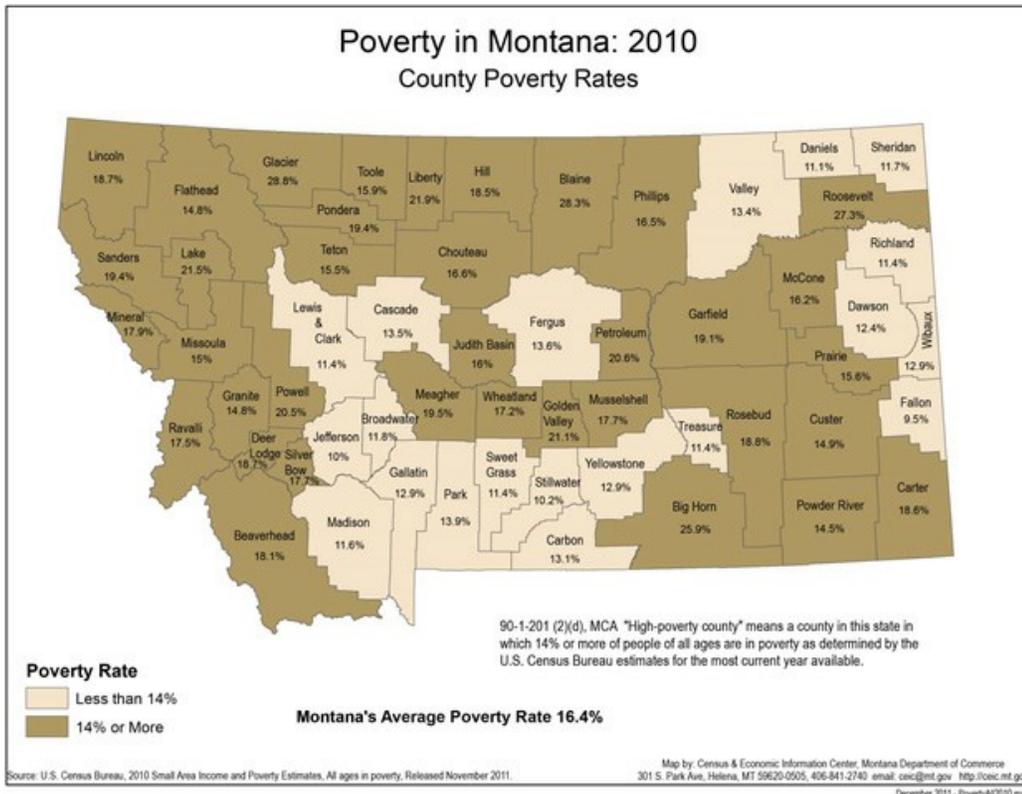
Montana's racial make-up is predominately white, with a 2013 census estimate at 89.5% of the population. American Indians make up the largest minority, at approximately 6.5%. The ethnic Hispanic or Latino population is only 3.3%, compared to 17.1% nationwide.

Census Population	2013 Estimate
White	89.5%
American Indian	6.5%
Asian	0.8%
Black	0.6%
Native Hawaiian / Pacific Islander	0.1%
Two or More Races	2.5%

All of Montana’s counties are designated as medically underserved in some way. According to the 2013 Montana BRFSS Annual Report, the prevalence of no personal health care provider was 29.6%. This is covered in more detail in the Needs Assessment Summary. The following map specifically shows the Health Professional Shortage Areas for Primary Care:



The 2012 Population Estimates and American Community Survey indicates that 21% of children under age 18 are below the federal poverty level. According to the 2010 census, the average poverty rate for Montana as a whole was 16.4%. This rate varies greatly by county, from a high of 25.9% in Big Horn to a low of 9.5% in Fallon. This is shown in detail on the next map.



According to the 2009-2013 American Community Survey 5-Year Average, median household income in Montana was \$46,230, compared to the U.S. total average of \$53,046. Under the same survey, Montana's per capita income was \$25,373, compared to the U.S. average of \$28,155. A recent positive economic indicator is an unemployment rate of only 3.9% for May of 2015.

Due to a long history of natural resource extraction, Montana has 16 Superfund sites on the National Priorities List, and 2 more are proposed. A Superfund site is an uncontrolled or abandoned place where hazardous waste is located. This contamination may lead to adverse effects on the health of people at or near the sites.

The Bakken Oil Field boom is continuing to place a major strain on infrastructure systems in eastern Montana. Especially hard hit are towns within the impact area, as they currently receive very little tax money from oil production. While the pace of explosive growth has slowed, government services are still struggling to meet the new levels of demand.

Montana is home to seven American Indian reservations, and one state recognized landless tribe (Little Shell Chippewa). State law recognizes that there is a unique government-to-government relationship between state government and the eight tribal governments in Montana. According to the U.S. Census Bureau: State and County QuickFacts for 2013, American Indians equal 6.5% of Montana's population, or approximately 66,533 in number. Of those, 57.6% live on tribal lands. Information on culturally competent delivery of maternal and child services is detailed in the Needs Assessment Summary.

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

The following table compares some of the MCH demographic profile information for the geographic area of each reservation. The median age for the whole state is 39.9 years.

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

The principle characteristics of Montana’s MCH population groups, with health status, needs and emerging issues, are detailed in the Needs Assessment Summary. Current priorities for DPHHS are specified in the State Selected Priorities narrative, as well as the competing factors impacting Title V services delivery.

The Montana Legislature passed a Medicaid expansion bill which was signed into law in April 2015. Coverage can begin upon federal approval and with securing a contractor to assist the state in administering the program. DPHHS is working to obtain federal approval as quickly as possible. However, there is no timeline by which the federal government must approve the plan. The new law extends health care coverage, through Medicaid, to adults between the ages of 19-64 who earn incomes less than about \$16,000/year for an individual and \$28,000/year for a family of three.

Children up to 250% FPL have had access to health care coverage through the Healthy Montana Kids program since 2008. Behind the scenes it is still two programs, CHIP and Children’s Medicaid – however, families only have to complete one application. Enrollment in Children’s Medicaid experienced a significant increase as a result of ACA health insurance market activity.

Twenty-one percent of Montana’s population under the age of 66 was uninsured in 2013. In 2014 that number fell to 15.8 percent, giving Montana the tenth-highest percentage reduction in uninsured rate in the nation. Of the 11 states with the highest percentage reduction in uninsured rate, all but Montana expanded Medicaid in 2014 and also established their own health insurance exchanges. Montana did neither, but still had a significant reduction in its

uninsured rate. When CMS approves the state's Medicaid expansion waiver, the uninsured rate should see another large drop.

During the 2015 open enrollment period, 54,266 people enrolled in private plans through the Montana exchange. Of the people who selected a plan during the 2015 open enrollment period, 41 percent are new to the exchange, and 85 percent are receiving premium subsidies. It appears that rates will rise considerably in Montana in 2016, as all three carriers in the exchange have requested double digit rate hikes.

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

Rules implementing the above authority are found in Titles 16 and 46 of the Administrative Rules of Montana (ARM). These rules define the State Plan for Maternal and Child Health, including children with special health care needs, family planning, school health, and the rules authorizing case management for high risk pregnant women. ARM 37.86.3901 defines case the Medicaid Primary Care Service's case management rules for children with special health care needs, and ARM 37.86.3401 for high-risk pregnant women. Title V is responsible for ARM Chapters 19, 21, 57 and 59.

Montana's Title V Program provides leadership and direction to state and local programs and partners, for issues affecting the health of the MCH population. The 2015 Needs Assessment resulted in the establishment of ten priority areas, and five State Performance Measures. The aging population, geographic realities, and access to care issues all pose unique challenges to health care delivery. Some County Public Health Departments are the sole source of certain MCH health care services, such as immunizations, for the surrounding population. Montana's Title V funds will directly support these County Public Health Departments in 50 counties in FY 2016, and are critical to meeting the public health needs of the MCH population all across the state.

## II.B. Five Year Needs Assessment Summary

### 2016 Five-Year Needs Assessment Summary

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

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

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

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

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

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#### Needs Assessment Summary Update –

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

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

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

##### Children and Adolescents:

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

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

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

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

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

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

<sup>4</sup> National Immunization Survey. Estimated Vaccine Coverage, child and teen, 2014: <http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/index.html>.

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

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

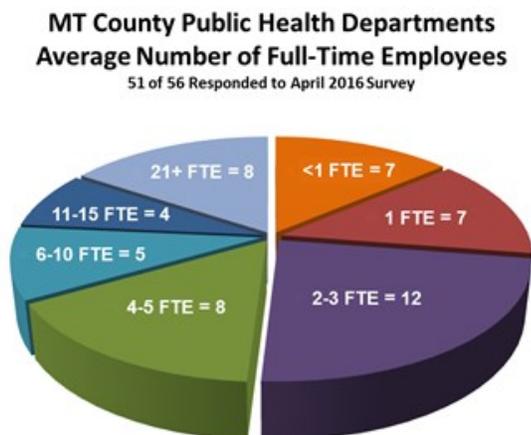
<sup>7</sup> Montana Department of Health and Human Services. Children Special Health Services, Newborn Hearing Screening Program, 2014. Special Statistical Request; May 31, 2016.

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

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

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

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



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

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

<http://dphhs.mt.gov/Portals/85/publichealth/documents/PrimaryCare/March2016PCNeedsAssessment.pdf>

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

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

- CSHS – CSHS has been providing direct financial assistance for medications, testing and medical services not covered by Medicaid. The direct financial assistance program, which ended March 31, 2016 expended \$11,351 to 20 families.
- Immunization (IZ) – Nineteen CPHDs have chosen SPM 3 for SFY17, and will receive a total of \$273,549 in funding. The IZ Program's budget has increased to \$1.8 million, and the value of the publically funded vaccine distributed has increased to an average of \$8 to \$10 million. MT's IZ Information System (imMTrax) consolidates vaccination data from vaccine providers either through manual data entry or electronic data exchange. The program also provides tools for designing, implementing and sustaining effective immunization strategies to improve immunization rates.

- MECHV – the home visiting program is now called Healthy Montana Families. Staffing has increased to include a program specialist, health education specialist, and financial specialist. The number of home visitors has also increased to 86. State general fund and tobacco trust settlement funding is currently \$587,000.
- MCH – NPM 13, Oral Health, was added to the CPHD performance measure selection choices for SFY17. In SFY15, 50 CPHDs provided group encounter services to 33,794 clients. They also served the following unduplicated numbers by population category:
  - Pregnant Women – 4,083
  - Infants age <1 – 6,688
  - Children ages 1 to 22 – 34,839
  - CYSHCN – 6,763
  - Women of Childbearing Age – 21,502

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

- MTUPP - According to MT's 2015 Youth Risk Behavior Survey, smoking among youth has decreased from 20% in 2005 to 13% in 2015. In SFY 2016 MTUPP's overall budget was approximately \$7.3 million. The number of tobacco-free medical campuses in MT has increased to 59, and as of June 2016, 72% of schools have adopted Comprehensive Tobacco-Free Policies. The MT Tobacco Quit Line has received over 84,000 calls since its inception in 2004.
- PCO - The Primary Care Office stands as a National Health Corp Services Ambassador and oversees the MT National Health Service Corps (NHSC) Student Loan Repayment Program, now with \$150,000 in federal funds and a matching \$75,000 from the state. In FFY2015, MT was home to 60 new NHSC Loan Repayment Program awardees, and 3 new NURSE Corp awardees. Currently, there are a total of 105 "returning awardees" for the 2015 NHSC cycle. The MT NHSC State Loan Repayment Program awarded five new applicants, and four second year awardees in FFY2015. As of September 1, 2015, the PCO had filled 10 of 30 J1 Visa Waiver Program slots, available for foreign born Primary Care Physicians and Specialists who provide services for a minimum of three years in a primary care HPSA.
- WIC – as of October 2016, there will be 29 local agencies, serving an average of 18,000 participants per month statewide.
- WMH – is now administering three grants, with the addition of the Rape Prevention and Education (RPE) Program. MT's RPE program focuses on primary prevention, and preventing sexual violence crimes before they occur, on 5 college campuses. With a \$226,000 award amount, efforts are focused on influencing the knowledge, attitudes, and behaviors of those most at risk to perpetrate, and include community organizing and policy creation focused on gender equity. It also includes education on several levels, based on awareness activities that support healthy relationships and respect.

In SFY 2015, Title X contractors provided reproductive health services, counseling, referrals, and preventive health screening to over 21,000 men and women. The PREP program is currently contracting with five agencies, serving seven counties, and in SFY 2015 1,410 youth received evidence-based classes on how to prevent teen pregnancy and sexually transmitted infections.

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

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

## Five-Year Needs Assessment Summary (Submitted on July 15, 2015)

### II.B.1. Process

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

#### Process:

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

The team identified desired outcomes for this assessment:

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

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

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

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

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

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

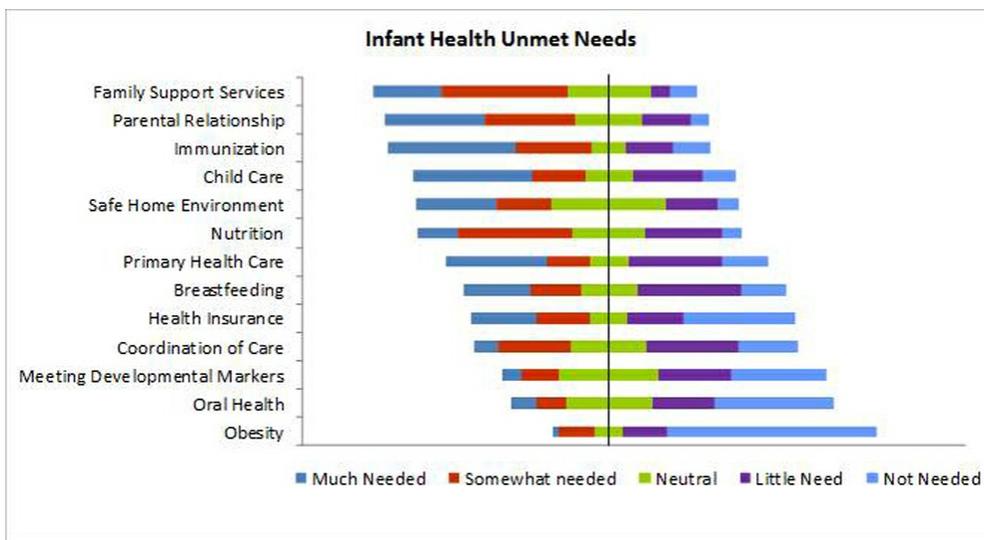
1. Please rank the following health needs, beginning with 1 as the most important (PC) health need in your service area.
2. Are there other common (PC) health needs in your service area, which were not listed in the previous question?

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

The survey responses were evaluated by four main criteria:

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

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



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

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

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

would it be and why?

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

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

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

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

Table 2: Montana Public Health and Safety Division Strategic Plan Assessment

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

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

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

## II.B.2. Findings

### Findings:

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

### **MCH Population Needs**

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

Women’s Maternal Health:

- Low-Risk Cesarean Deliveries (NPM 2)

Perinatal/Infant Health:

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

Child Health:

- Child Injuries (NPM 7)

- Immunizations (SPM 3-A)

#### Adolescent Health:

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

#### CYSHCN:

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

#### Cross-Cutting/Life Course:

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

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

#### Overview of Health Status by MCH Population Group

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

A snapshot of the health status of Montana's pregnant women, mothers, and infants can be seen from certain common health indicators. The percent of women who smoked during pregnancy was 16.5% in 2013<sup>1</sup> while the 67.2%<sup>2</sup> of women reported a routine check-up in the past year. Sixty-nine percent of infants were born to women receiving prenatal care beginning in the first trimester.<sup>1</sup> The percent of Caesarian deliveries in low-risk first births was 23.4%.<sup>1</sup> The percent of infants who were ever breastfed in 2013 was 83.5%<sup>3</sup>. Seven percent of live births were of infants weighing less than 2,500 grams, while 9% of births were infants of less than 37 weeks gestation.<sup>1</sup>

##### **Children and Adolescents:**

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

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

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

### State Health Needs Priorities

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

The SHIP action area categories are:

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

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

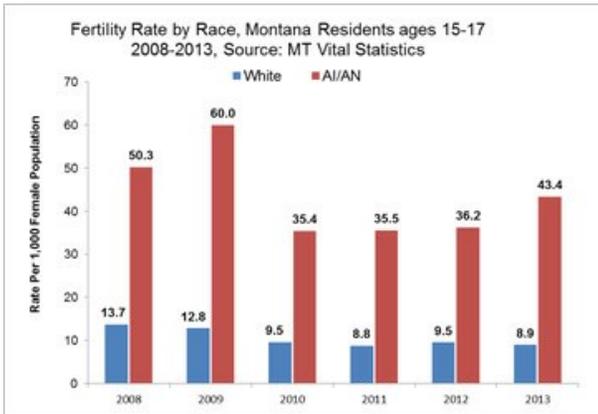
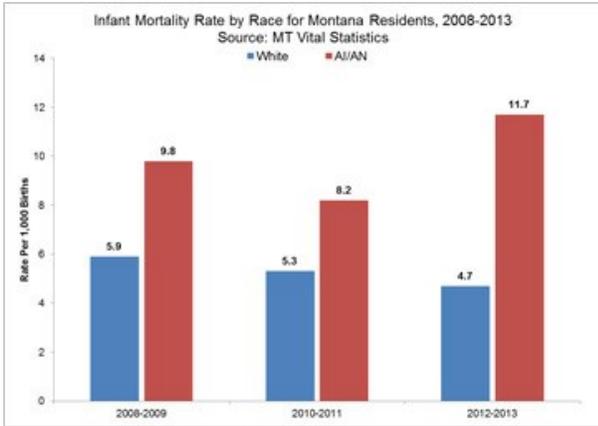
A complimentary source of guidance to the SHIP is the Public Health and Safety Division's Strategic Plan (PHSDSP), published in September 2013. The complete plan is included as an attachment. The 5-year plan includes seven key results areas:

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

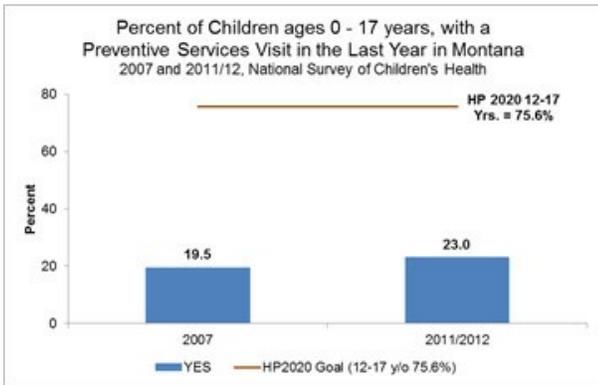
The main goals of the PHSDSP which effect external operations are:

- Develop and support policies to promote and protect health
- Enforce public health laws and regulations to promote and protect health
- Implement evidence-based health promotion and prevention programs
- Promote health by providing information and education to help people make healthy choices
- Improve the delivery of clinical preventive services
- Increase use of appropriate health services, particularly by underserved and at-risk populations
- Monitor health status, health-related behaviors, disease burdens, and environmental health concerns
- Provide leadership to strengthen the public health and health care system
- Lead by engaging the community and partners to identify and solve health problems
- Strengthen public health practice to improve population-based services
- Evaluate and improve public health programs
- Assess and continuously improve the satisfaction of Montanans with services provided directly by PHSD

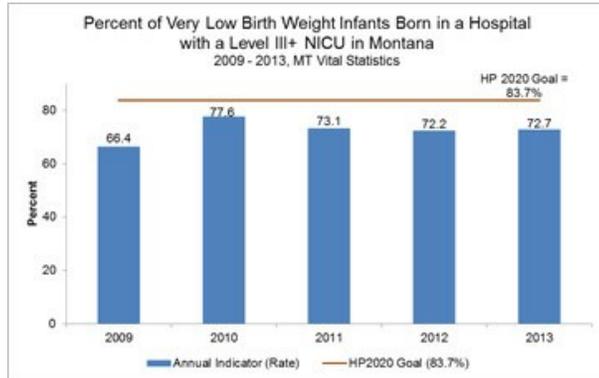
A detailed crosswalk is attached which shows the relationship between the SHIP, PHSDSP and Montana's MCHBG performance measure choices. For some performance measures, the choice was informed by rural geographic or minority American Native population health disparities. In these cases, the statewide data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



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



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



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

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

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

**SPM 1 - Access to Public Health Services:** Number of clients' ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 2,000 or less. (County public health departments report on state provided form.)

*Rationale - Access to Care was consistently identified as a continuing health care need on the Needs Assessment Surveys and Key Informant Interviews. Montana faces a large geographic health disparity. Access to Care is a fundamental action area in five sections of the SHIP, and one section is focused on strengthening the public health and health care system. It is also integral to Key Results Area 3 of the PHSDSP.*

**SPM 2 – Family Support and Health Education:** Number of clients' ages 0 – 21, and women ages 22 – 44 who are assessed for social service and health education needs; and then are placed into a referral and follow-up system, or provided with health education as needed. (County public health departments report on state provided form)

*Rationale - Family support and parental education emerged as essentials which are increasingly unmet; and as having a major effect on the health of the whole MCH population, especially ages 0 to 19 years. Numerous strategies in the SHIP and PHSDSP address working to improve outreach in this area.*

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

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

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

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

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

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

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

##### **Maternal / Women’s Health:**

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

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

According to the CDC 2014 Breastfeeding Report Card, the rate of infants who were ever breastfed in Montana was 91.2%. This compares well with the Healthy People 2020 (HP2020) goal of 81%. Montana also has good rates of health care coverage for infants through the comprehensive “Healthy Montana Kids” program, which incorporates children’s Medicaid, and CHIP for families up to 250% of the Federal Poverty Level. The FCHB is working to reduce cesarean deliveries among low-risk first births. From 2009 – 2013 Montana’s rate was close to the HP2020 goal of

23.9%, but that is still too high. The Infant Mortality CoIIN identified OB/GYN champions who are helping to make this a less acceptable practice. Montana still falls below the HP2020 goal of 83.7% of Very Low Birth Weight infants born in a Level III+ NICU, presumably due to geographic disparities.

### **Children and Adolescents:**

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

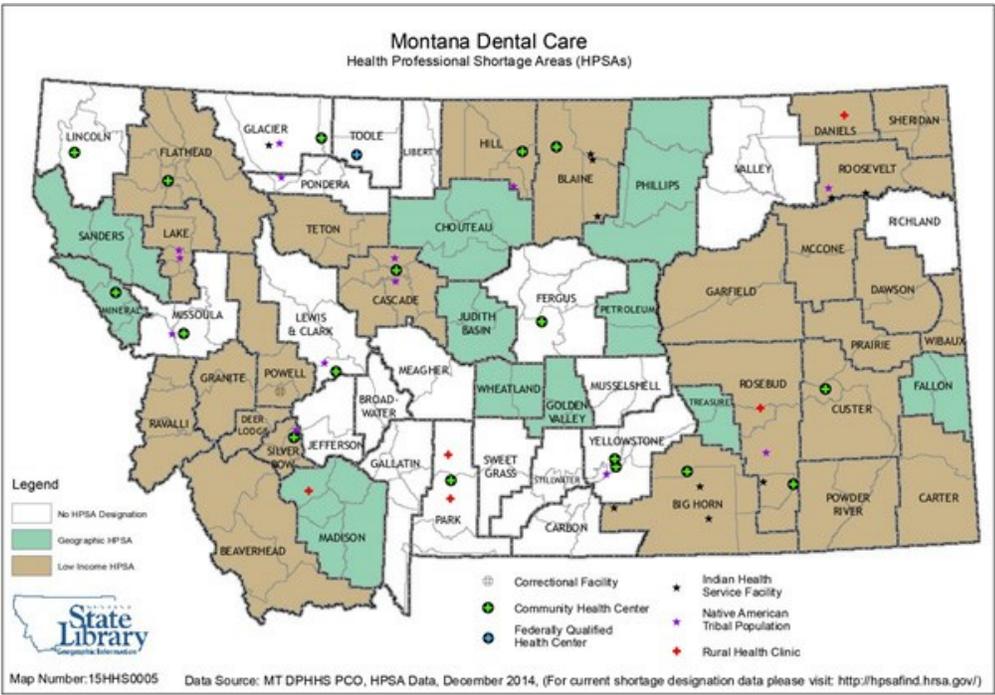
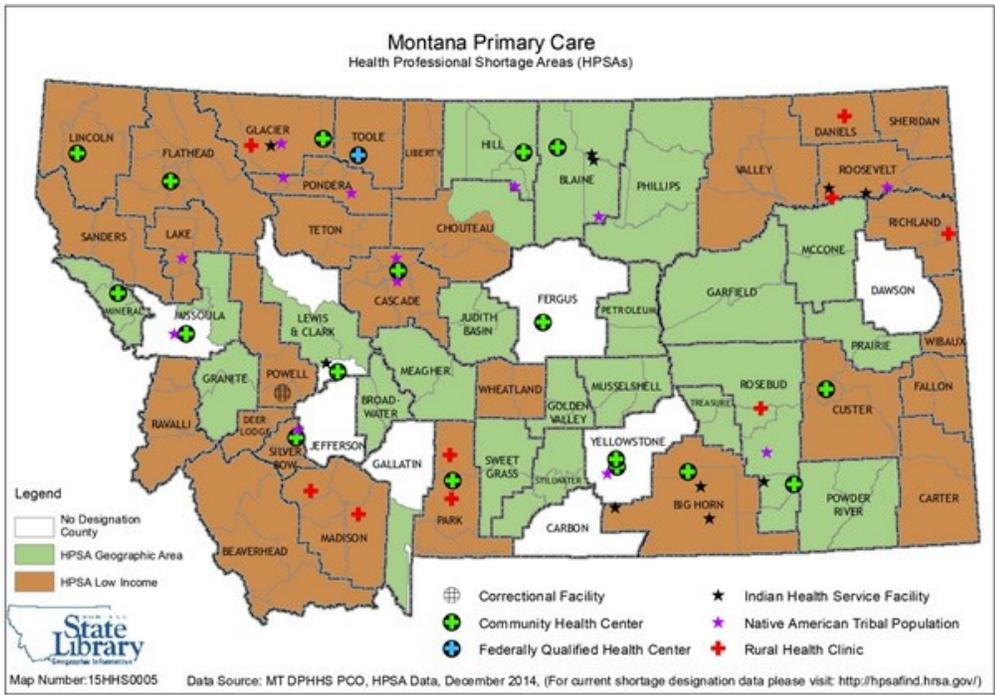
### **CYSHCN:**

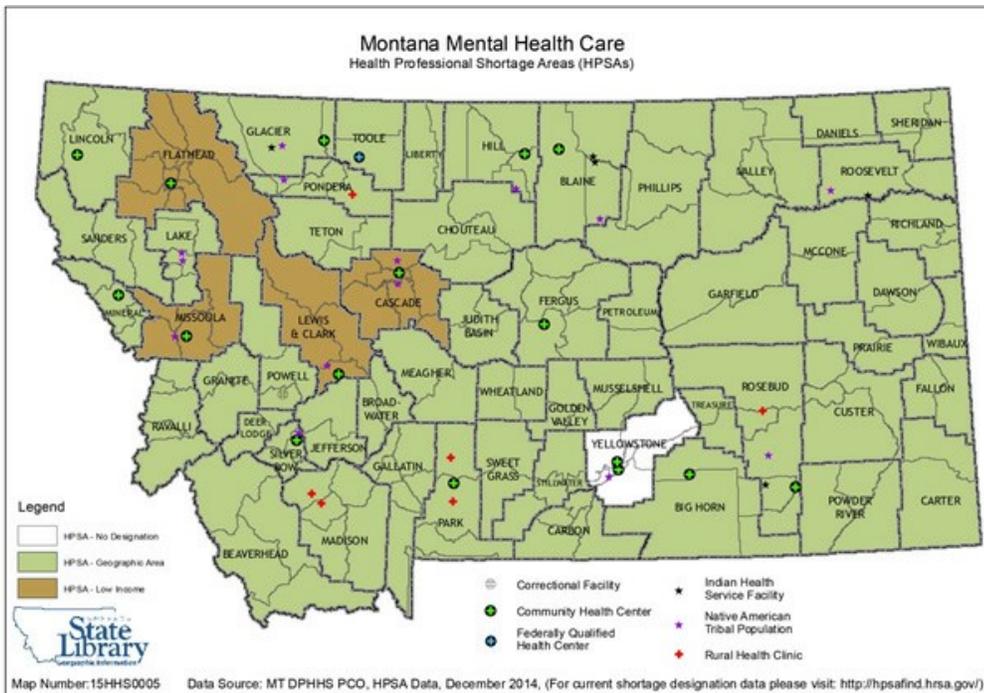
The main success for this domain in Montana is provided by CSHS regional specialty clinics. Nurse Coordinators connect to local resources as needed for providers and families. The challenge of access-to-care remains a large obstacle for many of these children. The CPHD surveys agreed that the top three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

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

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

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





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

### Analysis of Title V Program Approaches

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

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

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

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

There is a huge variation in the size of the maternal and child populations served by Montana's counties. In 2015, this number ranges from 197 individuals in Petroleum County to 73,779 individuals in Yellowstone County. Of the 56 counties, in fiscal year 2015 the 10 counties eligible for baseline funding accounted for less than 1% of the state's maternal and child population; 41 counties held only 20% of the population, and the 6 largest counties accounted for

60%. The counties with low populations are also those experiencing the greatest geographic health disparities due to access-to-care issues. These facts create challenges when it comes to program approaches.

In the past two years, the CPHD have been transitioned into increasing requirements for planning, reporting and evaluating their MCHBG activities. This transition has been accompanied by additional support at regional trainings and webinars. The large CPHDs take these requirements in stride; but many of the smaller ones have outdated record-keeping systems, and problems aggregating enough county specific data to measure the results of their activities in the short term. As a result Montana's Title V program has gone from having 54 counties participate in fiscal year 2013, to 50 in fiscal year 2016.

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

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

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

### **Title V Program Capacity**

#### Organizational Structure

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

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

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

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

The PHSD contains five bureaus and two offices:

- Financial Services and Operations
- Communicable Disease Prevention and Control, and Emergency Preparedness

- Family and Community Health
- Laboratory Services
- Chronic Disease Prevention and Health Promotion
- Office of Public Health System Improvement
- Office of Epidemiology and Scientific Support

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

The FCHB contains five sections:

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

The apportionment of Montana’s MCHBG funding is:

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

Other programs within the FCHB are:

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

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

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

Organizational charts are included as attachments.

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

### Agency Capacity

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

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

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

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

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

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

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

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

million annually for service delivery, and one-time federal expansion grants of \$5.7 million and \$5.2 million.

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

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

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

- NPM 4:Breastfeeding
- NPM 14:Pregnancy and Household Smoking
- SPM 1:Access to Public Health Services
- SPM 2:Family Support and Health Education
- SPM 3: Immunization
- SPM 5:Teen Pregnancy Prevention

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

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

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

All 56 Montana counties have federally designated Health Professional Shortage Areas (HPSA) or Medically Underserved Areas or Populations (MUA/P). Many federal and state programs use these designations for eligibility and prioritization purposes. For example, NHSC uses HPSA scores to prioritize funding. In FFY2014, Montana was

home to 152 NHSC Loan Repayment Program providers, 8 NHSC Scholars, and 29 MT NHSC State Loan Repayment Program providers. This is a total of 189 medical, dental, or mental health providers serving underserved populations in Montana. The J1 Visa Waiver Program also uses HPSA designations. The PCO currently has approved 16 J1 Visa Waiver Program physicians who are providing services for a minimum of three years in a primary care HPSA.

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

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

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

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

With \$250,000, the PREP grant's purpose is to prevent teen pregnancy and sexually transmitted infections. PREP contracts with six agencies serving eight counties. It uses two evidence-based curricula: Reducing the Risk, and Draw the Line/Respect the Line. During SFY 2104, PREP educated 1,687 youth in 18 regular public schools, 2 alternative schools for at-risk youth, 3 juvenile justice programs, 1 community-based organization, and 1 career development center.

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

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

The *Montana Tobacco Use Prevention Program* (MTUPP) is in the Chronic Disease Prevention and Health Promotion Bureau of the PHSD. MTUPP works to eliminate tobacco use, especially among young people, through statewide programs and policies. It has been highly effective and is a national model among tobacco use prevention programs. According to Montana's 2013 Youth Risk Behavior Survey, smoking among youth has decreased from 29% in 2001 to 15% in 2013. MTUPP's overall budget is funded through state special revenue from Master Settlement Agreement funds and through a CDC Cooperative grant. In SFY 2014 the program's budget was approximately \$4.75 million.

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

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

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

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

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

Women's Maternal Health:

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

Perinatal/Infant Health:

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

Child Health:

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

Adolescent Health:

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

CYSHCN :

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

Cross-Cutting/Life Course:

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

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

MCH Workforce Development and Capacity

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

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

Names and qualifications of senior management and program staff:

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

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

2004: Laboratory Preparedness Coordinator, DPHHS PHSD Laboratory Services Bureau

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

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

- MCH Supervisor, Ann Buss -

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

1991: Employment and Training Counselor, Miles Community College

1997: Executive Director, HANDS Child Care Program

2003: CACFP Program Specialist, DPHHS, HCSD, ECSB

2006: Maternal Child Health Section Supervisor, DPHHS PHSD FCHB

- CSHS Supervisor, Rachel Donahoe -

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

2006: Program Manager, Helena Food Share

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

2008: Medicaid Program Officer, DPHHS

2011: Marijuana Program Manager, DPHHS

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

- MECHV Supervisor, Dianna Frick -

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

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

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

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

2006: Maternal and Child Health Epidemiologist, Montana DPHHS

2008: Lead Maternal and Child Health Epidemiologist, Montana DPHHS

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

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

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

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

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

2014: WIC Section Supervisor, DPHHS, FCHB WIC Section
- WMH MCH Program Specialist, Kimberly Koch -  
 Kimberly graduated in 2001 with a B.S. in Health and Human Performance, Health Promotion Emphasis, from the University of Montana in Missoula, Montana. In 2012 she earned a Masters of Public Health from the University of Montana. Recent work history:

2003: Health Educator, Planned Parenthood of the Inland Northwest

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

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

2013: MCH Program Specialist, DPHHS Women's and Men's Health Section
- PCO Manager, Brandy Kincheloe (*Hired August 2015, information updated for final application submission.*) Brandy graduated in 2004 with an A.A. in Communication from Casper Community College. In 2009, she earned a B.S. in Sociology from the University of Montana. She became a LEAN instructor in 2014, and is a certified Wellcoach. Recent work history:

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

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

2013-2015: Community Health Improvement Specialist, Clark Fork Valley Hospital, Plains, MT
- FICMMR Program Coordinator, Kari Tutwiler -  
 Kari graduated in 1982 with a B.S. in Journalism from Utah State University in Logan, Utah. In 1983, she earned a M.A. in Speech Communications from Eastern Illinois University in Charleston. Recent work history:

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

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

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

2015: FICMMR Program Coordinator, DPHHS FCHB
- MCHBG Coordinator, Blair Lund -  
 Blair graduated in 1981 with a B.S. in Business Administration, from Rocky Mountain College in Billings,

Montana. In 2005 she earned an A.S. in Computer Science from the University of Montana's Helena College of Technology, in Helena, Montana. Recent work history:

1998: Executive Director, Helena Area Habitat for Humanity

2005: Medicaid Data Exchange Business Analyst, Affiliated Computer Services

2007: Internet Marketing Coordinator, Student Assistance Foundation

2010: CHIPRA Grant Coordinator, DPHHS Healthy Montana Kids

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

2013: MCHBG Coordinator, DPHHS FCHB

- Immunization Program Coordinator, Bekki Wehner -

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

1997: Case Manager – Big Brothers Big Sisters of Helena

2004: Immunization Information System Coordinator – DPHHS, PHSD

2010: Immunization Information System Manager – DPHHS, PHSD

2012: IT Business Analyst – State of Montana

2014: Montana Immunization Section Supervisor – DPHHS, PHSD

- MCH Epidemiologist, Anya Walker -

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

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

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

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

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

2015: MCH Epidemiologist, DPHHS PHSD OESS

### Culturally Competent Approaches to Service Delivery

Montana's main cultural minority, at approximately 6.5% of the population, is American Indian. There are 7 federally recognized tribes in Montana which have dedicated reservations, and one additional tribe recognized by the state which does not have reservation land. The Governor's Office of Indian Affairs facilitates annual Tribal Relations Training to support state employees in developing meaningful and productive interactions with tribes. It also publishes an annual State-Tribal Relations Report. This report includes a listing of the Governor's appointments of

American Indians serving on State boards, councils and commission. Additionally, it showcases the state's nearly 550 agreements, negotiations and collaborative efforts with tribal governments which were in effect during state fiscal year 2014. The 2014 Tribal Relations Report, "Partners in Building a Stronger Montana" is accessible at: <http://tribalnations.mt.gov/>

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

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

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

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

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

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

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

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

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

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

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

#### Partnerships, Collaboration and Coordination

CSHS has State Implementation Grant specific collaborations with:

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

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

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

Endnotes:

<sup>1</sup> Montana Department of Health and Human Services, Office of Vital Statistics, Special Statistical Request; June 8, 2015.

<sup>2</sup> Montana Department of Public Health and Human Services, Behavioral Risk Factor Surveillance System. MT Data Query, 2013; Available From: <http://dphhs.mt.gov/publichealth/BRFSS/MTDataQuery.aspx>.

<sup>3</sup> Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity. Breastfeeding

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

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

<http://childhealthdata.org/browse/survey>

<sup>5</sup> National Immunization Survey. Estimated Vaccine Coverage, Children 19-35 Months. 2013 Available From:

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

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

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

<http://childhealthdata.org/browse/survey>

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

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

## II.C. State Selected Priorities

No.	Priority Need
1	Family Support and Health Education
2	Access to Care
3	Immunization Rates
4	Child Injuries
5	Smoking During Pregnancy and Household Smoking
6	Breastfeeding Rates
7	Oral Health
8	Teen Pregnancy Prevention
9	Low-Risk Cesarean Deliveries
10	Infant Safe Sleep

### Maternal and Child Health Block Grant 2016-2020 State Selected Priorities

Montana's priority health needs selection was determined from the results of the 5-Year statewide Needs Assessment, and identified concurrently with relevant performance measures. Criteria were established from guidance provided by HRSA.

Early in the needs assessment process, the team identified the following desired outcomes:

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

The FCHB MCH Epidemiologist and the MCHBG Coordinator collaborated on an in-depth online survey, using questions distilled from the 2010 survey as a starting point. The top typically known responses were provided for the participants to rank, and then an "Other" category was provided for additional answers. This was used to gather needs assessment information from the CPHDs. The Public Health System Improvement Task Force was also polled, using individual 45-minute interviews.

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

- Montana’s State Health Improvement Plan (SHIP) – work began in 2012 with compiling the health status and needs of Montanans, which was then presented to stakeholder groups and the public. Information from focus groups, on-site meetings, surveys, and webinars also informed the plan. More than 300 individuals representing more than 130 organizations participated in its development. The SHIP addresses six main health topic areas, one of which is to promote the health of mothers, infants and children.
- The Public Health and Safety Division Strategic Plan (PHSDSP) - the FCHB is a part of the PHSD and in September of 2013 it released a strategic plan to set the direction for strengthening its programs, services, and operations over the next five years. The development of the strategic plan was a collaborative effort involving expertise and input from Montana public health system stakeholders, employees throughout the Public Health and Safety Division, and its management team. Many of the goals and strategies within the PHSD Strategic Plan specifically address both national and state MCHBG performance measures.

The Needs Assessment Team made initial priority needs and performance measure selections based on *highest need, the ability of CPHDs to have an impact, and availability of data*. In addition, the methodology included considering if the need was an area of responsibility for the PHSD. Evaluation of all quantitative and qualitative input resulted in the selection of the following MCH priorities for Montana:

Montana's State Selected Priorities - Final Selection with Related Domains & Performance Measures		
Priority Health Need	Domain	Performance Measure
Family Support & and Health Education	Life Course / Cross-Cutting	SPM 2
Access to Care & Public Health Services	Life Course / Cross-Cutting, CYSHCN	NPM 12, SPMs 1 and 4
Immunization Rates	Perinatal & Infant, Children, Adolescent	SPM 3
Child Injuries	Perinatal & Infant, Children, Adolescent	NPM 7
Smoking in Pregnancy & Households	Life Course / Cross-Cutting	NPM 14
Breastfeeding Rates	Perinatal & Infant	NPM 4
Oral Health	Life Course / Cross-Cutting	NPM 13
Teen Pregnancy Prevention	Adolescent	NPM 10, SPM 5
Low-Risk Cesarean Deliveries	Women & Maternal	NPM 2
Infant Safe Sleep	Perinatal & Infant	NPM 5

For some priority needs the choice was also informed by rural geographic or minority American Indian population health disparities. In these cases, statewide data do not provide the whole description of need, i.e. when looking at the American Indian population alone, for teen fertility rates and infant mortality.

More detailed discussion and rationale for National and State performance measure selections can be found in sections “II.D.” and “II.E.”, which are dedicated to explaining the linkage of each with the state selected priorities.

The following table contains 40 potential priority needs, and a summary of the information used for consideration:

Montana's State Selected Priorities - Potential Priority Analysis  
**Potential Priority Areas\* with Consideration Summary** \*Shows selected as priority need for FYs 2016 - 2020 (# Identifies individual topics related to Family Support

Services)

Access to Care and Public Health Services*	Consistently identified as a continuing need, and all 56 counties have Health Professional Shortage Areas. Geographic health disparities make CPHD services especially critical for a large area of the state. Basis for new State Performance Measure 1. New priority for 2016-2020.
Alcohol, Tobacco and Drug Prevention	Received high unmet need ranking for both adolescents and women of childbearing age. However, <i>except for smoking</i> , these are better addressed by other divisions within DPHHS. SPM 1 will also provide support.
Birth Control and Family Planning	Received high unmet need ranking for both adolescents and women of childbearing age. However, except for teen pregnancy prevention, these are areas that are better addressed by other sections within DPHHS. SPM 1 will also provide support.
Breastfeeding*	There is a large geographic area of Montana without access to a Breastfeeding Peer Counselor, and the amount of infants breastfed exclusively through 6 months is only 19.3%. New priority for 2016-2020.
Child Care	Ranked very high as an unmet need for all but the Adolescent domain, but this is an area better addressed by other divisions within DPHHS. The referral area of SPM 2 will help to cover as well.
Coordination of Care	Ranked as a high unmet need for CYSHCN, it is being addressed through SPMs 2 and 4. It was not chosen for the final priority list due to the limit of 10.
Exercise/Physical Activity	Ranked as a high unmet need for children, it is better addressed by other programs within DPHHS. SPM 2 will also provide support.
Family Support Services*	Emerged very high as an increasingly unmet need, especially when considered in combination with other topics (shown by a #) that fit in the same area. This helps to address social determinants of health. SPM 2 incorporates this topic with health education. New priority for 2016-2020.
Financial Assistance#	See Family Support Services.
Health Education#	Combined with Family Support Services
Health Insurance#	See Family Support Services.
Immunization*	Ongoing need and most CPHDs face challenges from parents with vaccine hesitancy. Basis for new State Performance Measure 3. Continued priority for 2016-2020.
Infant and Child Mortality	Addressing through more targeted topic areas, i.e. Infant Safe Sleep and Child Injury Prevention. (New NPMs 5 and 7)
Infant Safe Sleep*	Part of targeted approach to infant mortality, and one of the focus areas for Montana's Infant Mortality ColIN. The new 2015 Health Survey of Montana's Mothers and Babies will provide baseline data. New priority for 2016-2020.
	Encompasses all causes of injury and death for ages 0-19 years. In FY 2015, almost 20% of CPHDs chose to address unintentional injury as their performance measure, and 51 reported on injury

Injury Prevention*	prevention activities. Continued priority for 2016-2020.
Low Birth Weight	Targeted through focused areas which are related, such as those covered by NPM 2, and SPMs 1,2,and 5.
Low-Risk Cesarean Deliveries*	The DPHHS Director created the Montana Prenatal Quality Collaborative for Reducing Early Elective Deliveries in 2014. Birth certificate data for 2008-2012 show approximately 17% of pre-term births annually were the result of induction or cesarean section. New priority for 2016-2020.
Maternal Mortality	Not an area of high need, and is being addressed by local FICMMR Teams.
Medical Home	Ongoing need for CYSHCN, it is being addressed through SPM 4. It was not chosen for the final priority list due to the limit of 10.
Meeting Developmental Markers	Ranked high as an unmet need for children with and without special health care needs. It is being addressed by the more focused priority areas covered by NPM 2 and SPM 2.
Mental Health	Received high unmet need ranking for all domains except infants. However, it is better addressed by other divisions within DPHHS. SPMs 1 and 2 will also provide support.
Motor Vehicle Deaths	Covered under the injury prevention area.
Newborn Screening	Very important ongoing function. Process is well handled by CSHS and the PHSD Laboratory.
Nutrition#	Ranked as a high unmet need for infants, children and adolescents. Addressed by SPM 2 through health education, and by the WIC program. Not chosen for the final list due to the limit of 10.
Obesity#	Ranked as a high unmet need for children, adolescents and women of childbearing age.. Addressed by SPM 2 through health education. Not chosen for the final list due to the limit of 10.
Oral Health*	Ranked high as an unmet need for children. FCHB priority area with long-term effects over the life course. Also supported by SPM 1. Continued priority for 2016-2020, with NPM 13.
Parental Relationship#	Ranked high as an unmet need for infants and adolescents. Addressed as a part of Family Support Services & Health Education
Parenting Education#	Ranked high as an unmet need for adolescents and women of childbearing age. Addressed as a part of Family Support Services & Health Education, and also by NPMs 5, 7 and 14.
Preconception Health	The only priority need from the 2011-2015 Needs Assessment which is being replaced. It is a component of several other topic areas.
Prenatal Care	Ranked as a high need for women of childbearing age. Addressed by NPM 2 and SPM 1. Not chosen for the final list due to the limit of 10.
Reproductive Health Services	Ranked as a high need for adolescents. Addressed through SPMs 1 and 8. Not chosen for the final list due to the limit of 10.
Safe Home Environment#	Ranked as a high unmet need for infants and children. Addressed as a part of Family Support Services & Health Education, along with NPMs 5,7 and 14.
	High priority area for the PHSD, with long-term effects over the life

Smoking: Pregnancy and Household*	course. In 2014, approximately 30% of primary caregivers enrolling in home visiting reported smoking. Continued priority for 2016-2020, with NPM 14.
Specialty Health Care Services	Ranked as a high unmet need for CYSHCN, it is being addressed through the CSHS regional clinics, and CPHD referral requirements. It was not chosen for the final priority list due to the limit of 10.
STD/STI Education and Prevention#	Ranked as a high unmet need for adolescents and women of childbearing age. Addressed through SPM 2 and the Title X contractors. Not chosen for the final list due to the limit of 10.
Suicide	See Mental Health - Montana has a special state-level Suicide review team.
Teen Pregnancy Prevention*	High priority for the PHSD, and of concern as a minority health disparity area. Addressed through SPMs 1 and 2, and through the Title X contractors. New priority for 2016-2020.
Transition Services	A high priority for CSHS, which has a State Implementation Grant to help with support of transition services. Not chosen for the final list of state priorities due to the limit of 10. However, NPM 12 was chosen to fulfill the requirement of a national performance measure for the CYSHCN domain.
Violence / Bullying	Addressed through more targeted topic areas, i.e. NPM 7 and SPM 2.
Women's Health Services	Ranked as a high unmet need for women of childbearing age. Addressed through SPMs 1 and 5. Not chosen for the final list due to the limit of 10.

## II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 2 - Percent of cesarean deliveries among low-risk first births
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 5 - Percent of infants placed to sleep on their backs
- NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
- NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
- NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Montana's priority health needs selection was determined from the results of the 5-Year statewide Needs Assessment, and each identified concurrently with relevant performance measures. Criteria were established from guidance provided by HRSA. Of the ten priority needs chosen, eight have clear links to National Performance Measures (NPMs).

Montana's State Selected Priorities with Related National Performance Measures		
Priority Health Need	Domain	NPM #
Low-Risk Cesarean Deliveries	Women & Maternal	2
Breastfeeding Rates	Perinatal & Infant	4
Infant Safe Sleep	Perinatal & Infant	5
Child Injuries	Perinatal & Infant, Children, Adolescent	7
Teen Pregnancy Prevention	Adolescent	10
Access to Care & Public Health Services	Life Course / Cross-Cutting, CYSHCN	12
Oral Health	Life Course / Cross-Cutting	13
Smoking in Pregnancy & Households	Life Course / Cross-Cutting	14

The following is the rationale for each NPM choice:

**NPM 2 – Low-Risk Cesarean Deliveries:** reduce number of cesarean deliveries among low-risk first births.

*Rationale - The Montana Prenatal Quality Collaborative (MPQC) was created in 2014, to address the DPHHS Director's priority for reducing Early Elective Deliveries. Birth certificate data for 2008-2012 show approximately 17% of pre-term births annually were the result of induction or cesarean section.*

Montana's State Health Improvement Plan includes the goal to decrease the proportion of pre-term births from 9% to 7% by 2018 through PHSD and DPHHS program strategies. Also, Montana's Infant Mortality Collaborative Improvement & Innovation Network (IM ColIN) team is playing a pivotal role in developing and maintaining public and private organization partnerships, which aim to promote a 39 week gestational period. IM ColIN members include: representation from the MPQC and Indian Health Services; the Montana Tobacco Use Prevention Program Coordinator; and the Fetal, Infant, Child and Maternal Mortality Review (FICMMR) Coordinator.

All mothers who delivered during calendar year 2015 will be asked to complete the Health Survey of Montana's Mothers and Babies 2015, which is modeled on the CDC Pregnancy Risk Assessment Monitoring System (PRAMS). The survey is a collaborative effort with the FCHB, Office of Epidemiology and Scientific Support, and Montana HealthCare Foundation. It will provide additional data on low-risk mothers having cesarean deliveries. This data will also be used for developing and distributing targeted messages, in areas with a greater rate of low-risk cesarean deliveries.

**NPM 4 – Breastfeeding:** a) percent of infants ever breastfeed and b) percent exclusively through 6 months.

*Rationale - There is a large geographic area of Montana without access to a Breastfeeding Peer Counselor, and the amount of infants who are breastfed exclusively through 6 months is only 19.3%. Increasing breastfeeding rates has a proven health benefit towards helping infants and children to thrive.*

*WIC has discussed possible ways to expand the BPCP coverage across the state. NAPA's Montana Baby Friendly Hospital Initiative includes ten sites working to reach Baby Friendly status. Local WIC agencies near the sites are encouraged to collaborate with them to reach that status. With the assistance of an infrastructure grant, the FCHB is planning to increase the number of Certified Lactation Counselors (CLCs) available as WIC employees, and to address the shortage of such individuals statewide. The grant was developed with the goal of training 20 additional staff. Priority will be given to local program Breastfeeding Coordinators who have not yet received this training.*

*The Montana Breastfeeding Peer Counselor Program is working to add another local program in 2016. If negotiations are successful, an existing program will expand to provide services to a neighboring local agency. Planning includes providing some services via distance delivery. Using alternate methods such as phone or iPad will greatly increase outreach.*

**NPM 5 – Infant Back to Sleep:** increase number of infants placed to sleep on backs.

*Rationale - Montana is participating in the AMCHP/NICHQ/HRSA sponsored Infant Mortality Collaborative Improvement and Innovation Network (IM ColIN). IM ColIN members include several from the FCHB, the MT Tobacco Use Prevention Program Coordinator, Indian Health Services, the Medicaid Health Reform Specialist, the Medicaid EPSDT Nurse Consultant, and the FICMMR Program Coordinator. Safe Sleep is one of the Health Learning Networks that the team is participating in. The IM ColIN team will play a pivotal role in developing and maintaining public and private organization partnerships, and promoting the action plans developed for Safe Sleep.*

*All mothers who deliver during calendar year 2015 will be asked to complete the Health Survey of Montana's Mothers and Babies, which is modeled on the CDC Pregnancy Risk Assessment Monitoring System (PRAMS). The survey, a collaborative effort with the FCHB, OESS, and the Montana HealthCare*

*Foundation, will provide additional data on safe sleep practices. Along with data collected by local FICMMR teams, which is entered into the Child Death Review (CDR) Reporting System, it will be used for developing and distributing targeted messages.*

*The state FICMMR Program Coordinator will be leading a CDR quality improvement initiative, which focuses on 21 CDR Sections that are of critical importance for local teams to accurately complete. Those sections include sleeping or sleep environment. The Coordinator will also be implementing a back to sleep program.*

**NPM 7 – Child Injuries:** rate of injury-related hospital admissions per ages 0 – 19 years.

*Rationale - Encompasses all causes of injury and death for ages 0-19. In FY 2015, almost 20% of county public health departments (CPHDs) chose to address unintentional injury as their performance measure, and 51 reported on injury prevention activities.*

*The State Health Improvement Plan's Section D is focused on preventing injuries and exposures to environmental hazards. The state action plan will reflect strategies from the SHIP and the PHSD Strategic Plan. These include increasing awareness of injury prevention, implementing evidence-based programs to facilitate injury prevention, and providing training and technical assistance to schools and childcare settings.*

*Initial FCHB activity involves the MCH Epidemiologist, who will assess the primary causes of injury-related hospital admissions. The assessment results will yield information for identifying specific public and private subject matter experts with whom to partner, for creating strategy and outcome measures in a detailed action plan.*

**NPM 10 – Adolescent Preventive Care:** increase number ages 12 – 17 who have annual preventive services visit.

*Rationale – Many areas that ranked high as unmet needs on the 5-Year Needs Assessment surveys have to do with adolescent health. NPM 10 is a way to target many of these that are not covered by other performance measures. These categories include: substance abuse, reproductive health and education, mental health, nutrition and weight, and STD/STI prevention and education.*

*NPM 10 also helps put emphasis on a number of risky adolescent behaviors, some of which are addressed in the SHIP. Section E. focuses on improving mental health and reducing substance abuse in adolescents and adults. It includes decreasing the proportion of youth who report using alcohol in the past 30 days from 38% to 34%; decrease the proportion of youth who report having smoked marijuana in the past 30 days from 21% to 18%; and decrease the proportion of youth who report being depressed for 2 or more consecutive weeks in the past 12 months and stopped doing usual activities from 25% to 22%.*

*While the PHSD does not have a dedicated adolescent health FTE, various sections have funding for programs that target different aspects of adolescent health. NPM 10 will help provide a clearinghouse, to gather information and give each program an overall awareness of these different activities.*

**NPM 13 – Oral Health:** a) percent of women who had a dental visit during pregnancy and b) percent ages 1 – 17 with annual preventive dental visit.

*Rationale – Oral Health meets the criteria for both geographic and minority health disparities in Montana. Thirty-four counties have Health Professional Shortages Areas for dental care and the rate of preventive visits for ages 0-17 has stayed constant at about 76.6 percent since 2007. Also, approximately 6% of Montana’s population is American Indian and this group has a high incidence of dental disease.*

*Collection of dental sealant surveillance data began in February 2014, in collaboration with the Montana Dental Association, Montana Dental Hygienists’ Association and Sealants for Smiles; through a Basic Screening Survey (BSS) of 3rd grade children. The Oral Health Program (OHP) Coordinator has continued to develop the oral health surveillance system, and data collection includes the incidence of dental sealants among Medicaid-enrolled children and BSS prevalence data. The data collection will be utilized to foster program evaluation and future planning, and analysis will help to address disparities.*

*The OHP will continue to build capacity, by increasing the awareness of the impact of oral health on overall health. Outreach during FY 2015 offered an opportunity to begin collaboration with other Montana DPHHS programs and public health stakeholders, to integrate oral health promotion. The recently developed Montana Oral Health Surveillance System also includes data on the proportion of Medicaid-enrolled pregnant women that receive dental services. A communication plan includes outreach to obstetric providers with Centers for Medicare and Medicaid Services print materials to increase the proportion from the FY 2014 baseline of 20%. The OHP will continue to seek additional resources for structured programming focused on pregnant women.*

*All mothers who delivered during calendar year 2015 will be asked to complete the Health Survey of Montana’s Mothers and Babies 2015, which is modeled on the CDC Pregnancy Risk Assessment Monitoring System (PRAMS). It will provide additional data on the percent of women who had a dental visit during pregnancy.*

**NPM 14 – Pregnancy and Household Smoking:** a) percent of women who smoke during pregnancy and b) percent of children living in household where someone smokes

*Rationale - High priority area for the PHSD and in the SHIP, with long-term effects over the life course. In Section A of the SHIP two health indicator goals for 2018 are: 1) Decrease the average consumption of cigarettes in Montana from 58 to 52 packs per person per year, and 2) Decrease the proportion of youth who report they have smoked cigarettes in the past 30 days from 17% to 14%. An indicator goal in Section B is: Decrease the proportion of women who report they smoke during pregnancy from 16% to 12%.*

*Two components of the services that are provided in several home visiting models are tobacco use assessment, and referral to cessation resources as needed. Clients who use tobacco are referred to cessation services if appropriate. The Montana Tobacco Use Prevention Program (MTUPP) is a partner in providing cessation support for pregnant and post-partum women, and provides training as needed. In 2014, approximately 30% of primary caregivers enrolling in home visiting reported smoking.*

*All mothers who delivered during calendar year 2015 will be asked to complete the Health Survey of Montana’s Mothers and Babies 2015, which is modeled on the CDC Pregnancy Risk Assessment Monitoring System (PRAMS). It will provide additional data on the percent of women who smoked during pregnancy.*

National Outcome Measures (NOM) which link to Montana’s state selected priorities and National Performance Measure choices are:

- NPM 2 = NOMs 4.1-4.3, 5.1-5.3, 6 and 7
- NPM 4 = NOM 9.5
- NPM 5 = NOMs 9.1-9.3, and 9.5
- NPM 7 = NOMs 15, and 16.1-16.2
- NPM 10 = NOMs 19, and 22.2-22.5
- NPM 12 = NOM 17.2
- NPM 13 = NOMs 14 and 19
- NPM 14 = NOMs 2, 4.1-4.3, 5.1-5.3, 6, 8, 9.1-9.5, and 19

## II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 1 - Access to Care and Public Health Services
- SPM 2 - Family Support and Health Education
- SPM 3 - Immunization
- SPM 4 - CYSHCN Medical Home
- SPM 5 - Teen Pregnancy Prevention

### Linkage of Montana's MCHBG 2016-2020 State Selected Priorities with State Performance Measures

Montana's priority health needs selection was determined from the results of the 5-Year statewide Needs Assessment, and each identified concurrently with relevant performance measures. Criteria were established from guidance provided by HRSA. Of the ten priority needs chosen, four have clear links to State Performance Measures (SPMs).

Montana's State Selected Priorities with Related State Performance Measures		
Priority Health Need	Domain	SPM #
Access to Care & Public Health Services	Life Course / Cross-Cutting, and CYSHCN	1 and 4
Family Support & Health Education	Life Course / Cross-Cutting	2
Immunization Rates	Perinatal & Infant, Children, Adolescent	3
Teen Pregnancy Prevention	Adolescent	5

State Performance Measures (SPMs) were developed to address priorities not covered by any of the National Performance Measures. SPM 1 and SPM 2 were created new as a result of emerging trends, and were not available in previous years as either a national or state performance measure. Here is a description of all five SPMs, along with the data source:

**SPM 1 - Access to Public Health Services:** Number of clients' ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 2,000 or less. (County public health departments report on state provided form.)

*Rationale - Access to Care issues were consistently identified as a continuing health care need on the Needs Assessment Surveys and Key Informant Interviews. Montana faces a large geographic health disparity. Access to Care is a fundamental action area in five sections of the State Health Improvement Plan (SHIP), and one section is focused on strengthening the public health and health care system. It is also integral to Key Results Area 3 of the Public Health and Safety Division Strategic Plan (PHSDSP).*

**SPM 2 – Family Support and Health Education:** Number of clients' ages 0 – 21, and women ages 22 – 44 who are assessed for social service and health education needs; and then are placed into a referral and follow-up system, or provided with health education as needed. (County public health departments report on state provided form)

*Rationale - During the needs assessment process, family support and parental education emerged as essential services which are increasingly unmet; and as a having a major effect on the health of the whole MCH population, especially ages 0 to 19. Numerous strategies in the SHIP and PHSDSP address working to improve outreach in this area.*

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

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

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

*Rationale – Montana’s rural population and vast distances create unique challenges to serving children and youth with special health care needs and their families. It was decided that a performance measure that focused specifically on medical home solutions for this population was needed, along with the use of state generated data.*

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

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

## II.F. Five Year State Action Plan

### II.F.1 State Action Plan and Strategies by MCH Population Domain

#### Women/Maternal Health

##### State Action Plan Table

###### State Action Plan Table - Women/Maternal Health - Entry 1

###### Priority Need

Low-Risk Cesarean Deliveries

###### NPM

Percent of cesarean deliveries among low-risk first births

###### Objectives

To decrease the number of low-risk cesarean deliveries among first births to 21.5% by 2021.

###### Strategies

Ongoing strategies, in addition to the new ESM are: 1) Montana's Infant Mortality (IM) Collaborative Improvement & Innovation Network (CollIN) team plays a pivotal role in developing and maintaining public and private organization partnerships, which aim to promote a 39 week gestational period. 2) The Maternal Mortality Review (MMR) Work Group continues meeting in to review the local FICMMR team's maternal mortality review case reports, which are submitted to the State FICMMR Coordinator. Montana's maternal death rate averages about 12 deaths per year. In the coming years, the MMR Work Group will have the opportunity to develop maternal prevention recommendations using the information from the maternal mortality review case reports.

###### ESMs

ESM 2.1 - Understanding Pregnant Women's Cesarean Knowledge & Usage

## NOMs

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

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

## Measures

### NPM 2 - Percent of cesarean deliveries among low-risk first births

#### Annual Objectives

	2016	2017	2018	2019	2020	2021
Annual Objective	24	23.5	23	22.5	22	21.5

Data Source: National Vital Statistics System (NVSS)

#### Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	26.4 %	0.7 %	1,060	4,019
2013	24.9 %	0.7 %	1,013	4,066
2012	26.1 %	0.7 %	1,081	4,136
2011	24.9 %	0.7 %	1,013	4,066
2010	25.3 %	0.7 %	1,021	4,030
2009	24.2 %	0.7 %	1,034	4,277

#### Legends:

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

### ESM 2.1 - Understanding Pregnant Women's Cesarean Knowledge & Usage

#### Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

## Women/Maternal Health - Plan for the Application Year

Please see the FFY 2015 report section for background narrative on this domain through 9/30/15 -

Montana's Women and Maternal Health domain performance measure for FFYs 2016 – 2020 is:

- NPM 2 – Low-Risk Cesarean Deliveries

The following narratives contain current activities and upcoming plans –

### **NPM 2 – Low-Risk Cesarean Deliveries: reduce number of cesarean deliveries among low-risk first births.**

The Perinatal Quality Collaborative (PQC), established in January 2013, continued their work of supporting hospitals in reducing elective deliveries that occur before 37 weeks gestation. The PQC is based on a national model which: engages statewide stakeholder organizations, hospital leadership, physicians, and peer review. The PQC supports policies which are intended to ensure that induced or cesarean section deliveries, before 37 weeks, are medically indicated.

As of July 1, 2014, Montana Medicaid birthing facilities were required to have an elective deliveries “hard-stop policy” in place. The policy includes:

- Non-medically necessary inductions, or any C-sections prior to 37 weeks;
- Confirmation of gestational age;
- A multi-step review process for all inductions and C-sections, including that the final decision must be made by the Perinatology or Obstetrics Chair.

As of October 1, 2014, Montana Medicaid reduced reimbursement rates for any non-medically necessary inductions or C-section prior to 37 week. During FFY 2016, Medicaid analyzed hospital claims data to assess the rate of elective deliveries. The rate fell from 4.6% in 2012 to 0.5% as of February 2016.

Information learned at the July 2014 CoINN Meeting was integrated into Montana's PQC work plan as well as shared with other programs serving families. These programs include the sites providing home visiting services, as well as other maternal and child health services such as immunization and WIC.

The Healthy Montana Families Home Visiting sites, funded with state funding and/or federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding, continued to implement their selected home visiting model. The home visiting sites provided relevant training and information regarding healthy pregnancies and delivery with clients that were enrolled prenatally. 630 women have been enrolled prenatally since the program began providing services.

Nineteen new sites (and 15 new contractors) implemented evidence-based home visiting with federal MIECHV Expansion funds. These new sites followed the same guidelines and provided the same level of service as the existing sites. The total caseload capacity for the existing and new contractors was approximately 1000 clients. Programs implementing Nurse-Family Partnership enrolled women during pregnancy. 124 women were enrolled in NFP during FFY 2015. Parents As Teachers, SafeCare Augmented and Family Spirit enrolled families with young children in addition to pregnant women. If caregivers were already enrolled as a client and became pregnant while enrolled, the home visitor asked whether they wanted to enroll as a pregnant client and focus home visits on the pregnancy.

## Women/Maternal Health - Annual Report

**Background Narrative - Information Submitted for July 2015 Report:** (The only FFY 2015 performance measure for Montana which fits into the Women/Maternal Health Domain is State Performance Measure 3 - Gestational Diabetes: blood glucose measured postpartum.)

### Gestational Diabetes

In FY 2014, the Montana Diabetes Program continued to distribute gestational diabetes mellitus (GDM) patient education materials, in the form of magnets and flyers, upon request. 1,345 magnets were distributed to 71 health care facilities. To evaluate this outreach, a survey was developed and conducted with the health care and public health professionals who requested these materials. Analysis of the responses is not yet complete, but the results will guide the future direction of the project. The survey assessed:

- percentage of women with GDM at the health care facility
- time spent educating women diagnosed with GDM
- average number of monthly postpartum blood glucose screenings
- monthly number of referrals to the Diabetes Prevention Program
- monthly number of referrals to Diabetes Educators or Dietitians
- percentage or number of materials used or distributed by the health care facility to women with GDM
- helpfulness of the materials in their practice
- how the materials could be more helpful

Data was also collected from the 18 Montana Diabetes Prevention Program sites on the number of women that the program has enrolled with a history of GDM, or who had delivered a baby over 9 pounds, to determine whether the participation in the program has increased for this population.

The Montana Diabetes Program staff present information on this work during networking calls, called Communities of Practice, with other state diabetes programs funded by the Centers for Disease Control and Prevention. Current and past activities as well as lessons learned are shared, in particular with Alaska, Arkansas, Colorado, Idaho, North Dakota, Oregon, South Dakota, and Utah.

The Montana Diabetes Program staff and their conference planning committee have invited Dr. Debra Guinn to speak on GDM, and diabetes during pregnancy, at the Annual Montana Diabetes Professional Conference in October 2015. Speaker arrangements and presentation content are currently being planned.

The Montana Diabetes Program staff is making plans to conduct a re-analysis of Medicaid claims data and Montana birth records data to see if the rate of postpartum testing for diabetes has increased, as a measure of quality improvement in adhering to the clinical practice guidelines. These data would be compared to the outcomes published in November 2011, which used 2008-2009 data. The program plans to work with Medicaid to get this postpartum diabetes screening test covered, as part of the care provided to women who had been enrolled in Medicaid during their pregnancy, and also had a diagnosis of gestational diabetes mellitus. It is believed that this policy change will reduce financial barriers and help increase the number of these women who are screened for diabetes.

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### **FFY 2015 Report Updates:**

Montana Diabetes Program staff distributed Gestational Diabetes Mellitus (GDM) patient education materials (magnets and flyers) upon request. To evaluate this outreach, survey results were collected from the health care facilities which requested them, in each of the two years of the project.

Data was gathered from Diabetes Prevention Program (DPP) sites, from 2008-2015, on the number of women the program enrolled with a history of GDM and/or who had delivered a baby over 9 pounds (255). This was done to determine whether participation in the program has increased for this population. In 2015 the DPP data was analyzed from 2008-2014, and an abstract and data table was submitted to the American Diabetes Association 76<sup>th</sup> Scientific Sessions in 2016.

This project was also presented during networking calls, facilitated by the National Association of Chronic Disease Directors' Diabetes Council, with other state diabetes programs funded by the Centers for Disease Control and Prevention. Current and past activities, as well as lessons learned, were shared in particular with Alaska, Arkansas, Colorado, Idaho, North Dakota, Oregon, South Dakota, and Utah.

The DPP worked with Montana Medicaid to have the postpartum diabetes screening test covered, as part of care provided to women enrolled in Medicaid during their pregnancy who also had a diagnosis of GDM. This policy change has the potential to reduce financial barriers and increase the number of women with GDM who are screened for diabetes. In October 2014, the program proposed policy changes to Montana Medicaid for covering Medical Nutrition Therapy (MNT) for women with GDM, which is one of the most effective uses of MNT and promoting good outcomes for both mother and baby. The proposal was revised and discussed throughout the project year.

Data summaries on diabetes and pregnancy-associated hypertension were provided to the DPP in October 2014 by the Women's and Men's Health Section within Montana DPHHS. Data were preliminary, and showed that pregnant women with diabetes (either GDM or another form) have an increased risk of developed gestational hypertension.

Dr. Debra Guinn, a maternal fetal medicine specialist in MT, was invited to speak about GDM and diabetes during pregnancy to the 153 attendees at the Annual Montana Diabetes Professional Conference. Dr. Guinn prepared learning objectives for the educational activity, which were 1) identify and be able to review diagnostic criteria for GDM and diabetes and 2) analyze nutritional therapy interventions and outcomes for women with diabetes during pregnancy. Continuing education credits were available.

DPP staff are preparing to conduct a re-analysis of Medicaid claims and Montana birth records data, to see if the rate of postpartum testing for diabetes for women with GDM with live births from 2013-2014 has increased. The goal is to conduct a 5-year follow-up, analyze the data, and publish in November 2016. This is a measure of quality improvement in adhering to clinical practice guidelines. These data will be compared to the outcomes published in November 2011, which analyzed the rate of postpartum testing for diabetes for women with GDM with live births from 2008-2009.

## Perinatal/Infant Health

### State Action Plan Table

#### State Action Plan Table - Perinatal/Infant Health - Entry 1

##### Priority Need

Infant Safe Sleep

##### NPM

Percent of infants placed to sleep on their backs

##### Objectives

Increase the number of infants who are placed to sleep on their backs to 75% by 2021.

##### Strategies

Ongoing strategies in addition to the new ESM are: 1) Work by the IM CoIIN in developing and maintaining public and private organization partnerships, which have a strong focus on providing public education regarding infant safe sleep, and implementing back to sleep programs. 2) The FICMMR Coordinator continues to lead CDR quality improvement initiatives, which focus on CDR sections of critical importance for local teams to complete accurately. One of these sections is sleeping or sleep environment.

##### ESMs

ESM 5.1 - Understanding Caregiver's Infant Safe Sleep Knowledge & Practices

##### NOMs

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

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

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

## State Action Plan Table - Perinatal/Infant Health - Entry 2

### Priority Need

Breastfeeding Rates

### NPM

A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

### Objectives

Increase the percent of infants who are ever breastfed to 93% by 2021, and the percent of infants breastfed exclusively through 6 months to 21.3% by 2021.

### Strategies

Ongoing strategies, in addition to the new ESM are: 1) Use USDA/WIC infrastructure grant funding to increase the number of IBCLCs available as WIC employees, to address the shortage of such certified individuals. Other funds from the grant are planned for use in a more extensive Breastfeeding Learning Collaborative, partnering with the NAPA Program, with expanded dates and presenters. Also, for the development of a toolkit for local program staff to use to build relationships with local hospitals and staff in the promotion and support of breastfeeding. 2) WIC will continue to provide breastpumps to participants who meet the criteria found in the State Plan policy addressing breastpumps. Work is underway and will continue to develop methods of coordination with Medicaid in the provision of breastpumps.

### ESMs

ESM 4.1 - County Public Health Department's MCHBG Breastfeeding Collaborative

### NOMs

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

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

**Measures**

**NPM-4 A) Percent of infants who are ever breastfed**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	91.5	91.8	92.0	92.3	92.6	93.0

**Data Source: National Immunization Survey (NIS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	86.2 %	3.4 %	8,494	9,852
2011	91.2 %	2.3 %		
2010	90.3 %	1.9 %		
2009	85.1 %	2.9 %		
2008	82.2 %	2.4 %		
2007	84.9 %	2.3 %		

**Legends:**

-  Indicator has an unweighted denominator <50 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

**NPM-4 B) Percent of infants breastfed exclusively through 6 months**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	19.6	20.0	20.3	20.6	21.0	21.3

Data Source: National Immunization Survey (NIS)

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2012	26.7 %	4.1 %	2,593	9,701	
2011	19.3 %	3.1 %			
2010	21.6 %	3.3 %			
2009	23.6 %	3.3 %			
2008	21.1 %	2.4 %			
2007	21.4 %	2.4 %			

**Legends:**

- 🚫 Indicator has an unweighted denominator <50 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**ESM 4.1 - County Public Health Department's MCHBG Breastfeeding Collaborative**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	80.0	82.0	84.0	86.0	88.0

**NPM 5 - Percent of infants placed to sleep on their backs**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	50	55	60	65	70	75

**FAD not available for this measure.**

**ESM 5.1 - Understanding Caregiver's Infant Safe Sleep Knowledge & Practices**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

**Perinatal/Infant Health - Plan for the Application Year**

**Please see the FFY 2015 report section for background narrative on this domain through 9/30/15 -**

Montana's Perinatal and Infant Health domain performance measures for FFYs 2016 – 2020 are:

- NPM 4 – Breastfeeding
- NPM 5 – Safe Sleep

The following narratives contain current activities and upcoming plans –

**NPM 4 – Breastfeeding: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months**

The request for new applicants for a Montana Breastfeeding Peer Counselor Program (BPCP) for FFY 2017 was sent out in April 2016. Three local programs expressed interest, HRDC Region 6, Lincoln Community Health and Teton Region. Only Teton completed the application and will begin a program in FFY2017. The 11 existing programs have been encouraged to develop relationships and agreements for expansion of coverage of BPCP services through distance delivery (phone, texting, iPad FaceTime or WebEx) to other smaller local WIC program regions.

While 76% of WIC pregnant and breastfeeding participants have access to a Breastfeeding Peer Counselor (BPC), there is a large geographic area of Montana that is lacking coverage (mainly in North Central, North Eastern and Eastern Montana, along with six of the seven reservations). In addition, for many of these areas there are no other breastfeeding support services available. The area includes very little population and/or great distances to services.

The ability to provide breastfeeding support in an alternate method, such as phone or iPad, to these low population areas would greatly increase their resources. An existing BPCP would receive funding to provide services to the extended area, along with the funds for services to their existing areas. They could expand their BPC hours, with the result of being available to both areas for a larger number of hours.

A Breastfeeding Infrastructure Grant was received from the USDA in the fall of 2015, and has or been used to send a large number of local and state WIC staff to various breastfeeding related trainings:

- In October 2015, 13 local staff were sponsored to attend the Breastfeeding Education Conference in Missoula with registration, travel and per diem;
- Twelve local staff are attending an upcoming Certified Lactation Counselor and Loving Support training;
- The 2016 WIC Spring Meeting and Breastfeeding Learning Collaborative had 110 local staff in attendance. The Montana WIC Program sponsored: "Supporting Parents Who Pump Breastmilk" by Dawn Gordon-Wilcox, IBCLC; UC Davis Baby Behaviors speaker Jennifer Banuelos; and Dr. Bobby Ghaheri an Ear, Nose and Throat specialist, presenting two sessions related to breastfeeding and tongue-tie;
- Thirty-two local staff will be attending the National WIC Association Nutrition and Breastfeeding Conference in Denver in September;
- Five local staff will be attending the Minnesota Maternal Nutrition Intensive Course in Minneapolis later in July;
- Four local staff are expected to attend the United States Breastfeeding Committee Conference in Arlington in August;
- Two local staff will be attending a Certified Lactation Specialist training in Billings (different from the Certified Lactation Counselor training); and,

- Two state staff and two to three local staff plan to attend the Loving Support Train-the-Trainer Update in August 2016.

A toolkit is currently being developed to help local program staff to build relationships with local hospitals and staff, for promotion and support of breastfeeding. It is expected to be complete within this FFY, and will be distributed to local WIC programs. After a year of availability it will be re-evaluated.

Breastpumps continue to be provided to WIC participants meeting the criteria in the State Plan policy addressing breastpumps. Work is underway, and will continue, to develop methods of coordination with Medicaid in the provision of breastpumps.

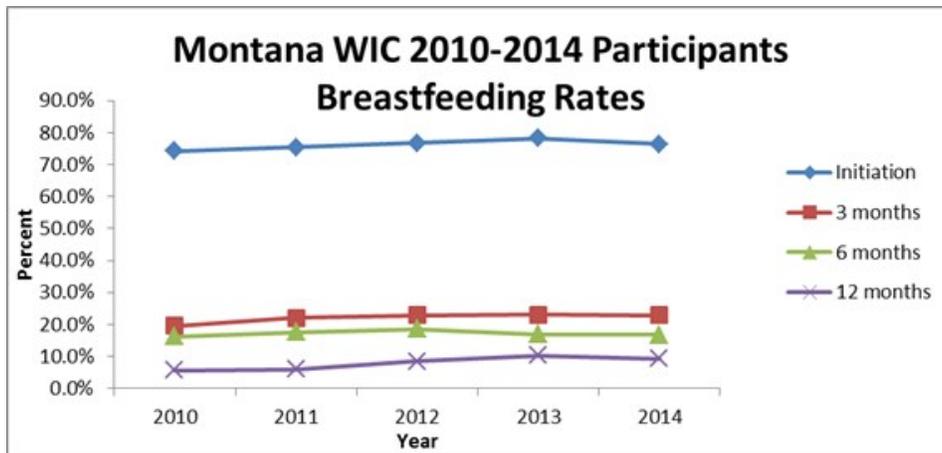
Another USDA infrastructure grant application was submitted and approved for 2016 and 2017. It contains a small request to continue support for breastfeeding and nutrition trainings. Potential conferences include: the National WIC Association's Annual Conference; the Pediatric Nutrition Practice Group Conference; the Academy of Nutrition and Dietetics Food and Nutrition Conference and Expo; and, if available in Montana, Certified Lactation Consultant training. The state WIC Program may also use a portion to sponsor speakers for an annual conference.

A partnership with the Nutrition and Physical Activity Program (NAPA), on the Breastfeeding Learning Collaborative, is continuing into next year. Many of the hospitals involved in their Baby Friendly Hospital Initiative have obtained designation. The first hospital under NAPA's Baby Friendly Hospital Initiative to complete the process was St. Peter's Hospital in Helena, in April 2016.

Montana now has three Baby Friendly facilities: Anaconda Community Hospital in Anaconda, Blackfeet Community Hospital in Browning (contract Indian Health Service) and St. Peter's Hospital in Helena. Six other hospitals are in the designation phase: Marcus Daly Hospital in Hamilton, Glendive Medical Center in Glendive, Central Montana Medical Center in Lewistown, Barrett Hospital and Healthcare in Dillon, Livingston HealthCare in Livingston and Community Medical Center in Missoula. There are 4 hospitals or health centers in the Dissemination Phase: Bozeman Deaconess Hospital in Bozeman, The Birth Center in Missoula, North Valley Hospital in Whitefish, and St. Vincent Healthcare in Billings. Northern Montana Health Care in Havre is in the Development Phase.

Work on an updated Breastfeeding Surveillance Report for 2010-2014 is in process. Estimated date of publication is in August 2016, in conjunction with World Breastfeeding Week. The 2014 breastfeeding data shows a slight downturn for initiation, and of fully breastfeeding infants. However, breastfeeding among 3, 6 and 12 month old infants who were breastfeeding "some" increased in 2014. Local WIC programs of a medium-size, with a BPCP, had higher rates of breastfeeding at initiation, and at 3, 6, and 12 months than those who did not have a program.

Data about childhood obesity among WIC participants will be released this fall. Preliminary data indicates that infants who were breastfed have substantially lower rates of obesity from ages 2-4. While the percent shows an increase in correlation with age of these infants, they still remain below the percentages for those with limited and no breastfeeding. The 27 local programs received breastfeeding, childhood obesity and hematological data specific to their program, during the 2016 WIC Spring Conference and Breastfeeding Learning Collaborative's session on data. They could use this data along, with other breastfeeding data provided, to develop their Nutrition Plans and Breastfeeding Plans for 2017.



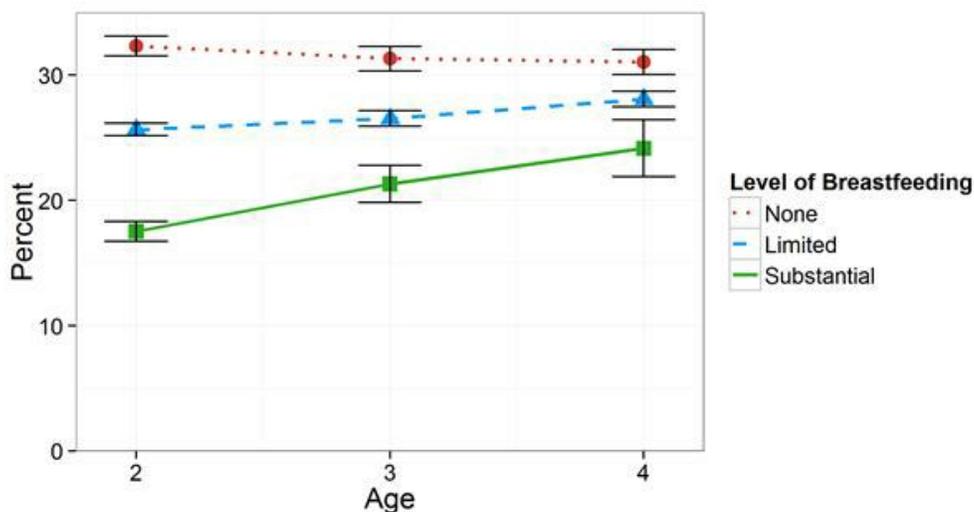
Montana WIC participant's fully breastfeeding rates by year.

	Peer Counselor	No Peer Counselor	P-value
Initiation	79.1% (5,244)	59.1% (4,121)	$2.8 \times 10^{-8}$
3 months (fully)	22.5% (4,608)	13.8% (3,805)	$< 2.2 \times 10^{-16}$
6 months (fully)	17.5% (4,839)	11.4% (3,930)	$1.6 \times 10^{-15}$
12 months (fully)	8.3% (4,779)	5.2% (3,884)	$2.7 \times 10^{-8}$

Medium sized agency breastfeeding comparisons for agencies with and without a peer counselor (with sample size in parentheses). The Montana WIC Program definition of a medium size local agencies is one with average monthly participation between 301 and 1,000.

### Overweight and Obesity Rates by Breastfeeding

Montana WIC 2011-2015



Montana WIC 2-4 year old weight category rates by initiation of breastfeeding. Black bars indicate standard error bars. Substantially breastfeeding is defined by the Montana WIC Program as the infant receiving approximately less than half of the maximum allowable infant formula for the month while still breastfeeding. Limited breastfeeding is defined by the Montana WIC Program as the infant receiving approximately more than half of the maximum allowable infant formula for the month while still breastfeeding.

### NPM 5 - Safe Sleep: Percent of infants placed to sleep on their backs.

Montana participated in the AMCHP/NICHQ/HRSA sponsored Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN). IM CoIIN members include: the MT Tobacco Use Prevention Program Coordinator, the Medicaid Health Reform Specialist, the Medicaid EPSDT Nurse Consultant, the Healthy Mothers/Healthy Babies Representative, and FCHB Staff including the FICMMR Coordinator, MCH Section Supervisor, MCH Epidemiologist, and the CSHS and Title X Nurse Consultants. The team is participating in the Smoking Cessation, Safe Sleep, and Preconception/Interconception Health Learning Networks, which allows the members access to a multitude of resources located on the IMCoIIN NICHQ website, and participation on topic specific webinars.

The team is focusing on the Smoking Cessation plan, which supports the State Health Improvement Plan (SHIP), developed by the PHSD. The SHIP includes two related goals to the IM CoIIN activities: 1) by 2018 decrease the proportion of women who report they smoke during pregnancy from 16% to 12%; and 2) increase the proportion of women who report they entered prenatal care in the first trimester from 76% to 83%. The FICMMR Coordinator and the MCH Supervisor serve as the co-leads for the monthly team meetings.

The IM CoIIN team is playing a pivotal role in developing and maintaining public and private organization partnerships. In August 2015, through a partnership with the March of Dimes and the Indian Health Services, over 40 healthcare providers, representing four Montana tribes, community health centers, and hospitals participated in a Coming of the Blessing training. The goal was to introduce Coming of the Blessing concepts as a means to generate interest and possible future implementation.

Following this training, conversations about improving birth outcomes, through a blended approach combining group prenatal care and Coming of the Blessing concepts, took place between the Medicaid Health Reform Specialist and the FCHB Bureau Chief. These conversations produced, Promising Pregnancy Care (PPC), an evidence-based health care delivery system that combines the prenatal visit with group education. It is a joint collaboration between Montana Medicaid and FCHB, to reimburse state approved Medicaid providers for group prenatal care.

Through a partnership with March of Dimes and the Children's Trust Fund, PPC will be introduced on July 21- 22, 2016. This particular training is specifically designed to work with providers who service Montana's Native American population, and to incorporate culturally appropriate education into a group pregnancy care program. Each program must include specific elements and report defined data elements to the department. The agenda also includes breakout sessions on Tobacco Cessation Methods; Period of Purple Crying; Neonatal Abstinence Syndrome – Finnegan Scoring Standardization; Brush, Book, Bed: How to Structure Your Child's Nighttime Routine; and Safe Sleep. More information is available at: <http://dphhs.mt.gov/publichealth/MCH.aspx>.

Strategies from the SHIP and PHSD Strategic Plan are ongoing, and are being incorporated into Division programs. They include:

- Increasing awareness of maternal, child, and infant health through public education, i.e. baby on back to sleep;
- Implementing quality improvement activities that improve the delivery of clinical preventive services and use of clinical practice guidelines, i.e. reduced induction and early elective cesarean sections;
- Supporting evidence-based health promotion and prevention activities, by providing training and resources to health professionals and others; and,
- Creating programs that improve modifiable risk factors for adverse outcomes of pregnancy, smoking cessation, and access to prenatal care.

All mothers who delivered during calendar year 2015 were asked to complete the Health Survey of Montana's Mothers and Babies 2015, which is modeled on the CDC Pregnancy Risk Assessment Monitoring System

(PRAMS). The survey, a collaborative effort with the FCHB, OESS, and MT HealthCare Foundation, is providing additional data on safe sleep practices, smoking habits, and preconception and interconception health practices. Preliminary data is anticipated in the fall of 2016.

Data collected by local FICMMR teams, and entered into the Child Death Review (CDR) Reporting System, includes information on smoking during pregnancy and safe sleep habits. Both datasets will be used for developing and distributing targeted messages.

The state FICMMR Program Coordinator recently led a CDR data quality improvement initiative, which focused on 20 select CDR Sections that are of critical importance for local teams to complete accurately. The CDR Sections include prenatal care access, smoking during pregnancy, and sleep environment. All of these critical data point questions are vital to identifying risk factors, directing education and prevention efforts, and measuring progress for the Montana State SHIP Plan.

The CDR data quality improvement plan focuses on assisting FICMMR leaders to enter accurate, consistent, and complete data in the 20 select CDR fields. The plan consists of several training components: a December 2016 FICMMR conference call introduction and discussion of the 20 CDR data fields; 2016 monthly email tips that cover two CDR sections; an in-depth review session implemented on all 20 CDR sections at the annual March 2016 FICMMR training; and a Captivate training film that provides guidance on all 20 CDR data fields for in-coming FICMMR leaders or as a refresher for any FICMMR leader.

At the regional FICMMR trainings in March 2016, four sites received safe sleep training. Two trainers from the National Center for the Review & Prevention of Child Deaths, including Executive Director Teri Covington, delivered a comprehensive, 70-slide presentation on safe sleep and the risks of bed sharing. This vivid presentation was shown to 75 county nurses and FICMMR team members.

All County Public Health Departments are contractually required to provide a minimum of one prevention activity per year. Activities to-date for fiscal year 2016 include:

- Meeting with providers from local clinics and the local hospital, regarding educating residents (parents, grandparents, caregivers) on Back to Sleep principles and the dangers of bed sharing to reduce infant deaths. The OB physicians agreed to try and initiate these discussions with clients during OB visits. Informational packets and posters were also provided throughout the clinics and in delivery rooms;
- Working to target, access, and provide Safe Sleep education materials to 100% of all post-natal mothers in the county;
- Partnering with Home Visiting at a Baby Expo to reinforce Back to Sleep principles and the message that the safest sleep environment for a baby is alone in their own sleep place.
- Continuing joint educational efforts with WIC, to new and expecting parents about safe sleep and the dangers of bed sharing;
- Setting up a Safe Sleep Discussion Booth at a local fair to talk with parents while distributing, "Sleep Baby Safe & Snug."
- Including safe sleep materials, along with other vital newborn topics, as part of their Welcome Baby Packets mailed out to homes.
- Creating a 30-day, safe sleep crib display in the lobby of the health department, with educational literature

available for the public to take home.

Multiple email messages, on a wide range of health topics, are distributed each month to all local FICMMR leaders. Two shared so far during fiscal year 2016 have been on safe sleep education:

1. An online, CEU opportunity - [Risk Reduction for Sudden Infant Death Syndrome \(SIDS\) and Other Sleep-Related Causes of Infant Death](#), for nurses and health care providers to update their knowledge about Sudden Infant Death Syndrome (SIDS) and other sleep related causes of infant death.
2. A Seattle Times newspaper article on a new hypothesis that an inner-ear defect may put babies at risk for SIDS.

## Perinatal/Infant Health - Annual Report

### Background Narrative - Information Submitted for July 2015 Report:

#### Breastfeeding

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Breastfeeding Peer Counselor Programs (BPCPs) operated in 10 local agencies.

The WIC Information Technology (IT) unit created BPCP data extracts which were used to evaluate the quality of services and impact of local programs. Reports were monthly, listing data for the prior 12 months, and four measurable indicators were used to report progress. The local BPCP chose two of the indicators to track over time, and use to support making any needed changes in operations.

In FY 2014, WIC worked on examining and analyzing the breastfeeding data extracted by the WIC IT unit for 2010, 2011, and 2012 with the assistance of the MCH epidemiologist. Data for initiation and duration by amounts and clinic size were examined. The impact of the BPCP on breastfeeding rates, by comparing those with and without a program, was also examined. This data will be published in 2015 by DPHHS, and data findings were presented to WIC local agency staff during the 2014 Fall Training. Data from 2013 were added after the 2014 calendar year was completed. Over this timeframe, breastfeeding rates in Montana continued to increase steadily.

Breastpumps continued to be supplied to all 27 local agency WIC programs. Regular WIC funds were used to order breastpumps this past year. Regular WIC funds were also provided to the Missoula Breastfeeding Coalition, for a stipend for WIC staff to attend the October 2013 *Professional Breastfeeding Conference*. A number of local agency staff and two state staff attended.

WIC and the PHSD's Nutrition and Physical Activity Program (NAPA) sponsored the *Learning Collaborative* training in September and October of 2014. The training established by NAPA was originally for hospital staff working on becoming a Baby Friendly Hospital. Molly Pessl, BSN, IBCLC, (Evergreen Perinatal Education), presented on day one to WIC BPCP and NAPA's Baby Friendly project attendees. On day 2 the WIC BPCP attendees met and presented highlights of their activities of the past year. They also discussed possible ways to expand the BPCP coverage across the state.

The NAPA attendees met on the second day, and Molly Pessl presented additional information on baby friendly topics. NAPA's MT Baby Friendly Hospital Initiative includes 10 sites working to reach Baby Friendly status. Local WIC agencies near the sites are encouraged to collaborate with them to reach that status. WIC has determined the collaboration with the NAPA Program on the Breastfeeding Learning Collaborative (BLC) was successful. As a result, another *Learning Collaborative* training, sponsored by NAPA and WIC, took place in June of 2015.

Registration was in high demand, as it was open to other organizations as well.

Announcements of breastfeeding trainings were shared via the WIC Newsletter. Sponsors in the Missoula area presented the Certified Lactation Counselor Training during July 2014. Local agency staff was informed of the training and several newer staff attended. The State Breastfeeding Coordinator and several staff from local agencies also attended the National WIC Association's Nutrition and Breastfeeding Conference in Atlanta, Georgia, during September 2014.

A USDA/WIC infrastructure grant has been submitted. Funds were requested for training newer staff. Requested funds would pay for registration and travel expenses at various trainings. Included on the list of possible trainings were two different Certified Lactation Counselor trainings to be held in Montana in fall 2015. In addition Montana WIC would provide testing fees for new IBCLC applicants taking the exam. Information about trainings and other methods of obtaining WIC CEUs is provided in our WIC newsletter.

Local WIC programs were notified of the opportunity to apply for Breastfeeding Peer Counselor Program funds or an existing program could submit a plan to expand their services to a currently unserved area. Their applications will be reviewed and if accepted the change will be implemented in 2016.

The Montana Breastfeeding Peer Counselor Program (BPCP) will be adding one more local program in 2016. If negotiations are successful, an existing program will expand to provide services to a neighboring local agency. These services will be provided via distance delivery which may include telephone and/or iPad FaceTime or WebEx for visual visits if available.

While the majority of breastfeeding participants have access to a Breastfeeding Peer Counselor, there is a large geographic area of Montana that is lacking coverage. In addition, in many of these areas there are no other breastfeeding support services available. The area includes very little population and/or great distances to services. Being able to provide breastfeeding support in an alternate method such as phone or iPad greatly increases their resources.

The FCHB would like to increase the number of IBCLCs available as WIC employees, and to address the shortage of such certified individuals. Other funds from the grant are planned for use in a more extensive Breastfeeding Learning Collaborative, partnering again with the NAPA Program, with expanded dates and presenters. The development of a toolkit for local program staff to use to build relationships with local hospitals and staff in the promotion and support of breastfeeding is also included in the grant application.

2014 breastfeeding data will be added to the 2010-2013 breastfeeding data. The results for each local agency will be distributed to them. Statewide data will be published and distributed to interested parties. The publication of this data is expected to be an ongoing activity, changing the years represented in the report. According to the CDC Breastfeeding Report Card for Montana (2011 data), the percent of infants who are ever breastfed is 91.2 % and the percent of infants breastfed exclusively through 6 months is 19.3 %.

WIC will continue to provide breastpumps to participants who meet the criteria found in the State Plan policy addressing breastpumps. Work is underway and will continue to develop methods of coordination with Medicaid in the provision of breastpumps. Montana Medicaid has taken a very proactive and favorable stance on supporting breastfeeding. Changes in how WIC issues breastpumps may occur in two to three years. An evaluation of the impact of the Affordable Care Act, and the access that all insured women now have to breastpumps, will have to be made. This may change the types of breastpumps the WIC program issues, the criteria for issuance, and possibly documentation that no appropriate breastpump was issued by the participant's health insurance.

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## FFY 2015 Report Updates:

The FFY15 updates for the Perinatal & Infant domain include the following performance measures:

- NPM 10 – Motor Vehicle Crash Deaths (Ages 0<1 apply)
- NPM 11 – Breastfeeding
- NPM 12 – Newborn Hearing Screening
- NPM 17 – Very Low Birthweights Born at NICU III+
- NPM 18 – Prenatal Care
- SPM 4 – Unintentional Injury Deaths (Ages 0<1 apply)

### **Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children**

The state FICMMR Program supported communities across the state in their efforts to reduce the rate of children's motor vehicle injuries and death. The state FICMMR Program Coordinator worked collaboratively with 50 local FICMMR team leaders, helping to educate them on safe practices and risk reduction behaviors.

One educational program shared by email, which is specifically applicable to infants, is the “**Not Even for a Minute**” campaign (never leave a child alone in a car). This campaign focused on educating parents and caregivers to never leave children unattended in or around vehicles. Dangers include injury and death (other vehicle drivers often can't see small children when backing up). The campaign also focused on driver distractions, providing tips to reduce the risk of accidents.

Local FICMMR Teams continued to review motor vehicle deaths, and implement related community prevention activities. As required by their county MCHBG Task Orders, local FICMMR Coordinators completed at least one FICMMR prevention activity, and most did at least one per quarter. The state FICMMR Coordinator continued to assist the local teams by sharing evidence-based practices, safety campaigns, and prevention activities through conference calls, emails, and newsletters.

During FFY 2015, 16 training opportunities targeting NPM 10 were offered by county public health departments accepting MCHBG funds. The trainings included seat belt usage, car seat installation, distracted driving prevention, and safe road advocacy. Also, the separate FICMMR teams planned and implemented numerous car seat safety clinics, educational sessions, distracted driving presentations, seat belt safety messaging, and safe road advocacy initiatives.

The state FICMMR coordinator facilitated quarterly conference calls with the local team leaders. Part of the agenda on these calls was a data quality initiative on the web-based Child Death Review (CDR) system. This system collects all of the data on a death, once a child's case has been reviewed and prevention determined. The initiative focused on 20 sections of critical importance for teams to complete accurately, one of which collects information about deaths involving a motor vehicle.

### **National Performance Measure 11: The percent of mothers who breastfeed their infants**

The Women, Infants, and Children (WIC) Program had a second successful collaboration with the Nutrition and Physical Activity Program (NAPA), on the Breastfeeding Learning Collaborative (BLC) in June 2015. Participant

evaluations indicated a very positive overall satisfaction with the training. Of 100 attendees, eleven individuals were from health organizations not specifically connected with WIC or the NAPA Baby Friendly Hospital Initiative. Following the 2015 BLC, NAPA and WIC staff started planning for a BLC to be held in April 2016.

A USDA/WIC infrastructure grant for breastfeeding training was awarded to MT's WIC program in 2015. Funding is available for use until September 30, 2016 (two-year grant cycle). A significant portion of this grant was set aside for the 2016 BLC. In addition, financial assistance was offered for two Certified Lactation Counselor trainings. The results of the trainings provided to local WIC staff were as follows: 13 new certified lactation counselors (CLC); Loving Support training attended by 32 new staffers, and 7 attendees to the Missoula Breastfeeding Coalition's Health Professional Breastfeeding Conference. One staff member is also planning to take the initial IBCLC certification exam in the upcoming year.

In FY 2015, the state WIC program published breastfeeding data for 2010-2013 as a surveillance report (<http://dphhs.mt.gov/publichealth/WIC/WICData>). Breastfeeding initiation rates consistently increased during this time, from 74.3% in 2010 to 78.2% in 2013, an average of 1.5% per year. During this time "fully" breastfeeding rates also increased in the WIC population at 3, 6 and 12 months. The report was shared with local agencies, the USDA Food and Nutrition Service regional office, Montana DPHHS staff, and in an article and link in the Montana Academy of Nutrition and Dietetics newsletter.

In March 2016, an invitation to apply was sent to agencies who might be interested in having a local Breastfeeding Peer Counselor Program (BPCP). Sanders County WIC agency, which also serves Mineral County, applied for the BPCP funds. Their application was reviewed and approved for FFY 2016. As of October 1, 2015, Montana had 11 local BPCPs in operation.

In addition, during FFY 2015, discussions began with the local BPCPs about providing breastfeeding peer counselor services to other currently unserved areas. This would be through distance delivery, and could include the use of phone/texting, iPad face-to-face or WebEx. Most of the remaining area in Montana that is not served by a BPCP is very rural, with a low density of WIC participants. Two local programs were interested but decided not to pursue the option at the time. The state WIC program plans to continue considering ways to provide BPCP services to all WIC participants. This could be through: the expansion of existing programs' service areas, several smaller local agencies grouping together - with one agency taking the lead, or by continuing to recruit more individual agencies.

### **National Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge**

The Universal Newborn Hearing Screening Intervention (UNHSI) program continued to support coordinated, comprehensive care for children who are diagnosed with or who have a potential hearing loss. Audiologists are designated as pediatric in the State of Montana by their ability to perform sedated AABR diagnostic tests at a licensed health care facility.

The Hearing Conservation Program (HCP) audiologists provided follow-up hearing screenings for hospital births or initial and follow-up screenings for non-hospital births in their regions at no cost to the parents. This program is provided as a partnership with the Office of Public Instruction. They worked with preschool and school-aged children to evaluate and monitor hearing, and provided technical assistance for school-based amplification needs. The HCP audiologists continued to collaborate with other providers, teachers of the deaf and general school staff as part of a team approach for each child's educational needs. They make medical referrals as needed for ear health concerns, such as otitis media. The UNHSI program screened 96% of all babies born in Montana during FFY15.

The Children's Special Health Services section provided statewide training on newborn screening (NBS) to

midwives in Montana who deliver outside of a hospital setting. Historically, midwives have had low rates of NBS participation and reporting in Montana. The four regional trainings were attended by 34 midwives and apprentices. The training was very well received and NBS reporting from midwives rose by 19%. The result has been better coordination of services for babies with out-of-range results.

On-site quality assurance visits continued as planned in the UNHSI quality assurance plan. Five hospitals were visited during this period. During these visits, program staff verified that the UNHSI program had access to accurate data and hospitals were providing appropriate educational materials and hearing screening services. If a hospital is found to be out of compliance the UNHSI program sends a corrective action letter to the facility and does a follow up review six months after the initial visit.

### **Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates**

The Perinatal Quality Collaborative (PQC), established in January 2013, continued their work of supporting hospitals in reducing elective deliveries that occur before 39 weeks gestation. The PQC is based on a national model which engages statewide stakeholder organizations, hospital leadership, physicians, and peer review. The PQC supports policies which are intended to ensure that induced or cesarean section deliveries, before 39 weeks, are medically indicated.

As of July 1, 2014, Montana Medicaid birthing facilities were required to have an elective deliveries “hard-stop policy” in place. The policy includes:

- Non-medically necessary inductions, or any C-sections prior to 39 weeks;
- Confirmation of gestational age;
- A multi-step review process for all inductions and C-sections, including that the final decision must be made by the Perinatology or Obstetrics Chair.

As of October 1, 2014, Montana Medicaid reduced reimbursement rates for any non-medically necessary inductions or C-section prior to 39 week. During FFY 2016, Medicaid analyzed hospital claims data to assess the rate of elective deliveries. The rate fell from 4.6% in 2012 to 0.5% as of February 2016.

Information learned at the July 2014 CoINN Meeting was integrated into Montana’s PQC work plan as well as shared with other programs serving families. These programs include the sites providing home visiting services, as well as other maternal and child health services such as immunization and WIC.

The Healthy Montana Families Home Visiting sites, funded with state funding and/or federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding, continued to implement their selected home visiting model. The home visiting sites provided relevant training and information regarding healthy pregnancies and delivery with clients that were enrolled prenatally.

Nineteen sites implemented evidence-based home visiting with federal MIECHV Expansion funds. The new sites followed the same guidelines and provided the same level of service as the existing sites. The total caseload capacity for the existing and new contractors was approximately 1000 clients. Programs implementing Nurse-Family Partnership enrolled women during pregnancy. Parents As Teachers, SafeCare Augmented and Family Spirit enrolled families with young children in addition to pregnant women. If caregivers were already enrolled as a client and became pregnant while enrolled, the home visitor asked whether they wanted to enroll as a pregnant client and focus home visits on the pregnancy.

### **Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning**

## **in the first trimester**

The Healthy Families Home Visiting sites funded with state funding and/or federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding continued to implement their selected home visiting model. The home visitors discussed prenatal care with clients enrolled prenatally and provided referrals and assistance as needed. The program outcome measure is: Percent of pregnant women enrolled prenatally who receive 80% or more of the recommended number of prenatal care visits after program enrollment.

Nineteen sites implemented evidence-based home visiting with federal MIECHV Expansion funds. The new sites followed the same guidelines and provided the same level of service as the existing sites. The total caseload capacity for the existing and new contractors was approximately 1000 clients. Programs implementing Nurse-Family Partnership (NFP) enrolled women during pregnancy. Parents as Teachers, SafeCare Augmented and Family Spirit enrolled families with young children in addition to pregnant women. Even when clients enrolled while they were pregnant, the majority of clients enrolled after the first trimester of pregnancy. If caregivers were already enrolled as a client and became pregnant while enrolled, the home visitor asked whether they wanted to enroll as a pregnant client and focus home visits on the pregnancy.

Prior to providing home visiting services, sites were trained in the specific home visiting model to be used. They were also trained in the Montana specific program components, such as: screening requirements, assessment tools, continuous quality improvement, and the program forms and data system. All client data were entered into the MTmechv data system or, in the case of NFP sites, downloaded to Montana's program from the NFP ETO data system. Since the program started providing services, over 630 women have been enrolled during pregnancy.

Three county public health departments chose NPM 18 as the performance measure they wanted to focus on in fiscal year 2015: Lewis & Clark, Blaine and Richland.

## **State Performance Measure 4: The rate of death to children 0 through 17 years of age caused by unintentional injuries**

Prevention initiatives specific to Infant <1 included County Public Health Department activities to: provide Shaken Baby Syndrome education to new mothers; conduct home safety assessments in partnership with home visiting programs; distribute Shaken Baby Syndrome, safe sleep, and Period of Purple Crying educational literature in doctor's offices, hospital waiting rooms, OB clinics, and Well Child Clinics; implement Safe Sleep initiatives; and conduct multiple car seat installation clinics.

### General SPM 4 Activities -

The FICMMR Program continued to support community and state efforts to reduce the rate of unintentional deaths in children ages 0 through 17 years. The plan included to 1) work collaboratively with 50 local FICMMR Leaders and 29 local FICMMR Teams, especially in the counties which experienced higher rates of unintentional injuries, 2) work collaboratively with other agencies to target unintentional injury deaths, particularly the Montana Injury Prevention Program, and 3) help with the development of resources and tools for community education and activities/policies to reduce unintentional injury deaths.

The 29 local FICMMR Teams continued to review all unintentional child deaths, and implement community prevention initiatives focused on deaths attributed to unintentional injuries. The state FICMMR Program Coordinator utilized an array of technology (web-based Child Death Review Reporting System, Captivate, WebEx, etc.) to train and meet with FICMMR team leaders throughout the year. She also provided prevention information, journal articles, training opportunities, and contributions to a newsletter distributed to county FICMMR Coordinators.

A desired outcome in the FICMMR Program Logic Model was for local FICMMR leaders to be knowledgeable of the types of deaths that are preventable, including unintentional injury. FICMMR leaders enhanced their knowledge base of preventable deaths via: their case reviews, team discussion of the deaths in their counties, ongoing training in how to run Child Death Review (CDR) Standardized Reports (Manner & Cause) for their counties, and receiving reports with statewide data provided by the state FICMMR program coordinator.

There were ten Montana Counties that chose the unintentional injury State Performance Measure for FY 2015 (Glacier, Pondera, Judith Basin, Wheatland, Golden Valley, Broadwater, Madison, Park, Fallon, and Wibaux).

The state FICMMR program coordinator provided technical support and checked in quarterly on the progress of county activities.

The state coordinator continued to participate on calls and at meetings to discuss unintentional injury prevention campaigns and strategies at the federal, state, and local level. She also continued to be an active member of the Western-States Coalition for Child Death Review, state of Montana Injury Prevention Coalition and the Emergency Services for Children Committee. The state coordinator collaborated with the Maternal & Early Childhood Home Visiting Program and Healthy Mothers, Healthy Babies to address injury prevention education and activities related to motor vehicle crashes, drowning, unsafe sleep conditions, falls, and poisoning.

Information was consistently shared with the local FICMMR leaders via newsletter, WEBEX call, and email.

From October 1, 2014 through March 31, 2015, there were 62 prevention educational initiatives by the 50 health departments accepting MCHBG funds. Also, the separate FICMMR teams implemented 106 prevention initiatives from April 1, 2015 through September 30, 2015.

A new State FICMMR Coordinator was hired on May 18, 2015. Early activities were to learn Version 4.0 of the web-based CDR Case Reporting System, and to create and implement a data quality plan to help teams increase their knowledge of the CDR system. This increased the accuracy and consistency of CY 2015 case reports. Other activities of the new FICMMR Coordinator were to become familiar with the IM CoIIN Objectives; serve as a resource to 50 internal and external partners; and develop an awareness of the FICMMR Program's role in the State Health Improvement Plan (SHIP) and SHIP Strategic Plan.

## Child Health

### State Action Plan Table

#### State Action Plan Table - Child Health - Entry 1

##### Priority Need

Child Injuries

##### NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

##### Objectives

Decrease the rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 19 to 200.

##### Strategies

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

##### ESMs

ESM 7.1 - Analyze Hospital Discharge Data for County-Level Child Injury Causes

##### NOMs

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

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

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

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

## State Action Plan Table - Child Health - Entry 2

### Priority Need

Immunization Rates

### SPM

Immunization

### Objectives

For part A of SPM 3 - Increase the percent of 19 to 35 month olds who have received a full schedule of age appropriate immunizations to 76.5% by 2021.

### Strategies

Ongoing strategy for part A, in addition to the new ESM is: Children's immunization status is assessed by the Maternal and Early Childhood Home Visiting Programs, at WIC appointments, and at Children's Special Health Services regional clinics. All children behind with their immunizations are then appropriately referred. The MCHC section will continue to share immunization information with all the CPHDs and attend the quarterly IZ VFC provider calls and offer assistance as appropriate.

### Measures

**NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Child Health)**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	182	180	178	176	174	172

**Data Source: State Inpatient Databases (SID) - CHILD**

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2013	132.5	10.2 %	168	126,838	
2012	131.3	10.3 %	162	123,409	
2011	148.9	11.0 %	184	123,537	
2010	159.9	11.5 %	192	120,069	
2009	176.8	12.3 %	207	117,060	

**Legends:**  
 Indicator has a numerator ≤10 and is not reportable  
 Indicator has a numerator <20 and should be interpreted with caution

**ESM 7.1 - Analyze Hospital Discharge Data for County-Level Child Injury Causes**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

**Child Health - Plan for the Application Year**

Please see the FFY 2015 report section for background narrative on this domain through 9/30/15 -

Montana’s Child Health domain performance measures for FFYs 2016 – 2020 are:

- NPM 7 – Child Injuries, ages 1 – 10
- SPM 3A – Immunizations, ages 19 – 35 months

The following narratives contain current activities and upcoming plans –

**NPM 7 - Child Injuries: Rate of injury-related hospital admissions per population ages 0 – 19 years**

In the coming year, FCHB staff will take the lead on developing the state action plan. The initial activity requires the MCH Epidemiologist to assess the primary causes of injury-related hospital admissions. The assessment results will yield information for identifying subject matter experts within the Public Health and Safety Division (PHSD), DPHHS, and other public and private entities and organizations with whom to partner in SFY 2017.

The PHSD State Health Improvement Plan (SHIP), Section D is focused on preventing injuries and exposures to environmental hazards. Many division programs are implementing strategies from the SHIP and the PHSD Strategic Plan, which include: increasing awareness of injury prevention; implementing evidence-based programs to facilitate

injury prevention and child health; providing training and technical assistance to schools and childcare settings for protecting health; and promoting health by providing information and education to help people make good safety choices.

The FCHB promotes DPHHS approved injury prevention messages, developed from evidence-based approaches, which are distributed amongst the FCHB's established partner network as indicated in the Needs Assessment. The PHSD's Emergency Medical Services for Children (EMS – Child) program has been awarded a State Partnership of Regionalization of Care grant to help strengthen pediatric readiness in Montana. EMS – Child staff will be contributing to the activities for NPM 7's State Action Plan.

Local county efforts that addressed child injury prevention were numerous and diverse, examples are highlighted here:

- A county FICMMR team had several members join the local Child Abuse Prevention Coalition. This coalition is working to establish a crisis nursery in their community, where families in crisis situations have a safe place to drop their children off for the day. The coalition developed a business plan, applied for 501c3 status, secured in-kind services from an accounting firm and is working to form a board of directors.
- After two teen suicides, another county created a Mental Health Coalition with key stakeholders from the community. The coalition called in the state suicide prevention coordinator to identify critical next steps during this crisis period; identified high risk students and worked closely with them and their families; launched a media campaign with radio PSAs, newspaper ads, and billboards promoting mental health and suicide prevention; and sent educational literature mailings to parents.
- A partnership with the Department of Fish, Wildlife & Parks placed warning signs be placed on unstable river banks, and also created a life-preserver station, which allows visitors to borrow a life-preserver while playing in and near the water.
- One county partnered with the local Chemical Dependency program and educated middle and high school students on the harmful effects and long term consequences of drug and substance abuse.
- Creation of an interactive Red Thumb Campaign (Prevent Distracted Driving) at the local high school that involved multiple community partners. One partner provided a big screen and displayed anti-texting videos. The main exercise involved an evacuation drill at the school. Upon returning, students watched additional anti-texting videos and had to stop at several stations where they were given the opportunity to take the pledge not to text and drive, had their thumbs painted red, have their photo taken using hashtag social media, and participated in hand-only CPR. There were 186 students who participated at the event, 137 signed the pledge, and 42 learned hand-only CPR.
- Planning with key community partners to enhance bicycling and walking safety. As a starter activity, one county purchased gift certificates for low income children to buy helmets. Local bike shop staff worked with the families on bike safety and insured helmets fit. Another county focused extensively in distributing children bike helmets and conducted an ad campaign on bike safety.
- Building a comprehensive winter safety campaign with infographs, 4 radio public service announcements, educational packets sent to daycare providers, a newspaper article, and a handout for school kids to take home.
- Focusing on poison prevention during National Poison Prevention Week. County public health department staff went to a high traffic area in their community, and provided educational literature, magnets, and stickers.
- Other activities by various counties included: car seat safety, gun locks and fire arm safety, shaken baby syndrome, period of purple crying, drowning prevention, and fire safety.

Motor vehicle deaths and injuries continue to be high in Montana, and this was a featured topic at the annual FICMMR training in March 2016. Two national trainers delivered a presentation on motor vehicle crashes which

included: webcams showing kids texting and driving while going off the road, the additional risks of young drivers, the importance of parent engagement, and the fact that emerging technology such as cell phones should be shut down before a vehicle is started. Approximately 90 FICMMR leaders and team members received this training, and evaluated it as follows:

- When asked if the training enhanced their knowledge, 98% either agreed or strongly agreed;
- When asked if they would be able to apply the knowledge to their jobs, 100% either agreed or strongly agreed.

To date during FFY 2016, the state FICMMR Program Coordinator has distributed eight educational and training emails to local FICMMR leaders on a variety of child injury prevention topics.

**SPM 3 – Immunization: a) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Haemophilus Influenza Type B, Hepatitis B, Varicella, and Pneumococcal**

The DPHHS, Immunization Section is continuing to partner with 53 contractors across the state to improve the immunization rate in Montana. Contractor and state staff activities consist of:

- Maintaining immunization records in the statewide immunization information system.
- Providing outreach and referrals for children and adolescents identified by immunization information systems that are missing or coming due for immunizations.
- Developing and implementing a protocol for reducing missed opportunities for vaccination (e.g. Reviewing immunization records at every visit, and eliminating missed opportunities for simultaneous vaccination).
- Meeting quarterly with key internal partners to review data provided and discuss strengths and opportunities for improvement.
- Meeting quarterly with local vaccinations for children (VFC) providers to review the data reports and share best practices for increasing immunization rates.
- Maintaining records received from local schools for children entering kindergarten and 7th grade, review for completeness and accuracy, and following up on children who are conditionally attending.
- Assessing immunization records of children enrolled in daycare settings for appropriate immunization status, and notifying day care providers of children who are enrolled without appropriate documentation of immunization.
- Providing follow-up in the daycare settings for children not up-to-date as required for daycare attendance.
- Ensuring the perinatal Hepatitis B prevention protocol is updated to include standards developed by the CDC.

Twenty-six county public health departments chose SPM 3 for state fiscal year 2016. These counties all implement at least two activities that fit in either the Enabling Services category, or the Public Health Services and Systems category. They also plan, in advance, how to evaluate their effectiveness. Reports are made to state MCH staff each quarter. Data on county immunization levels are measured as a baseline before efforts begin, and then again at the end of the year using the state's imMTrax system.

The state Immunization program is providing a series of trainings via WebEx on a variety of topics. For example: Immunizations - Building Trust During the Time of Twitter. It featured Dr. Wendy Sue Swanson, a practicing pediatrician and Executive Director of Digital Health at Seattle Children's Hospital. She gave an overview of how social media can be leveraged to communicate vaccine science and safety, and addressed the use of social media tools in the US; messaging for vaccine hesitancy; and strategies for using social and traditional media to communicate vaccine information.

**Child Health - Annual Report**

## Background Narrative - Information Submitted for July 2015 Report:

Performance Measures Included: (**P** designates performance measures for fiscal years 2011-2015, and **N** designates new performance measures for fiscal years 2016-2020)

Last Year's Accomplishments and Current Activities =

- **PNPM 7 – Immunization** (Ages 19 – 35 months)
- **PNPM 10 – Motor Vehicle Deaths** (Ages 1 – 10)
- **PNPM 14 – Obesity** (Ages 2 – 5 years)
- **PSPM 4 – Unintentional Injury Deaths** (Ages 1 – 10)
- **PSPM 6 & 7 – Additional Vaccines**

Plan for the Coming Year and for 5-Year Action Plan =

- **NNPM 7 – Injury Related Hospital Admissions** (Ages 1 – 10)
- **NSPM 3a – Immunizations** (Ages 19 – 35 months)

The main MCHBG categories of activity that fit into the Children Domain for Montana are: Immunization, Obesity and Injury. This narrative will report on past accomplishments and challenges, current effectiveness, and initiation of new efforts based on the needs assessment analysis.

Two of these categories contain performance measures which span the timeframes of two 5-Year Statewide Needs Assessments: Immunizations and Injury. Obesity is a part of the reporting on last year's accomplishments and current activities, and is not one of the priorities in the upcoming state action plan. However, childhood obesity continues to be of importance to the Public Health Safety Division (PHSD) and the Department of Public Health and Human Services (DPHHS).

### Immunizations

Montana created a state performance measure for immunization to address the ongoing need, and the fact that many County Public Health Departments (CPHDs) face challenges from vaccine hesitancy. The child population of the measure is as follows: *a) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Haemophilus Influenza Type B, Hepatitis B, Varicella, and Pneumococcal.*

In FYs 2014 and 2015, the PHSD Immunization (IZ) Section partnered with 53 contractors to improve immunization rates in Montana through an Immunization Action Plan (IAP). Contractor activities consisted of:

1. Contractors routinely maintained immunization records in the statewide immunization information system (imMTrax). This maintenance consisted of not only adding newly acquired records but also performing data quality assurance activities including patient de-duplication.
2. Provided outreach and referrals for children identified by immunization information systems as missing or coming due for immunizations, by implementing new clinic reminder/recall processes.
3. Developed new protocols for reducing missed opportunities for vaccination (e.g. reviewing immunization records at every visit, and eliminating missed opportunities for simultaneous vaccination). Many contractors also worked with IZ staff to build a targeted quality improvement plan for increasing vaccination rates.
4. Met quarterly with local Vaccine for Children (VFC) providers to review the data reports provided by the IZ program, and share best practices for increasing immunization rates.

5. Assessed immunization records of children enrolled in daycare settings for appropriate immunization status, and notified day care providers of children who were enrolled without appropriate documentation of immunization.
6. Provided follow-up in daycare settings for children not up-to-date, as required for daycare attendance and recommending exclusion, if necessary.
7. All activities done as a part of the IAP contract were reported to the IZ program on a quarterly basis.

Children's immunization status is also assessed by the Maternal and Early Childhood Home Visiting Programs, at WIC appointments, and at Children's Special Health Services regional clinics. All children behind with their immunizations are then appropriately referred.

A new Immunization Program Manager began in December 2013. Meetings between the IZ program and the MCHC section were held, to facilitate collaboration with the 20 counties who chose NPM 7 for their performance measure. The MCHC section will continue to share immunization information with all the CPHDs and attend the quarterly IZ VFC provider calls and offer assistance as appropriate.

The Montana Maternal and Early Childhood Home Visiting program sites, located in 19 communities, will continue to assess and refer children as needed for well-child visits and immunizations. Children attending WIC Clinics and one of the three CSHS regional clinics will also be assessed for their immunization status and referred as needed.

For FY 2016, the activities carried out by IZ contractors in previous years will be continued. These activities, which have also been under way in past years, include:

- Meeting quarterly with key internal partners to review data provided and discuss strengths and opportunities for improvement
- Maintaining records received from local schools for children entering kindergarten and 7th grade, review for completeness and accuracy, and follow up on children who are conditionally attending
- Ensuring the perinatal Hepatitis B prevention protocol is updated to include standards developed by the CDC

### Obesity

Montana WIC offered participants the option to complete secondary, low-risk nutrition education online through [www.wichealth.org](http://www.wichealth.org), as a means of providing increased access to services. Encouragement and training on the use of this technology was provided to local agency staff at conferences, on conference calls and during monitoring visits. During federal fiscal year 2013 a total of 297 participants utilized [wichealth.org](http://www.wichealth.org) for their quarterly nutrition education contact. An average of 1.6 lessons was taken for a total of 479 total lessons delivered. Participants are only required to complete one lesson, so this means that they often decided to complete a second lesson to obtain more information. The most popular lessons were, "Secrets for Feeding Picky Eaters", "Fun and Healthy Drinks for Kids", and "Trust Your Child to Eat Enough." All of these topics assist parents in making healthy choices for their families.

All 47 Montana WIC clinics have a registered dietitian (RD) either on staff or available by contract to provide nutrition assessment, intervention and follow up to participants considered high-risk, including overweight/obese children.

Dietitians are uniquely qualified to address complex topics such as excess weight gain and less than ideal feeding practices. For clinics that do not have an RD on staff, the contact was completed by phone, or using web-based technology (WebEx). This use of distance education improved access to quality nutrition services in areas where they would otherwise not have been available.

Local agency staff continue to weigh and measure all participants at their certification and mid-certification. Education is provided and documented for parents about their child's growth. WIC state staff monitor for this documentation. Children with a risk factor for overweight or obesity are referred to the registered dietitian for additional services. Data collection on overweight and obese children, ages 2-5 years old, is analyzed and distributed to local agencies regularly and shared with the MCH epidemiologist. With this data, local agencies, state programs and state staff look at trends and target training and interventions to the population.

The 2014 Farmers Market Program was very successful. A total of 8,738 benefits for fresh fruits and vegetables were redeemed at Farmers Markets by 2,169 participants from 8 clinics statewide. The monetary value of the benefits redeemed was \$43,599, which is about 89% of our total grant. Compared to the national average of 59%, Montana has one of the most successful programs in the country. Increasing access to fresh produce has been a huge benefit for families. The Montana Farmers Market program continues through the 2015 season.

Local agency staff have training standards specific to each role in the WIC program, which standardizes the staff competencies across agencies. This allows a broader group of staff to provide quality nutrition education to low risk participants. Training topics include: breastfeeding issues, counseling skills, program quality improvement methods, updated/new policies, and external resources. A form is used to verify staff training and to verify requested WIC continuing education credit. Staff members are required to complete continuing education credits every year.

Local agency staff members are provided training and information in a variety of ways. In April, 2014 the Montana WIC program held its spring conference, which included a presentation called, "Bridges Out of Poverty." This training was highly successful at educating local clinic staff about the complexities of working with low-income families, and how to improve communication with our participants.

In addition, nutrition-related trainings, articles, and webinars were posted in a newsletter to promote and support continuing education among staff. WIC also collaborated with the Nutrition and Physical Activity program to host the Breastfeeding Collaborative in September, 2014. It is well established that breastfeeding promotes healthy growth and reduces the risk for overweight and obesity during childhood.

### Injury

The Montana State Health Improvement Plan (SHIP) includes the objective: "By 2018, increase the proportion of motor vehicle occupants that report they wear seat belts from 73% to 83%." One SHIP Action Area Strategy provides for increasing awareness about the importance of seatbelt and car seat use through training opportunities and providing educational materials. Data from the timeframe of January 2006 through December 2011 indicate that 129 infants, children, and teens were killed by motor vehicles in Montana. A copy of Montana's FICMMR Program November 2013 report: "Childhood Motor Vehicle Deaths, Montana, 2006-2011", is at: <http://dphhs.mt.gov/publichealth/cdrp#148211275-ficmmr-coordinator-resources>. Reports on other topics can be accessed at the same link.

Twenty-seven local Fetal, Infant, Child and Maternal Mortality Review (FICMMR) Teams, representing 54 County Public Health Departments (CPHDs), review motor vehicle and all other unintentional injury-related deaths. CPHDs also implement community injury-prevention activities. Through the Maternal and Child Health Block Grant (MCHBG) Task Orders, CPHDs are required to complete one injury prevention activity each year. In the first three quarters of SFY 2015, 62 injury prevention activities were completed.

The state FICMMR Program Coordinator assists with: researching evidence-based practices and prevention activities, and providing training on submitting accurate reports through quarterly conference calls, newsletters, webinars, trainings, and emails. In November 2013, a packet of educational materials was mailed out to all 56 counties and 7 tribes which included: car seat safety, the importance of seat belt use, farm equipment safety, teen drinking and driving, safe sleep, poison control, and choking hazards.

The FICMMR Coordinator and the MCH Epidemiologist collaborated on three FICMMR Quarterly Reports which addressed statewide findings in Montana from 2006 through 2012. In 2013, Montana implemented the Child Death Review (CDR) Case Reporting System, for use by the local review teams in reporting FICMMR information.

The FICMMR Program Coordinator worked with Pondera County on their choice of FY 2014 MCHBG performance measure, NPM 10. In March 2014, they held a "Red Thumb" event to raise awareness "Not to Text and Drive." The May 2014 FICMMR Program newsletter highlighted the successful event, where over 100 high school students, law enforcement officials, teachers, and business owners learned about the dangers of texting and driving. Support has also been ongoing in FY 2015 for the ten counties working on State Performance Measure 4: The rate of death to children 0 through 17 years of age caused by unintentional injuries.

The Director of the National Center for Child Death Review, Teri Covington, was an instructor at the four 2014 FICMMR regional trainings. Ms. Covington and the FICMMR Program Coordinator co-presented on using the Child Death Review (CDR) Reporting System, which is a web-based data collection tool maintained by the National Center for the Review & Prevention of Child Deaths. Montana's local FICMMR Teams were required to start reporting their FICMMR review data in the CDR beginning with calendar year 2013 deaths. One tutorial in the regional trainings focused on how the local teams could extract CDR data for standardized reports. For example, "Motor vehicle and other transport death demographics" was demonstrated to the 68 attendees.

The FICMMR Program Coordinator participates on the Montana Seatbelt Workgroup, and is a member of the Injury Prevention Coalition. Information and resources learned from these resources are posted on the FICMMR website, shared on conference calls, and emailed to the local FICMMR teams. Information obtained from death reviews and prevention activity reports are shared with the Montana Injury Program and the Montana Department of Transportation. The state FICMMR Program will continue to partner with community organizations, and state programs such as "Buckle Up MT", which provide support to parents about proper car seat installation, child transportation safety, and parental responsibility when in and around cars.

In the coming year, FCHB staff will take the lead on developing the state action plan. In the area of child injuries, the initial activity requires the MCH Epidemiologist to assess the primary causes of injury-related hospital admissions. The assessment results will yield information for identifying subject matter experts within the Public Health and Safety Division (PHSD), DPHHS, and other public and private entities and organizations with whom to partner in SFY 2016 while creating the state action plan.

Section D of the SHIP is focused on preventing injuries and exposures to environmental hazards. The state action plan will reflect the strategies from the SHIP and the PHSD Strategic Plan, which include: increasing awareness of injury prevention; implement evidence-based programs to facilitate injury prevention and maternal and child health;

provide training and technical assistance to schools and childcare settings to implement evidence-based programs to promote and protect health; and promote health by providing information and education to help people make healthy choices.

The state action plan will include the development of DPHHS approved injury prevention messages, developed from evidence-based approaches. These will be distributed among the FCHB's established partner network, as indicated in the Needs Assessment.

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### **FFY 2015 Report Updates:**

The FFY15 updates for the Child domain include the following performance measures:

- NPM 7 – Immunizations, ages 19 – 35 months
- NPM 10 – Motor Vehicle Deaths, ages 1 – 10
- NPM 14 – Obesity in WIC clients, ages 2 – 5
- SPM 4 – Unintentional Injury Deaths, ages 1 – 10
- SPMs 6 & 7 – Additional Immunizations, 4<sup>th</sup> DTaP and Varicella, ages 19 – 35 months

The report on [Immunization](#) combines information from all three of the measures which apply:

**National Performance Measure 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B**

**State Performance Measure 6: The percent of children 19-35 months of age who have received the 4th immunization in the diphtheria, tetanus, and pertussis (DTaP) series**

**State Performance Measure 7: The percent of children 19-35 months of age who have received an immunization against varicella**

The DPHHS Immunization Section contracted with 53 contractors to improve immunization rates in Montana. Contractors completed the following activities:

1. Entry of immunization records in the statewide immunization information system.
2. Provided outreach and referrals for children, identified by immunization information systems, which are missing or coming due for immunizations.
3. Developed and implemented a protocol for reducing missed opportunities for vaccination (e.g. Review immunization records at every visit, or eliminate missed opportunities for simultaneous vaccination).
4. Assessed immunization records for children enrolled in daycare settings for appropriate immunization status, and alerted day care providers of children who are enrolled without appropriate documentation of immunization.
5. Provided follow-up in the daycare settings for children not up-to-date as required for daycare attendance.
6. Meet quarterly with other local Vaccine for Children (VFC) providers to review the data reports provided by DPHHS and share best practices for increasing immunization rates.

The 22 counties which chose MCHBG NPM 7 for state fiscal year 2015 completed the activities outlined in their pre-contract surveys. Prior to the Pre-Contract survey a listing of recent IZ support activities from all participating

counties was distributed as a way to provide ideas. The MCH section shared immunization information with all the health departments and they attended the quarterly IZ VFC provider calls and offered assistance as appropriate.

The Healthy Montana Families Program sites, located in 19 communities, referred children as needed for well-child visits and immunizations. Children attending WIC Clinics, or CSHS supported team clinics were assessed for their immunization status and referred as needed.

A Memorandum of Understanding between Montana WIC and the Immunizations Program allows for data sharing between the programs, for the purpose of maximizing childhood immunizations among Montana WIC participants. At the local level, WIC staff and Public Health Nurses who administer the Immunization Program coordinate efforts to review the immunization status of WIC participants. At scheduled visits, those who are out of date with any immunizations receive a referral. Specifically, WIC is mandated to review immunization status among children ages 0-24 months.

### **Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children**

The state FICMMR Program supported communities across the state in their efforts to reduce the rate of children's motor vehicle injuries and death. The state FICMMR Program Coordinator worked collaboratively with 50 local FICMMR team leaders, helping to educate them on safe practices and risk reduction behaviors.

Local FICMMR Teams continued to review motor vehicle deaths, and implement related community prevention activities. As required by their county MCHBG Task Orders, local FICMMR Coordinators completed at least one FICMMR prevention activity, and most did at least one per quarter. The state FICMMR Coordinator continued to assist the local teams by sharing evidence-based practices, safety campaigns, and prevention activities through conference calls, emails, and newsletters.

Some of the specific information shared regarding children ages 1 - 10 included:

- **“Not Even for a Minute”** campaign (never leave a child alone in a car). This campaign focused on educating parents and caregivers to never leave children unattended in or around vehicles. Dangers include injury and death (other vehicle drivers often can't see small children when backing up). The campaign also focused on driver distractions, providing tips to reduce the risk of accidents.
- Montana children who live on farms and ranches typically operate motor vehicles (trucks, tractors, ATVs, etc.) at an earlier age than those who live in more urban areas. They do so in order to contribute to family operations. A critical, well thought out Safe Practices Guide and PowerPoint, **“Child Deaths on Farms”**, was secured from the National Center for the Review and Prevention of Child Deaths and distributed to all local teams.

During FFY 2015, 16 training opportunities targeting NPM 10 were offered by county public health departments accepting MCHBG funds. The trainings included seat belt usage, car seat installation, distracted driving prevention, and safe road advocacy. Also, the separate FICMMR teams planned and implemented numerous car seat safety clinics, educational sessions, distracted driving presentations, seat belt safety messaging, and safe road advocacy initiatives.

The state FICMMR coordinator facilitated quarterly conference calls with the local team leaders. Part of the agenda

on these calls was a data quality initiative on the web-based Child Death Review (CDR) system. This system collects all of the data on a death, once a child's case has been reviewed and prevention determined. The initiative focused on 20 sections of critical importance for teams to complete accurately, one of which collects information about deaths involving a motor vehicle.

**Performance Measure 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.**

In FFY 2015, a data project was completed to assess the percent of overweight and obese 2-5 year olds who participated in the WIC program between 2011-2013. The WIC state agency also did an analysis of breastfeeding data. The results of these data sets were shared with local agency staff at the state WIC annual conference in April, 2015. Local agency staff were asked to review their data and select a data point to target for intervention using their nutrition and breastfeeding education plans during the 2016 FFY. In developing these plans, local agency staff were required to implement a local needs assessment and use available data to consider their projects for the next year.

Local agency staff were also required to complete orientation training as well as continuing education credits to work in the WIC office. The standards are specific to their role and consistent across most agencies. With relation to childhood obesity, staff undergo training in weighing and measuring techniques, nutrition assessment, counseling skills (participant centered), and breastfeeding. At the state WIC office, the Nutrition Coordinator and Breastfeeding Coordinator monitored the completion of these trainings and made sure sufficient opportunities were available for local agency staff to meet the requirements.

In addition to online resources, training was provided at the 2015 Spring Conference. This entailed a guest speaker, Dana Sturevant, who covered motivational interviewing skills, specifically using weight concerns as an example of how this conversation can be most effective. Ninety-eight percent of the attendees were either satisfied or highly satisfied with her presentation. The state WIC office also provided local agency staff with many articles via a weekly newsletter that they could read, and then submit a request for credits.

Local staff weighed and measured WIC participants at certification and mid-certification appointments, and additionally at follow up visits if there were concerns. This was monitored by state WIC staff at local agency reviews.

The Montana Farmers Market program continued through the 2015 season. This provided additional benefits for the purchase of fresh fruits and vegetables, at local farmer's markets throughout the summer months. As of October 22, 2015, the Farmer's Market redemption amount was \$41,627, or 84% of the total grant amount. The national average redemption rate is only 59%.

**State Performance Measure 4: The rate of death to children 0 through 17 years of age caused by unintentional injuries**

The state FICMMR Program continued to support community and state efforts to reduce the rate of unintentional deaths in children. Efforts included: 1) working with and providing resource information to local FICMMR Leaders

and Teams, especially in counties which experienced higher rates of unintentional injuries; 2) collaborating with other agencies to target unintentional injury deaths, particularly the Montana Injury Prevention Program; and 3) helping with the development of resources and tools for community education, activities and policies to reduce unintentional injury deaths.

Local FICMMR Teams continued to review all unintentional child deaths, and implement community prevention initiatives. The state FICMMR Program Coordinator utilized an array of technology (web-based Child Death Review Reporting System, Captivate, WebEx, etc.) to train and meet with FICMMR team leaders throughout the year. She also provided prevention information, journal articles, training opportunities, and contributions to a newsletter distributed to county FICMMR Coordinators.

One of the state FICMMR Program goals was for local FICMMR leaders to be knowledgeable of the types of deaths that are preventable, including unintentional injury. Local FICMMR team leaders enhanced their knowledge base of preventable deaths through: case reviews, team discussion of the deaths in their counties, ongoing training in how to run Child Death Review (CDR) Standardized Reports (Manner & Cause) for their counties, and receiving reports with statewide data provided by the state FICMMR Program Coordinator.

Ten county public health departments chose the SPM 4 for FY 2015 (Glacier, Pondera, Judith Basin, Wheatland, Golden Valley, Broadwater, Madison, Park, Fallon, and Wibaux). The state FICMMR program coordinator provided technical support and checked-in quarterly on the progress of county activities.

The state coordinator continued to participate on calls and at meetings to discuss unintentional injury prevention campaigns and strategies at the federal, state, and local level. She also continued to be an active member of the Western-States Coalition for Child Death Review, state of Montana Injury Prevention Coalition and the Emergency Services for Children Committee. The state coordinator collaborated with the Healthy Montana Families Program and Healthy Mothers, Healthy Babies to address injury prevention education and activities related to motor vehicle crashes. Information was consistently shared with the local FICMMR leaders via newsletter, WEBEX call, and email.

There were 62 prevention educational initiatives by the 50 county public health departments accepting MCHBG funds. Also, the separate FICMMR teams implemented 106 prevention initiatives. Some of the initiatives which specifically targeted children ages 1 – 10 included: sessions on bicycle safety and helmet use, community education on poison control, home safety assessments, and choking hazards.

A new State FICMMR Coordinator was hired on May 18, 2015. Early activities were to learn Version 4.0 of the web-based CDR Case Reporting System, and to create and implement a data quality plan to help teams increase their knowledge of the CDR system. This increased the accuracy and consistency of CY 2015 case reports.

## Adolescent Health

### State Action Plan Table

#### State Action Plan Table - Adolescent Health - Entry 1

##### Priority Need

Teen Pregnancy Prevention

##### NPM

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

##### Objectives

Increase the percent of adolescents who have received a preventive medical visit in the past year to 78% by 2021.

##### Strategies

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

##### ESMs

ESM 10.1 - Adolescent Preventive Care Advocates Survey

## NOMs

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

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

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

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

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

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

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

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

## State Action Plan Table - Adolescent Health - Entry 2

### Priority Need

Immunization Rates

### SPM

Immunization

### Objectives

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

## Strategies

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

## State Action Plan Table - Adolescent Health - Entry 3

### Priority Need

Teen Pregnancy Prevention

### SPM

Teen Pregnancy Prevention

### Objectives

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

### Strategies

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

## Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	75.4	76	76.5	77	77.5	78

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	75.4 %	2.2 %	52,087	69,078
2007	79.0 %	1.9 %	65,286	82,664
2003	68.6 %	1.9 %	55,728	81,280

**Legends:**

- 🚫 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**ESM 10.1 - Adolescent Preventive Care Advocates Survey**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	60.0	60.0	60.0	60.0	60.0

**Adolescent Health - Plan for the Application Year**

**Please see the FFY 2015 report section for background narrative on this domain through 9/30/15 -**

Montana's Adolescent Health domain performance measures for FFYs 2016 – 2020 are:

- NPM 10 – Adolescent Preventive Care
- SPM 3B – Immunizations, ages 13 – 17 years
- SPM 5 – Teen Pregnancy Prevention, ages 15 – 17 years

The following narratives contain current activities and upcoming plans –

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

Adolescent preventive care is still a relatively new performance measure for Montana. In the 2015 Statewide Needs Assessment, county health officials identified two common needs for this population: education regarding the dangers of prescription drugs and opiates addiction, and suicide prevention.

NPM 10 is helping the Public Health and Safety Division (PHSD) to put additional focus on risky adolescent behaviors, some of which are addressed in several sections of the PHSD State Health Improvement Plan (SHIP). Section E of the SHIP focuses on improving mental health, and reducing substance abuse in our adolescents and adults. It includes: decreasing the proportion of youth who report using alcohol in the past 30 days from 38% to 34%; decreasing the proportion of youth who report having smoked marijuana in the past 30 days from 21% to 18%; and decreasing the proportion of youth who report being depressed for two or more consecutive weeks in the past 12 months, and have stopped doing usual activities from 25% to 22%. Section B in the SHIP aims to decrease the rate of teen pregnancies in girls aged 15 to 19 years, from 46 to 42 births per 1,000.

Directly addressing adolescent preventive care is a new endeavor for the PHSD's Family & Community Health Bureau (FCHB). Neither, the FCHB nor PHSD has a dedicated adolescent health FTE. Rather, that role is filled by multiple program coordinators whose funding targets adolescent health. The first step this coming fiscal year is to complete an assessment of available adolescent programs, then the FCHB will move forward to partner with these public and private entities, and provide education about the importance of adolescents receiving a preventive medical visit. Another planned activity is the development of evidence-based adolescent health-related messages. These will be distributed through organizations and programs across the state with an interest in adolescent health.

In January 2016, there was a preliminary meeting with representatives from DPHHS and the Office of Public Instruction, whose programs work with issues and data related to adolescents. Attendees included: the DPHHS Suicide Prevention Coordinator, the Youth Risk Behavior Survey Data Specialist, the Women's and Men's Health Program Specialist, the Medicaid Child and Maternal Health Nurse, and the Maternal & Child Health Section Supervisor. NPM 10 was introduced as a new initiative for the FCHB, and information and ideas for making improvements were solicited. General categories included: optimizing episodic visits such as sports physicals, using social media, increasing convenience for parents and teens, provider education and encouraging providers to adopt a policy of private visits with adolescents. These partners will continue to be involved with assessing current adolescent programs and creating evidence-based messaging on the benefits of preventive services visits.

**SPM 3 – Immunization: b) Percent of 13-17 year olds who have received age appropriate adolescent immunizations against Diphtheria, Tetanus, Pertussis, meningococcal, and Human Papillomavirus.**

The 2015 Montana Legislature revised school immunization requirements for school attendance effective October 1, 2015. The new law requires Tetanus, diphtheria, and pertussis (Tdap) vaccine for students starting at 7th grade. In previous years, only a Td, or tetanus/diphtheria, shot was required. Students currently in grades 8th-12th who had not yet received their Tdap vaccine needed to be caught up. Students in kindergarten through 12th grade are required to have two doses of varicella (chickenpox) vaccine. Prior to the passage of this law, Montana was the only state that did not require the varicella series and one of five not requiring a pertussis booster for school attendance.

A tremendous effort was required on behalf of all the Immunization Program contractors, including the 26 County Public Health Departments who chose SPM 3 for FY 2016. This work continues to include: reviewing school records and sending letters to parents regarding immunizations that are required for school attendance; working with partners such as the Blue Cross / Blue Shield Care Van, to provide vaccines in remotes areas where it is very difficult to transport vaccines; using advertising campaigns and social media posts; offering incentives as part of adolescent outreach, such as gift cards; and holding additional school immunizations clinics. The new school

immunization requirements also provide an opportunity to offer the other adolescent specific vaccinations such as meningococcal, and Human Papillomavirus, at the same time.

As a part of the MCHBG task order requirements, the counties choosing SPM 3 all implement at least two activities that fit in either the Enabling Services category, or the Public Health Services and Systems category. They also plan, in advance, how to evaluate their effectiveness. Reports are made to state MCH staff each quarter. Data on county immunization levels are measured as a baseline before efforts begin, and then again at the end of the year using the state's imMTrax system.

The state Immunization program is providing a series of trainings via WebEx on a variety of topics. For example: Immunizations - Building Trust During the Time of Twitter. It featured Dr. Wendy Sue Swanson, a practicing pediatrician and Executive Director of Digital Health at Seattle Children's Hospital. She gave an overview of how social media can be leveraged to communicate vaccine science and safety, and addressed the use of social media tools in the US; messaging for vaccine hesitancy; and strategies for using social and traditional media to communicate vaccine information.

The DPHHS Immunization Section is continuing to partner with 53 contractors across the state to improve the immunization rate in Montana. Contractor and state staff activities consist of:

- Maintaining immunization records in the statewide immunization information system.
- Providing outreach and referrals for adolescents identified by immunization information systems that are missing or coming due for immunizations.
- Developing and implementing a protocol for reducing missed opportunities for vaccination (e.g. Reviewing immunization records at every visit, and eliminating missed opportunities for simultaneous vaccination).
- Meeting quarterly with key internal partners to review data provided and discuss strengths and opportunities for improvement.
- Meeting quarterly with local vaccinations for children (VFC) providers to review the data reports and share best practices for increasing immunization rates.
- Maintaining records received from local schools for adolescents, review for completeness and accuracy, and following up on children who are conditionally attending.
- Promoting delivery of vaccination services to underinsured adolescents.

#### **SPM 5 - Teen Pregnancy Prevention: Rate of birth for girls ages 15 - 17 years.**

Women's and Men's Health Section (WMHS) contracts and provides technical assistance with 13 Delegate Agencies (DAs); offering services in 26 locations, representing all 56 MT counties. WMHS disseminates information through a weekly online newsletter; including funding opportunities, upcoming trainings and events, and information for Title X agencies. DAs ensure that women and men of reproductive age, including adolescents, have access to comprehensive reproductive health care, education information, and services that include how to prevent unintended pregnancy. The agencies' sliding fee schedule is based on family size and income. The sliding fee schedules ensure the affordability of these reproductive health services and supplies.

WMHS performance measure goal as of June 30, 2017 is that 85% of female patients < 19 years will use a highly or moderately effective method of contraception (defined as Implant, IUD, OCPs, patch, ring or Depo). To reach this goal WMHS is providing highly effective methods of contraceptives to adolescents in need of comprehensive reproductive health services, based on the income of the adolescent in order to reduce barriers to care. Title X clinics continue to provide adolescents with quality family planning services and include counseling on abstinence,

the importance of family involvement, avoiding coercion, and confidentiality.

The WMHS Program Specialist coordinates with the Office of Epidemiology and Scientific Support to distribute information to local DAs on current teen pregnancy rates and trends on a yearly basis. So far in fiscal year 2016, the Information and Education Committee has met four times to ascertain family planning priorities. Priorities were identified in the fall of 2015, and include Teen Pregnancy Prevention Month, HIV, Domestic Violence/Teen Dating Violence, and STI. Information is being disseminated through outreach campaigns, community presentations, training, newsletter articles, and toolkits.

The PS worked with the University of Montana to coordinate the Montana Family Planning Training Conference on March 30-31, 2016, which had 42 attendees. Topics included “Continuous Hormonal Contraception” which focused on highly effective methods of contraception, and “Abnormal Uterine Bleeding” which focused on how contraceptives can assist in menstrual disorders.

WMHS receives funding from the Administration for Children and Families for teen pregnancy prevention through the Personal Responsibility and Education Program (PREP) grant. WMHS provides oversight and technical assistance to the six PREP contractors including: Custer County Health Department, Butte Silver Bow Health Department, Northern Cheyenne Reservation, Anaconda Family Resource Center, Missoula Teen Recovery Center and Flathead County Health Department.

Office of Population Affairs (OPA) funding is distributed to DAs for dispensing highly effective and emergency contraceptives targeting low income women, including adolescents. WMHS is part of a learning collaborative focused on increasing the number of Title X patients on highly effective methods of contraception, especially Long Acting Reversible Contraceptives (LARCs). Examples of activities to increase LARC use are include:

- Providing all LARC methods on a sliding-fee schedule
- Purchased and stocked Liletta
- March training for all providers on Liletta insertion
- Application assistance to Montana Medicaid and Medicaid Waiver

There are two OPA performance measures focused on all women of reproductive age, and those 14-19 years old. WMHS is piloting a project in one of the Title X clinics to review same day insertions, stocking low cost LARCs, and providing training to clinicians. WMHS plans to continue a focus on increasing LARCs for all women, especially those 14-19 years old, which includes searching for additional funding opportunities. The wording of the measures is as follows:

Intermediate Outcome Measure: Maintain the percentage of women 15–44 years of age who are at risk of unintended pregnancy that adopt or continue use of FDA-approved methods of contraception that are most or moderately effective (i.e., male or female sterilization, implants, intrauterine devices [IUD] or intrauterine systems [IUS], Depo-Provera (the ‘shot’), oral contraceptive pills, patch, ring, and diaphragm) at 80%.

Access measure: Increase the percentage of women 15–44 years of age who are at risk of unintended pregnancy that adopt or continue use of FDA-approved methods of contraception that are long-acting reversible contraception (LARC) (i.e., implants, IUDs, or IUSs) from 11% to 25%. (April 12016 data shows 23% of clients were using a LARC method.)

## **Adolescent Health - Annual Report**

### **Background Narrative - Information Submitted for July 2015 Report:**

Performance Measures Included: (P designates performance measures for fiscal years 2011-2015, and N designates new performance measures for fiscal years 2016-2020)

Last Year's Accomplishments and Current Activities =

- PNPM 8 – Rate of Teen Pregnancy (Ages 15 – 17)
- PNPM 10 – Motor Vehicle Deaths (Ages 11 – 14)
- PNPM 16 – Suicide (Ages 15 – 19)
- PSPM 4 – Unintentional Injury Deaths (Ages 11 – 17)

Plan for the Coming Year and for 5-Year Action Plan =

- NNPM 7 – Injury Related Hospital Admissions (Ages 11 – 19)
- NNPM 10 – Adolescent Preventive Services Visit
- NSPM 3 – Immunizations (Ages 13 – 17)
- NSPM 5 – Teen Pregnancy Prevention (Ages 15 – 17)

The main MCHBG categories of activity that fit into the Adolescent Domain for Montana are: Teen Pregnancy Prevention, Preventive Services, Immunizations, Injury, and Suicide. This narrative will report on past accomplishments and challenges, current effectiveness, and initiation of new efforts based on the needs assessment analysis.

Two of these categories contain performance measures which span the timeframes of two 5-Year Statewide Needs Assessments: Teen Pregnancy Prevention and Injury. Preventive Services and Immunizations are new performance measures specific for this age group. Suicide is a part of the reporting on last year's accomplishments and current activities, and while not one of the priorities in the upcoming state action plan, continues to be of importance to the Department of Public Health and Human Services (DPHHS).

#### Teen Pregnancy Prevention

From 2007 to 2013, the Montana teen birth rate declined by 25% for 15-17 year old females. However, the national rate declined 45% during the same time frame to 12.3/1,000. From 2012 to 2013, there were 458 births to females aged 15-17 in Montana for a rate of 12.6/1,000.

The FCHB's Women's and Men's Health Section (WMHS) served 5,147 adolescents aged 19 and under, from July 1, 2013 through June 30, 2014. During that time, 78% of females 19 years and under were using highly effective methods of contraceptives that include Intrauterine Devices (IUD), oral contraceptives, vaginal ring, hormonal patch, Depo-Provera injection, and implants. One WMHS performance measure is that 85% of female patients < 19 years will use a highly or moderately effective method of contraception by June 30, 2017. To reach this goal WMHS will provide highly effective methods of contraceptives to adolescents in need of comprehensive reproductive health services, based on the income of the adolescent to reduce barriers to care.

WMHS will continue to contract with and provide technical assistance to 13 Delegate Agencies (DAs), offering services in 28 locations and representing all 56 MT counties. Office of Population Affairs funding is distributed to DAs for dispensing highly effective and emergency contraceptives, targeting low income women. The DAs ensure that women and men of reproductive age, including adolescents, have access to comprehensive reproductive health care, education information, and services that include how to prevent unintended pregnancy. The agencies' sliding fee schedules are based on family size and income.

In FFY 2013, the DAs served an estimated 2,137 female adolescents (15-17) and also provided specific outreach projects designed for adolescents at high risk for teen pregnancy and birth. The number of women of childbearing age receiving services was 18,979. They will continue to provide adolescents with quality family planning services and include counseling on abstinence, the importance of family involvement, avoiding coercion, and confidentiality.

The WMHS Program Specialist worked with the Office of Epidemiology and Scientific Support to create the Montana Teen Birth and Pregnancy Report 2014. The report provided information to local DAs on current teen pregnancy rates and trends in January 2015. WMHS will continue to coordinate with the Office of Epidemiology and Scientific Support to distribute information to local DAs on current teen pregnancy rates and trends on a yearly basis.

WMHS maintains contracts with and provide technical assistance to six Personal Responsibility Education Programs (PREP), through funding from the Administration for Children and Families. These programs offer evidenced-based teen pregnancy prevention, and sexually transmitted infections curriculum, to middle and high school aged youth. Draw the Line/ Respect the Line is the curriculum for middle school, and Reducing the Risk is for high school students. Both curriculums were created by ETR Associates.

One PREP contractor, Northern Cheyenne Tribal Health, works directly with schools on the reservation in Rosebud County. Rosebud County had a high teen birth rate of 64.6/1,000 (females 15-19 years, 2009-2013). The PREP program presented curricula to 1,008 students in the high school (16 lessons) and 697 in the middle school (5 lessons). The other five PREP contractors are: Custer County Health Department, Butte Silver Bow Health Department, Anaconda Family Resource Center, Teen Recovery Center and Flathead County Health Department. Teen pregnancy prevention curriculum is also provided to high risk youth at the Pine Hills Correctional Facility (Custer County), and at the youth substance abuse facility in Missoula.

WMHS will continue to seek funding from the Administration for Children and Families for teen pregnancy prevention through the Personal Responsibility and Education Program grant. WMHS will also provide oversight and technical assistance to the six PREP contractors.

The state family planning Information & Education Committee (IEC) met four times in 2013 -2014 to review and plan family planning priorities: Teen Pregnancy Prevention Month, Cervical Cancer Awareness Month, Sexually Transmitted Infections Awareness Month, and "Get Checked MT" Human Immunodeficiency Virus (HIV) awareness through outreach campaigns and toolkits. Toolkits were distributed to the 13 DAs and 12 satellite service sites reaching an estimated 7,608 individuals across Montana. Priorities for 2015 include: Teen Pregnancy Prevention Month, Cervical Cancer Awareness Month, STD Awareness Month, and Domestic Violence/Teen Dating Violence Awareness Month awareness. Information is provided through outreach campaigns and toolkits provided by WMHS.

WMHS worked with the University of Montana for the Montana Family Planning Training Conference in April 2014, with the following seminars: "Are you kidding me: not any reduction in unintended pregnancy," "Opening doors-opening minds for teen pregnancy prevention," and "Getting inside the teen mind." The PREP Program also organized a statewide campaign for Teen Pregnancy Prevention Month in May 2014. Outreach packets were created that included a press release, sample letter and updated teen pregnancy rates for Montana.

WMHS will work with the University of Montana (UM) to coordinate the Montana Family Planning Training Conference in the spring 2016. Topics on health education and adolescents will continue to be part of the training to ensure family planning staff are providing up to date and relevant information to teen patients on preventing teen pregnancy.

WMHS applied for an additional Teen Pregnancy Prevention grant that would have targeted communities with the greatest need. These communities (Hill County, Roosevelt County, Big Horn County, and Lake County) were identified as having a high teen birth rate and include all or part of a reservation. Unfortunately, this grant was not approved. Butte Silver Bow Family Services was able to partner with the Pregnant and Parenting Teen Grant and WMHS has supported them in this effort by providing data and teen pregnancy toolkits.

WMHS will continue to collaborate with agencies serving youth at risk of pregnancy, and look for more opportunities to collaborate and reduce teen pregnancies in Montana. WMHS disseminates information through a weekly online newsletter, to 280 recipients. Topics include: funding opportunities, upcoming trainings and events, and information for DAs.

### Preventive Services

Adolescent preventive care is a new performance measure for Montana and one that has not been assessed by the county health departments in their yearly Pre-Contract Survey (PCS), which gathers information about their county's met and unmet health needs. Even though the SFY 2016 PCS did not include specific questions about adolescent health needs, the county health officials included the following comments about needs for this population: education regarding the dangers of prescription drugs, opiates, and addiction and suicide prevention.

NPM 10 focuses on a number of risky adolescent behaviors, some of which are addressed in the State Health Improvement Plan (SHIP). Section E. focuses on improving the mental health and reducing substance abuse in adolescents and adults. It includes decreasing the proportion of youth who report using alcohol in the past 30 days from 38% to 34%; decrease the proportion of youth who report having smoked marijuana in the past 30 days from 21% to 18%; and decrease the proportion of youth who report being depressed for 2 or more consecutive weeks in the past 12 months and stopped doing usual activities from 25% to 22%. Section B in the SHIP aims to decrease the rate of teen pregnancies in girls aged 15 to 19 years from 46 to 42 births per 1,000.

DPHHS' structure includes the Addictive & Mental Disorders Division (AMDD). The AMDD's mission is to implement and improve an appropriate statewide system of prevention, treatment, care and rehabilitation for Montanans with mental disorders or addictions to drugs or alcohol. AMDD provides substance abuse and adult mental health services by contracting with behavioral health providers throughout Montana. Programs such as FICMMR, and the Maternal and Early Childhood Home Visiting, work closely with AMDD staff by sharing resources.

Addressing adolescent health issues will require the FCHB to depend on these and other partnerships. While PHSD does not have a dedicated adolescent health FTE, program coordinators from various programs target adolescent health. This includes the Designated Agencies providing reproductive health care across the state. Crafting a state action plan for NPM 10 will involve several steps so as to maximize the strategies impact. A foundational action is to have the MCH epidemiologist conduct a more in-depth analysis of data. Another significant step will be to complete an assessment of all available state-level adolescent programs. This knowledge will enable the FCHB identify which of these public and private entities to seek out as potential partners for the state action plan.

The state action plan will include the development of DPHHS approved adolescent health-related messages. These will be developed from evidence-based approaches, and will be distributed to the FCHB's established partner network as indicated in the Needs Assessment.

### Immunizations

Montana created a state performance measure for immunization to address the ongoing need, and the fact that many CPHDs face challenges from vaccine hesitancy. The adolescent population has been included to make the measure more comprehensive, as follows: *Percent of 13-17 year olds who have received age appropriate adolescent immunizations against Diphtheria, Tetanus, Pertussis, meningococcal, and Human Papillomavirus.*

The DPHHS Immunization Section partners with 53 contractors statewide. Contractor activities targeted to adolescents consist of:

- Maintaining immunization records in the statewide immunization information system.
- Providing outreach and referrals for adolescents identified by immunization information systems that are missing or coming due for immunizations.
- Developing and implementing a protocol for reducing missed opportunities for vaccination.
- Meeting quarterly with key internal partners to review data provided and discuss strengths and opportunities for improvement.
- Meeting quarterly with local vaccinations for children (VFC) providers to review the data reports provided by Department of Public Health and Human Services (DPHHS) and share best practices for increasing immunization rates.
- Maintaining records received from local schools for children entering 7th grade, reviewing these records for completeness and accuracy, and making follow-up contacts on children who are conditionally attending.
- Promoting delivery of vaccination services to underinsured adolescents.

## Injury

The Montana State Health Improvement Plan (SHIP) includes this objective: “By 2018, increase the proportion of motor vehicle occupants that report they wear seat belts from 73% to 83%.” The SHIP Strategic Plan provides for increasing awareness about the importance of seatbelt and car seat use through training opportunities and providing educational materials. Data from the timeframe of January 2006 through December 2011 indicate that 129 infants, children, and teens were killed by motor vehicles in Montana. A copy of Montana’s FICMMR Program November 2013 report: “Childhood Motor Vehicle Deaths, Montana, 2006-2011”, is at:

<http://dphhs.mt.gov/publichealth/cdrp#148211275-ficmmr-coordinator-resources>. Reports on other topics can be accessed at the same link.

Twenty-seven local Fetal, Infant, Child and Maternal Mortality Review (FICMMR) Teams, representing 54 CPHDs, review motor vehicle and all other unintentional injury deaths. They then implement community activities related to prevention. The state FICMMR Program Coordinator assists with: researching evidence-based practices and prevention activities, and providing training on submitting accurate reports through quarterly conference calls, newsletters, webinars, trainings, and emails. In November 2013, a packet of educational materials was mailed out to all 56 counties and 7 tribes which included: car seat safety, the importance of buckling up, farm equipment safety, teen drinking and driving, safe sleep, poison control and choking hazards.

The FICMMR Coordinator and the MCH Epidemiologist collaborated on three FICMMR Quarterly reports which addressed statewide findings in Montana from 2006 through 2012. The report findings were based on data collected prior to Montana entering into a Data Use Agreement with The National Center for the Review & Prevention of Child Deaths to report FICMMR review results in the Child Death Review (CDR) Case Reporting System.

Through the Maternal and Child Health Block Grant (MCHBG) Task Orders, County Public Health Departments (CPHDs) are required to complete one injury prevention activity each year. In the first three quarters of SFY 2015, 62 injury prevention activities were completed.

The FICMMR Program Coordinator worked with Pondera County on their choice of FY 2014 MCHBG performance measure, NPM 10. In March 2014, they held a “Red Thumb” event to raise awareness “Not to Text and Drive.” The May 2014 FICMMR Program newsletter highlighted the successful event, where over 100 high school students, law enforcement officials, teachers, and business owners learned about the dangers of texting and driving. Support has also been ongoing in FY 2015 for the ten counties working on State Performance Measure 4: The rate of death to children 0 through 17 years of age caused by unintentional injuries.

The Director of the National Center for Child Death Review, Teri Covington, was an instructor at the four 2014 FICMMR regional trainings. Ms. Covington and the FICMMR Program Coordinator co-presented on using the Child Death Review (CDR) Reporting System, which is a web-based data collection tool maintained by the National Center for the Review & Prevention of Child Deaths. Montana’s local FICMMR Teams were required to start reporting their FICMMR review data in the CDR beginning with calendar year 2013 deaths. One tutorial in the regional trainings focused on how the local teams could extract CDR data for standardized reports. For example, “Motor vehicle and other transport death demographics” was demonstrated to the 68 attendees.

The FICMMR Program Coordinator participates on the Montana Seatbelt Workgroup, and is a member of the Injury Prevention Coalition. Information and resources learned from these resources are posted on the FICMMR website, shared on conference calls, and emailed to the local FICMMR teams. Information obtained from death reviews and prevention activity reports are shared with the Montana Injury Program and the Montana Department of Transportation. The state FICMMR Program will also continue to partner with community and state organizations, such as “Buckle Up MT”, which provide support to parents about proper car seat installation, child transportation safety, and parental responsibility when in and around cars.

In the coming year, FCHB staff will take the lead on developing the state action plan. In the area of child injuries, the initial activity requires the MCH Epidemiologist to assess the primary causes of injury-related hospital admissions. The assessment results will yield information for identifying subject matter experts within the Public Health and Safety Division (PHSD), DPHHS, and other public and private entities and organizations with whom to partner in SFY 2016 while creating the state action plan.

Section D of the SHIP is focused on preventing injuries and exposures to environmental hazards. The state action plan will reflect the strategies from the SHIP and the PHSD Strategic Plan, which include: increasing awareness of injury prevention; implement evidence-based programs to facilitate injury prevention and maternal and child health; provide training and technical assistance to schools and childcare settings to implement evidence-based programs to promote and protect health; and promote health by providing information and education to help people make healthy choices.

The state action plan will include the development of DPHHS approved injury prevention messages, developed from evidence-based approaches. These will be distributed among the FCHB’s established partner network, as indicated in the Needs Assessment.

## Suicide

Data collected from January 2006 through December 2012, reveals 42 children ranging in age from 12 to 17 died from suicide. Twenty-eight decedents were white and 14 American Indian/Alaska Native (AI/AN); 26 decedents were male and 16 female. This data as well as additional information is available in the March 2014 Montana Fetal, Infant, Child and Maternal Death Review (FICMMR) Report: Childhood Suicide Deaths, Montana, 2006-2012, which was co-written by the FICMMR Coordinator and the MCH Epidemiologist and is accessible at:

<http://dphhs.mt.gov/publichealth/cdrp#148211275-ficmmr-coordinator-resources>

The 2013 Legislature recognized the need to address Montana's suicide rate, which was and continues to be among the highest in the United States. Funding was allocated for the Suicide Prevention Coordinator position housed in the Addictive & Mental Disorders Division within the Department of Public Health and Human Services. The Suicide Prevention Coordinator leads the work of Montana Suicide Review Team (MSR) which is charged to identify factors associated with suicide, in an effort to develop prevention strategies.

In January 2014, Montana's first Suicide Review Team meeting was held. It meets eight times a year and anticipates reviewing up to 27 suicide deaths each month. The team will make recommendations to the governor to prevent future deaths. Montana is the first state to have this type of team and hopes to become a role model for other states with high suicide rates. The MSR has published a Summary Report for the time period of January 1 to December 31, 2014. More information is available at: <http://dphhs.mt.gov/amdd/Suicide.aspx>. The Suicide Prevention Coordinator serves as a statewide resource, and the suicide prevention webpage has a large amount of prevention resources materials.

From December 2013 through January 2014, Silver Bow County encountered a cluster of teen suicides. The Montana Suicide Program provided warning sign materials, trainings, and spoke at two town hall meetings and two high schools. In May 2014, the Suicide Prevention Coordinator gave a talk at the Silver Bow Community Health Center to educate medical staff about the warning signs of suicide.

The FICMMR Program continues to provide technical assistance to communities for development of activities and policies to reduce the rate of youth suicide. This is achieved through 1) partnerships with Lead Local FICMMR Coordinators, especially counties experiencing higher suicide rates; 2) collaborating with: the Office of Public Instruction to focus on bullying in schools, and the Montana Suicide Prevention Program on prevention of youth suicide; and 3) help with development of resources and tools for community education and activities/policies to reduce youth suicides. One of the desired outcomes is that the local FICMMR Coordinators are knowledgeable of the types of deaths that are preventable, including suicide.

Twenty-seven local FICMMR Teams review youth suicides, and implement community activities related to prevention. Sixty eight FICMMR team members attended one of the regional trainings during June 2014, which included a break out session on how to conduct a suicide death review.

MCHBG contracts require at least one prevention activity to be completed and reported on the MCHBG Quarterly Report. The Butte-Silver Bow County Health Department's suicide prevention activity was featured in the March 2014 FICMMR Newsletter, which can be accessed at: <http://dphhs.mt.gov/publichealth/cdrp#148211280-ficmmr-newsletters>. Three CPHDs chose National Performance Measure 16 for State Fiscal Year 2015. From July 1, 2014 through March 31, 2015, 17 CPHDs offered either a suicide prevention activity, including one on the importance of gun locks.

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### **FFY 2015 Report Updates:**

The FFY15 updates for the Adolescent domain include the following performance measures:

- NPM 8 – Teen Pregnancy, ages 15 – 17
- NPM 10 – Motor Vehicle Deaths, ages 11 – 14
- NPM 16 – Suicide Deaths

- SPM 4 – Unintentional Injury Deaths, ages 11 – 17

**Performance Measure 08: The rate of birth (per 1,000) for teenagers aged 15 through 17 years**

The Women's and Men's Health Section (WMHS) contracted and provided technical assistance with 13 Delegate Agencies (DAs), offering services in 26 locations representing all 56 MT counties. Technical assistance was provided through four Health Education Conference calls, four clinical conference calls, four Administrator conference calls, two in-person administrator meetings, three front desk/billing conference calls, and one statewide training.

DAs ensured that women and men of reproductive age, including adolescents, had access to comprehensive reproductive health care, education information, and services that included how to prevent unintended pregnancy. The agencies' sliding fee schedules were based on family size and income. The sliding fee schedules ensure the affordability of these reproductive health services and supplies. Office of Population Affairs funding was distributed to DAs for dispensing highly effective & emergency contraceptives targeting low income women, including adolescents.

WMHS served 1,867 adolescents 15-17 years old from July 1, 2014 through June 30, 2015. During that time 82% of females 15-17 were using highly effective methods of contraceptives that include Intrauterine Devices (IUD), oral contraceptives, vaginal ring, hormonal patch, Depo-Provera injection, and implants; and 2% of 15-17 year olds were using a long acting reversible contraceptive (LARC) that include only IUD and Implants. Title X clinics continued to provide adolescents with quality family-planning services, and included counseling on abstinence, the importance of family involvement, avoiding coercion, and confidentiality. There were 3,009 family planning visits for adolescents 15-17 years old.

The WMHS Health Program Representative (HPR) worked with the Office of Epidemiology and Scientific Support to create the Montana Teen Birth and Pregnancy Report 2014, and distributed information to local DAs on current teen pregnancy rates and trends in January 2015.

The Information and Education Committee met on a regular basis to review and to plan family planning priorities. The priorities included: Teen Pregnancy Prevention Month, Cervical Cancer Awareness Month, STD Awareness Month, and Domestic Violence/Teen Dating Violence Awareness Month. Information was provided through outreach campaigns and toolkits provided by HPR. The following table provides details:

<b>Metric</b>	<b>FY15 Actual</b>
Number of educational outreach events conducted from toolkits	132
Number of educational presentations provided to local community members	522
Number of contact hours providing training and technical assistance with health educators	8
Number of individuals receiving weekly newsletter	285

The WMHS provided funding from the Administration for Children and Families for teen pregnancy prevention through the Personal Responsibility and Education Program grant. The WMHS provided oversight and technical assistance to the six PREP contractors including: Custer County Health Department, Butte Silver Bow Health

Department, Northern Cheyenne Reservation, Anaconda Family Resource Center, Teen Recovery Center in Missoula, and Flathead County Health Department. Teen pregnancy prevention curriculum was provided to high risk youth at Pine Hills Correctional Facility (Custer County), youth substance abuse facility (Teen Recovery Center), and on the Northern Cheyenne Reservation. During State Fiscal Year 2015, PREP participants reached 1,410 students.

The WMHS disseminated information through a weekly online newsletter, including: funding opportunities, trainings and events, and information for Title X agencies and PREP grantees. The WMHS applied for an additional Teen Pregnancy Prevention grant that targeted communities with the greatest need. These communities (Hill County, Roosevelt County, Big Horn County, and Lake County) were identified as having a high teen birth rate and include all or part of a Native-American Indian reservation. Unfortunately, WMHS did not receive the grant. WMHS continues to collaborate with agencies serving youth at risk of pregnancy, and look for more opportunities to collaborate and reduce teen pregnancies in Montana.

### **Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children**

The state FICMMR Program supported communities across the state in their efforts to reduce the rate of children's motor vehicle injuries and death. The state FICMMR Program Coordinator worked collaboratively with 50 local FICMMR team leaders, helping to educate them on safe practices and risk reduction behaviors.

Local FICMMR Teams continued to review motor vehicle deaths, and implement related community prevention activities. As required by their county MCHBG Task Orders, local FICMMR Coordinators completed at least one FICMMR prevention activity, and most did at least one per quarter. The state FICMMR Coordinator continued to assist the local teams by sharing evidence-based practices, safety campaigns, and prevention activities through conference calls, emails, and newsletters.

Some of the specific information shared regarding children ages 11 - 14 included:

- With younger teens operating motor vehicles in Montana's rural areas, a national campaign on the **"5 Deadly Behaviors of Teen Drivers"** was shared with all the local FICMMR teams. The '5 to Drive Campaign,' encouraged parents about the need to talk to their children about 5 critical rules: wear seat belts, limit the number of people in the vehicle, no alcohol, no texting, and no speeding. Campaign materials included fact sheets, marketing collateral, newspaper Op-Ed pieces and new releases.
- **National Tween Seat Belt Advertising Campaign** – Data shows that as children get older they are less likely to buckle up. This campaign targeted parents of children ages 8-14 to make sure their kids were consistently and properly wearing their seat belts every time the car was moving. A toolkit link to television, radio, digital and outdoor ads was distributed to all the teams.

During FFY 2015, 16 training opportunities targeting NPM 10 were offered by county public health departments accepting MCHBG funds. The trainings included seat belt usage, car seat installation, distracted driving prevention, and safe road advocacy. Also, the separate FICMMR teams planned and implemented numerous car seat safety clinics, educational sessions, distracted driving presentations, seat belt safety messaging, and safe road advocacy initiatives.

The state FICMMR coordinator facilitated quarterly conference calls with the local team leaders. Part of the agenda on these calls was a data quality initiative on the web-based Child Death Review (CDR) system. This system

collects all of the data on a death, once a child's case has been reviewed and prevention determined. The initiative focused on 20 sections of critical importance for teams to complete accurately, one of which collects information about deaths involving a motor vehicle.

### **Performance Measure 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19**

The Fetal, Infant, Child and Maternal Mortality Review (FICMMR) Program provided technical assistance to communities for the development of activities and policies with the goal of reducing youth suicide. This was achieved through: 1) partnerships with local FICMMR leaders, 2) collaborating with the Montana State Suicide Prevention Program on youth suicide prevention; and 3) helping to develop various resources for community education, activities, and policies to reduce youth suicides.

Local FICMMR teams continued to study and review youth suicides and implement community-specific activities aimed at reducing these preventable deaths. The state FICMMR Program Coordinator provided access to specialty websites, powerful videos, articles, and prevention activity information to ensure local team leaders were up-to-date on warning signs of suicide and proper ways to intervene.

Three county public health departments (CPHDs) chose National Performance Measure 16 for State Fiscal Year 2015. Presentations to students covered a host of topics: depression, bullying, peer pressure (alcohol, drugs, sex), how to identify safe spaces and the benefits gained in utilizing positive role models. During FFY 2015, 17 CPHDs and 10 local FICMMR teams provided a suicide prevention activity. Many of these focused on suicide prevention education and gun locks.

One CPHD formed an active sub-group of the local mental health advisory committee, which organized a suicide prevention week. Activities included: a) a Question Persuade Refer (QPR) community training, b) PSAs generated/delivered every morning by middle school students, c) radio public service announcements, and posters geared towards college students, d) a college campus booth broadcasting music by Rascal Flatts, to draw students over to the suicide prevention table. The popular country band served as celebrity ambassadors for the B1 Pledge (*Be Aware, Be Able, Be Prepared to Act*). The suicide prevention week also included a newspaper article about suicide prevention with additional literature going home with students for parents. Late in 2015, this same county delivered a presentation to education majors at UM Western, other secondary schools and organized a Youth Mental Health First Aid class.

Another CPHD presentation utilized the SAMHSA suicide prevention toolkit for high schools. This county worked with the school counselor in advance to determine the specific educational support this school needed (depression, bullying, STD, etc.) and tailored the presentation to meet those needs.

A suicide prevention activity was implemented by a CPHD which did not chose NPM 16, as a response to three teen suicides occurring within a 6-week period. They partnered with the father of one of the teens who died, and with other community partners, to help sponsor House Bill 374 which passed into law in 2015. HB 374 allows for suicide awareness and prevention training to be available for every teacher or specialist who applies for certification renewal. Plans are under way to strengthen this bill and make the training mandatory at the next legislative session in 2017. The FICMMR team leader also participates on the newly formed community suicide prevention team. In 2015, FICMMR team members helped organize the first annual Out of the Darkness Walk that funds suicide prevention education for their county.

A goal of the state FICMMR Program was for local FICMMR leaders to be knowledgeable regarding preventable death, including suicide. FICMMR leaders enhanced their knowledge base of preventable deaths through case reviews, rigorous team discussions on these types of deaths, and ongoing training on how to run county specific standardized reports. These reports provide specific data on any case reviewed, and help identify trends over time.

The state FICMMR Coordinator participated as an active member of the Western-States Coalition for Child Death Review and the National Center for the Review & Prevention of Child Deaths. She also continued to participate in meetings to discuss suicide prevention campaigns and strategies at the federal, state, and local level. Key information was shared with local FICMMR leaders via conference calls, individual phone calls, and emails.

The FICMMR Program continued to partner with the Montana State Suicide Prevention Program, which is also in the Department of Public Health & Human Services. The state FICMMR Coordinator linked counties to the state Suicide Prevention Coordinator, who provides training sessions and consultation to teenagers, parents, school personnel, professionals, and community members across the state. Topics include: suicide warning signs, intervention methods, steps to take in crisis situations to prevent suicide clusters from forming, bullying, statistics, and suicide prevention activities. More information is available on the state suicide prevention program website at: <http://dphhs.mt.gov/amdd/Suicide.aspx>

#### **State Performance Measure 4: The rate of death to children 0 through 17 years of age caused by unintentional injuries**

The state FICMMR Program continued to support community and state efforts to reduce the rate of unintentional deaths in children. Efforts included: 1) working with and providing resource information to local FICMMR Leaders and Teams, especially in counties which experienced higher rates of unintentional injuries, 2) collaborating with other agencies to target unintentional injury deaths, particularly the Montana Injury Prevention Program, and 3) helping with the development of resources and tools for community education, activities and policies to reduce unintentional injury deaths.

Local FICMMR Teams continued to review all unintentional child deaths, and implement community prevention initiatives. The state FICMMR Program Coordinator utilized an array of technology (web-based Child Death Review Reporting System, Captivate, WebEx, etc.) to train and meet with FICMMR team leaders throughout the year. She also provided prevention information, journal articles, training opportunities, and contributions to a newsletter distributed to county FICMMR Coordinators.

One of the state FICMMR Program goals was for local FICMMR leaders to be knowledgeable of the types of deaths that are preventable, including unintentional injury. Local FICMMR team leaders enhanced their knowledge base of preventable deaths through: case reviews, team discussion of the deaths in their counties, ongoing training in how to run Child Death Review (CDR) Standardized Reports (Manner & Cause) for their counties, and receiving reports with statewide data provided by the state FICMMR Program Coordinator.

Ten county public health departments chose the SPM 4 for FY 2015. The state FICMMR Program Coordinator provided technical support, and monitored the progress of county activities on a quarterly basis.

The state FICMMR Program Coordinator continued to participate on calls and at meetings to discuss unintentional injury prevention campaigns and strategies at the federal, state, and local level. She also continued to be an active member of: the Western-States Coalition for Child Death Review, the State of Montana Injury Prevention Coalition, and of the Emergency Services for Children Committee.

The state FICMMR Program Coordinator collaborated with the Maternal & Early Childhood Home Visiting Program, and Healthy Mothers Healthy Babies, to address injury prevention education and activities related to motor vehicle crashes. Information was consistently shared with the local FICMMR leaders via newsletter, WebEx calls, and email.

There were 62 prevention educational initiatives by the County Public Health Departments accepting MCHBG funds. Also, the separate FICMMR teams implemented 106 prevention initiatives.

Some of the initiatives which specifically targeted adolescents ages 11 – 17 included:

- 1) Partnering with a high school football program in administering physicals before the first practice. The student athletes underwent a neurological evaluation while also being assessed for any previous concussions;
- 2) Partnering with a school to perform Active Shooter Incident Training. The training focused on reducing response time and lockdown drills;
- 3) Planning and implementing a Red Thumb Campaign to educate youth about the dangers of texting while driving. This CPHD partnered with other counties, businesses, and schools to create a regional campaign. A key message “W8 2 Text. Park your Phone. Drive your Car” was distributed through a variety of mediums. Students canvassed the town in the lead county, approaching community members and asking them to take the red thumb pledge not to use their cell phone while driving;
- 4) Providing sessions on bicycle safety and helmet use; and
- 5) Educating their communities on substance abuse.

## Children with Special Health Care Needs

### State Action Plan Table

#### State Action Plan Table - Children with Special Health Care Needs - Entry 1

##### Priority Need

Access to Care

##### NPM

Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

##### Objectives

Increase the percent of all adolescents who receive services necessary to make the transition to adult health care to 59% by 2021.

##### Strategies

Ongoing strategies in addition to new ESM are: 1) 3) CSHS will continue to support Cystic Fibrosis, Cleft/Craniofacial, and Metabolic Clinics in Montana. Contracts will include language requiring clinics to promote transition assistance to adolescents who attend clinics. 2) The parent partner project includes transition to adult care projects.

##### ESMs

ESM 12.1 - Transition Services Survey of CYSHCN Families

##### NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table - Children with Special Health Care Needs - Entry 2

Priority Need

Access to Care

SPM

CYSHCN Medical Home

Objectives

Increase the percent of CYSHCN which have a medical home to 59% by 2021.

Strategies

Ongoing strategies in addition to new ESM are: 1) CSHS will continue to support Cystic Fibrosis, Cleft/Craniofacial, and Metabolic Clinics in Montana. Contracts include language requiring clinics to promote medical homes to CYSHCN who attend clinics. CSHS will collaborate with providers to define, implement and evaluate strategies in clinics. 2) Montana will continue the medical home portal project.

**Measures**

**NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	48.6	49	49.5	50	50.5	51

**Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	48.6 %	4.9 %	6,230	12,815
2005_2006	46.2 %	2.9 %	5,846	12,655

**Legends:**

- 🚫 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**ESM 12.1 - Transition Services Survey of CYSHCN Families**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	80.0	80.0	80.0	80.0	80.0

**Children with Special Health Care Needs - Plan for the Application Year**

Please see the 2015 report section for background narrative on this domain through 9/30/15 -

Montana’s CYSHCN domain performance measures for FFYs 2016 - 2020 are:

- NPM 12 – Transition to Adult Health Care
- SPM 4 – Medical Home

The following narratives contain current activities and upcoming plans –

**NPM 12 -Transition Services: Percent of children with and without special health care needs who received services necessary to make transitions to adult health care.**

In 2012, Children’s Special Health Services (CSHS) of Montana was awarded the D70 State Implementation Grant for Systems of Services for CYSHCN. As part of the grant, CSHS funded a transitions project through the University of Montana Rural Institute for Inclusive Communities (RI). Because of the continued success of the project and the mutually beneficial partnership it has created, CSHS has chosen to continue the RI Transition Project in FFY 2017. The project was partially funded with MCHBG funds in SFY 2016 and will be completely funded by MCHBG beginning in SFY2017.

The focus of the project is three-fold:

1. Outreach and Education:
  - a. Identify training topics and opportunities for CYSHCN, families and service providers to improve knowledge and increase advocacy in transition topics. Conduct at least four webinars per year on identified topics.

- b. Develop and disseminate transition related information via listserv. Promote the listserv among families, CYSHCN and providers in Montana.
2. Resource Development:
  - a. Develop and disseminate a health care transition guide. Make the guide available and accessible in various formats and promote use of the guide to families, CYSHCN and providers.
3. Engagement:
  - a. Include CYSHCN in the existing Consumer Advisory Council (CAC), to advise and promote transition issues facing CYSHCN in Montana.
  - b. Provide orientation, education and mentoring to new members in promoting youth advocacy.
  - c. Facilitate quarterly CAC meetings. At least one meeting annually must be held in person .
  - d. CAC members will form work groups or committees to work on special projects such as conference trainings.
  - e. CAC members will interview peers about their experiences, which are recorded and featured in a column titled *emerging leaders* on the transitions listserv.

FFY2016 is developing into another successful year of activities with the RI Transitions Project. Webinars continue to be well attended and receive positive feedback. An April 12, 2016 webinar titled "Technology for All" included presentations by a consumer on the CAC and a parent. There were 61 participants from 19 states. Ninety-six percent of respondents to the webinar evaluation said they were satisfied or very satisfied with the webinar, while 88% agreed it increased their knowledge about assistive technology.

The health care transition guide was updated and is currently being reevaluated by members of the CAC. Hard copies have been distributed at conferences including the annual Montana Youth Transitions Conference and the Council for Exceptional Children Conference.

CAC members continue to be highly engaged in the activities of the RI Transitions Project. The annual in-person meeting took place in November, 2015 at the annual Montana Youth Transitions Conference. CAC members presented eight sessions during the two-day conference.

Strategies of the RI Transitions Project for FFY 2017 will include continuing the activities outlined above and working to strengthen transition resources for CYSHCN and families. These plans include:

- Develop an *Alternative to Guardianship Toolkit* with sample forms for consumers and families.
- Assist Montana Medical Home Portal staff to identify adult providers who will accept referrals of CYSHCN from pediatricians.
- Capture and disseminate 'Kindred stories', a collection of real-life health care transitions stories (both successes and challenges) families can use as an advocacy tool with medical providers, policy-makers and law makers.

In addition to the RI Transitions project, CSHS has taken steps to ensure CYSHCN in Montana have access to transition resources. All requests for proposals and contracts with services providers (parent mentor program, interdisciplinary team clinics, Montana Medical Home Portal) contain the following language:

Contractor will work to provide a system of coordinated services for children and youth with special health care needs (CYSHCN). In addition to services detailed in this contract, two system outcomes for CYSHCN must be sought:

- Medical Home: CYSHCN will receive family-centered, coordinated, ongoing comprehensive services

within a medical home.

- All CYSHCN will have the services necessary to transition to all aspects of adult life.

Contractors must describe how they will support medical home and transition through their work and interactions with families and CYSHCN. RI Transitions staff is available to train contractors and offer resources to help them integrate support for transitioning youth into their practice.

#### **SPM 4 – Medical Home: percent of CYSHCN ages 0 – 18 who have a medical home.**

In FFY 2016 CSHS has continued many projects to promote access to, and the effectiveness of medical homes for CYSHCN in Montana.

CSHS changed the way Metabolic and Cystic Fibrosis statewide, multidisciplinary clinics are supported. Rather than paying regional clinic sites to host these hospital provider teams, and provide care coordination to the patients, CSHS began paying hospitals to provide the clinical services *and* to coordinate patient care. The hospitals, in turn, make arrangements to provide services statewide. This new structure enabled CSHS to require the hospital teams to play an active role in care coordination and quality improvement, rather than having a decentralized model with various nurse coordinators throughout the state who report to CSHS.

The contracts for these hospital teams required they provide coordinated, ongoing, comprehensive care in partnership with the patient's medical home and work with CSHS to determine a means to measure these outcomes. The contracts also require an annual survey of families to assess their satisfaction with the clinics, care, coordination and convenience.

The Cleft/Craniofacial team clinics continue to be managed through pediatric specialty clinics, regionally. However, new contracts included formal language requiring coordinated, ongoing, comprehensive care in partnership with the patient's medical home and work with CSHS to determine a means to measure these outcomes.

The eight HALI Project Parent Partners (PPs) continue to provide support to families of CYSHCN in three pediatric clinics and one community health center in Montana. The goal of the program is to help families navigate the 'non-medical' components of the medical home. Parent Partners are recruited at the practice level. They must be parents of CYSHCN and exhibit leadership and skills necessary to mentor other parents of CYSHCN as they navigate their child's care. CSHS is continuing to partner with the State of Wyoming Department of Health and the HALI Project to evaluate the program and measure family satisfaction. The current contract is in effect until June 30, 2016. A request for proposal to solicit bids, to continue the parent mentor program in Montana, was released in April, 2016.

The Medicaid State Plan Amendment (SPA), which includes changes to Targeted Case Management (TCM) for CYSHCN, has been approved this fiscal year. CSHS began to collaborate with Montana Medicaid and local agencies, to make changes to the Administrative Rules of Montana (ARM) in order to reflect the changes to the SPA. With these changes to TCM for CYSHCN, more agencies will be able to bill Medicaid for care coordination for CYSHCN. Medicaid members are able to receive services which include coordinating with the patient's primary care provider and specialty providers, development of a care plan, referrals and ongoing monitoring and follow-up activities. The new ARM will be filed during FFY2016. CSHS plans to develop marketing and training materials for new and prospective TCM providers. CSHS will also actively recruit and train providers in additional communities in Montana, to extend care coordination to CYSHCN who are Montana Medicaid members. This will be an ongoing project.

The Children's Special Health Services (CSHS) program logic model includes the following desired outcome: "Medically complex children and youth with special healthcare needs receive coordinated care that links and supports care coordination at community, regional, and statewide levels." CSHS continues to collaborate with Montana Medicaid to ensure reimbursement of services not previously covered, if they are deemed medically necessary as required by EPSDT.

The Universal Newborn Hearing Screening Intervention (UNHSI) program continues to support coordinated, comprehensive care for children who are diagnosed with or who have a potential hearing loss. Changes to the Child Health Referral and Information System (CHRIS) during this period allowed the Hearing Conservation Program (HCP) audiologist to report directly into the CHRIS database. The HCP is a school-based audiology program under the direction of the Office of Public Instruction.

HCP audiologists provide follow-up hearing screenings for hospital births, or initial and follow-up screenings for non-hospital births, in their regions at no cost to the parents. They work with preschool and school-aged children to evaluate and monitor hearing, and provide technical assistance for school-based amplification needs. The HCP audiologists continue to collaborate with other providers, teachers of the deaf and general school staff as part of a team approach for each child's educational needs. They make medical referrals as needed for ear health concerns, such as otitis media.

CSHS contracts with the Rural Institute for Inclusive Communities (RI) to continue development of the Montana Medical Home Web Portal. The goal of the Web Portal is to provide current and reliable information to families and providers of CYSCHN regarding diagnosis, medical and other services available to them locally. During this reporting period RI added resources in many categories, and conducted a statewide survey of providers to address the need for mental health services on the portal.

## **Children with Special Health Care Needs - Annual Report**

### **Background Narrative - Information Submitted for July 2015 Report:**

Performance Measures Included: (**P** designates performance measures for fiscal years 2011-2015, and **N** designates new performance measures for fiscal years 2016-2020)

Last Year's Accomplishments and Current Activities =

- **PNPM 1 – Screen Positive Newborns**
- **PNPM 2 – Families partner in Decisions and Service Satisfied**
- **PNPM 3 – Medical Home**
- **PNPM 4 – Adequate Insurance for CYSHCN**
- **PNPM 5 – Community-Based Systems, Ease of Use**
- **PNPM 6 – Transition to Adult Health Care**
- **PSPM 1 – Cleft Lip and/or Palate Interdisciplinary Clinics**

Plan for coming year and Five-Year Action Plan =

- **NSPM 4 – Medical Home**
- **NNPM 12 – Transition to Adult Health Care**

The main MCHBG categories of activity that fit into the CYSHCN domain for Montana are: Diagnosis and Treatment, Adequate Insurance, Family Inclusion in Decision and Community Care Systems, Medical Home, and Transition to Adult Care.

Two of these categories contain performance measures which span the timeframes of two 5-Year Statewide Needs Assessments: Medical Home and Transition to Adult Health Care. Categories which are only part of reporting on last year's accomplishments and current activities are: Diagnosis and Treatment, Adequate Insurance for CYSHCN, and Family Inclusion in Decision and Community Care Systems. While these are not specific priorities in the upcoming state action plan, they will continue to be of importance to the FCHB.

### Diagnosis and Treatment

The performance measures covered in this section are: PNPM 1 and PSPM 1.

### **Newborn Screening and Follow-Up**

The Montana Newborn Screening (NBS) program is a partnership between Children's Special Health Services (CSHS), the Montana Public Health Laboratory (MT-PHL), and the infant's primary care provider. The Montana Public Health Laboratory receives all Montana bloodspot specimens and screens for all the conditions in the Recommended Uniform Screening Panel. Specimens are shipped to the Wisconsin State Laboratory of Hygiene (WSLH) for Tandem Mass Spectrometry and Severe Combined Immunodeficiency (SCID) screening.

The Department of Public Health and Human Services (DPHHS) proposed a rule change for NBS to add point of care pulse oximetry screening for CCHD to the mandated panel, effective July 1, 2014. These rules required use of the department's CCHD screening protocol and reporting system. Parent and provider CCHD educational materials and resources were made available on the CSHS website. On July 1, 2015, Montana began screening for SCID.

These rule changes also updated bloodspot screening to require: collection by 48 hours of age (instead of 72), more than one bloodspot screen for infants hospitalized for neonatal intensive care, detail of the process of reporting and follow-up of out of range results, to require documentation of parental refusal of newborn screening, and to stipulate the use and storage of residual bloodspot specimens by the department. These rules incorporated national recommendations for newborn screening system improvement.

Timeliness in newborn screening received a lot of attention during this period as a result of a national survey and newspaper article that outlined the deadly consequences of delays in newborn screening. In January 2014, Montana completed a survey from the Association of Public Health Laboratories (APHL) on the timeliness of "Specimen Collection and Transport within Newborn Screening Programs." WSLH began sending timeliness reports to Wisconsin submitters in January 2014 which incorporated quality indicators from the HRSA-supported Newborn Screening Technical Assistance and Evaluation Program (NewSTEPS) at APHL. Montana received a Wisconsin report on the specimens we submitted. Development of similar reports from MT-PHL to Montana submitters was initiated, and a data specialist began building the reports in June 2014.

Neometrics iCMS, a web and role-based case management software system for NBS, was purchased and installed in the summer of 2013. Implementing its functionality was met with challenges, which were addressed in meetings held every two weeks with: the NBS coordinator, laboratory managers, IT systems support staff, and vendor staff. The HL-7 export of results from the laboratory system to Neometrics is in operation, but follow-up actions are not functional.

CSHS is working to provide resources and technical assistance to hospitals and providers in implementing and reporting CCHD screening. Over 85% of babies born in hospital settings in May 2015 were reported to have had CCHD screening. Three workshops (“Safe, Sound, and Screened”) were held in the spring of 2015 (and more planned around Montana), offering direct entry and certified nurse midwives, as well as apprentices, coordinated information and training from bloodspot, hearing, and CCHD screening staff. Twenty-nine individuals attended the trainings. Evaluations were overwhelmingly positive and CSHS received valuable feedback about barriers midwives face when implementing and reporting screening. This feedback is helping direct CSHS strategies to offer effective and consistent support and training to midwives.

The Newborn Hearing Screening Program is working with a marketing group to rebrand the program and provide educational materials and media spots through several platforms including social media and radio. New brochures have been approved and are going to print. Digital ads are online and a NBS new parent magazine is being developed which will be available by October 1, 2015.

### **Cleft Lip and/or Palate Interdisciplinary Clinics**

CSHS continued to contract with 40 specialty providers and 3 sites to provide specialty clinics throughout the state. CSHS funds clinic teams to provide Metabolic, Cystic Fibrosis and Cleft/Craniofacial Clinics. CSHS bills for the clinics, but does not balance bill the patient if they are uninsured or under-insured. Clinics were offered in accessible areas around the state, including two on American Indian reservations. Team staffing remained stable, with experienced staff providing evaluations and recommendations to children, families and their health care providers. CSHS maintained existing contracts and assisted in securing additional providers where necessary. From 10/01/2013-09/30/2014 twenty clinic days were held at 8 different locations and there were 319 visits to cleft/craniofacial clinics by 297 individual clients. CSHS maintained and upgraded the Child Health Referral and Information System (CHRIS); a statewide database that supports documentation of clinic recommendations, care coordination activities, and referrals to local follow up.

Optimal outcomes for children with cleft/craniofacial conditions require sequential treatment provided by multiple professionals and programs. CSHS provided technical assistance to cleft team providers and clinic staff for local care coordination and follow up resources.

CSHS neared completion of a self-rating speech satisfaction survey of parents and children. The survey concluded in spring, 2015. The study compared how parents and older children rate their speech, compared with a speech assessment by team speech language pathologists. The results were used to assess parent/child satisfaction with speech development.

CSHS will continue to bill for Cleft/craniofacial team clinics and provide technical support for provider teams.

CSHS works closely with the Medicaid Maternal and Child Health Nurse to facilitate care coordination for Montana children admitted to out-of-state tertiary care centers. Many medically complex newborns and children are eligible for Medicaid. However, Montana’s rural nature makes follow-up care difficult in many regions of the state. This collaboration helps to identify gaps in coverage, identify local community resources, and provide consultation about local resources available in the community. In the past year, CSHS helped approximately 100 families to establish strong community supports prior to discharge from a tertiary center. Out-of-state tertiary care centers have become more familiar with CSHS as the information source for hospitals, which helps the program to provide better transitions back to the community for children receiving out-of-state care.

The Medicaid Child and Maternal Health Nurse also works with the CSHS Nurse Consultants on reviewing medical

necessity for various therapies, medical tests, medications and durable medical equipment under Medicaid's Early & Periodic Screening, Diagnosis and Treatment (EPSDT).

#### Adequate Insurance for CYSHCN

CSHS continued to assist families to obtain health care coverage by providing outreach materials and consultation, and by supporting care provided at the specialty clinic sites.

CSHS continued monitoring coverage issues for CYSHCN, and has worked to raise awareness regarding helmet therapy to treat severe plagiocephaly. The Healthy Montana Kid's Program (HMK) is now covering helmet therapy.

During FFY 2014 there were 23 families determined to be at or below 250% of the FPL who qualified for CSHS financial assistance which paid up to \$2,000 for services/items not covered by insurance, i.e. plagiocephaly helmets. There were 77 individuals that were approved to receive financial assistance for genetic testing not covered by private insurance companies.

Children's Special Health Services (CSHS) continues to provide minimal financial assistance to families who are primarily underinsured or uninsured and at, or below, 250% of poverty. CSHS will continue to provide financial assistance for genetic testing which is not covered by health insurance, or which is not available to clients with Medicaid.

CSHS plans to continue team billing for Cleft/craniofacial, Cystic Fibrosis and Metabolic Clinics. Families are not balance billed for team clinics billed by CSHS; if a child does not have adequate insurance, or is uninsured, CSHS absorbs the additional cost.

CSHS will continue to work with Medicaid to facilitate Early Periodic Screening, Diagnosis and Treatment (EPSDT) activities. CSHS nurse consultants meet with the Medicaid Family and Maternal Health Nurse weekly to discuss care issues and to promote understanding of Medicaid programs and the needs of CYSHCN.

CSHS nurse consultants and the Medicaid Maternal and Child Health Nurse Consultant reviewed and revised the CYSHCN Targeted Case Management (TCM) rules, which included a 2% rate increase for providers. A public hearing on the revised CYSHCN TCM rules was held on May 28, 2014, and they became effective July 1, 2014. CSHS will continue to explore sustainability of targeted case management services for CYSCHN by encouraging local health departments to bill Medicaid for CYSHCN TCM.

#### Family Inclusion in Decision and Community Care Systems

The performance measures covered together in combination in this section are: PNPM 2 and PNPM 5.

CSHS is developing a Cleft/Craniofacial Clinic Stakeholders Group which will have parent representation. This group will be responsible for providing recommendations to the Montana Cleft Team members for achieving American Cleft Palate Association (ACPA) Standards for team care, and for providing consultation to the department.

Three families participated in the rules hearing for the implementation of screening for Critical Congenital Heart Defects (CCHD), providing testimony in support of CCHD screening for all newborns. Sharing personal family stories, they emphasized that early identification and treatment of their child's critical congenital heart disease would have made a difference in their child's outcome.

The Rural Institute of the University of Montana continued work with the Consumer Advisory Council (CAC), which directed the efforts of the Institute in planning strategies to educate families about CYSHCN transition to adult services. The CAC is made up of 19 members who are primarily youth and young adults with special healthcare needs and their parents.

A parents-as-mentors program called *The HALI Project* has been implemented in three pediatric practices and one FQHC in Montana. There are seven parent mentors currently working in the practices. The goal of the HALI Project parent partners is to support and empower families of CYSHCN when making decisions about their child's care and accessing services.

The HALI Project was developed and has been implemented in parts of Texas, Wyoming and now Montana, by the program developer, Brad Thompson. Mr. Thompson provides annual in-person training, monthly group calls, and individual support calls to the parent mentors. Mr. Thompson is a licensed counselor and the parent of a child with special health care needs. A CSHS staff-person attended in-person training in June, 2014 with Mr. Thompson and the Parent Partners.

Parent Partners told personal stories about their interactions with other CYSCHN parents and brainstormed ideas to better serve CYSHCN families. In addition to one-on-one work with families, the parent partners do outreach and education to the community and the providers they work with. Providers consistently report parent partners are a great asset to their practices, and they continually refer families at a higher frequency.

A cooperative effort between the Wyoming Department of Health, Mountain States Genetic Regional Collaborative, the HALI Project and CSHS is currently under way to evaluate the HALI Project. The evaluation is meant to gauge the effectiveness of the parent partners in their efforts to assist CYSHCN families to navigate the healthcare system, access community and government resources and provide ongoing mentoring and generally support and empower CYSHCN families. A survey was given to CYSHCN parents before and after a period of time when the CYSHCN family received services from a parent partner. A compilation of results are expected in late summer, 2015.

### Medical Home

The Newborn Hearing Screening program supported coordinated, comprehensive care by requiring pediatric audiologists to use the Child Health Referral and Information System (CHRIS) to document screening and diagnostic assessment results. The matching process in CHRIS allowed for hearing screening data to be matched directly to birth record information. Development in CHRIS was started to allow for the import and matching of bloodspot data using the same principles of the hearing screening match process. An important goal of CSHS is for primary care physicians to be able to access the database to see a unified record within CHRIS that contains all newborn screening results along with patient demographics.

St. Vincent's Healthcare continued development of the Montana Medical Home Web Portal to provide current, reliable information and resources to providers and families of CYSHCN in a convenient and user-friendly format. Clinical resources posted on the portal, such as specialty providers and multi-disciplinary clinic information, were vetted by a team which included CSHS staff, a developmental pediatrician, and St. Vincent Healthcare staff.

The CHRIS software application was enhanced to include the generation of faxback forms. These forms included the patient's name and date of birth, mother's name, and the dates of referred (not pass) hearing screenings. The hearing program can now fax forms to the primary care physician to either prompt the physician to make a referral to an audiologist or report back to the program with any follow up results. The goal was to generate more medical home involvement with hearing screening follow-up.

## Transition to Adult Care

CSHS addressed transition issues for CYSHCN by providing educational materials to families and communicating with healthcare payers, including Healthy Montana Kids (Children's Health Insurance Program and Children's Medicaid). The CSHS transition website continued to be maintained and updated to provide accurate information and resources on transition issues faced by CYSHCN.

Specialty clinic staff and contractors continued to provide education to families who attend clinics on issues that arise for CYSHCN when they transition from one treatment phase to another and when they transition to the adult healthcare system. These efforts were targeted to specific needs of families based on the diagnosis of the child, and the resources available in their communities.

The Rural Institute of the University of Montana continued to provide opportunities for CYSHCN to offer input on the Consumer Advisory Council. The RI continued to maintain a transition listserv which provided education and resources, and it published 300 copies of a healthcare coverage and transition resource guide of healthcare options in Montana, in adaptive formats. The guide is available online and has been distributed throughout Montana. The Rural Institute (RI) provided six webinars focused on healthcare transition topics. RI is currently working on an evaluation of the transitions guide and the webinars they have presented. This evaluation should be complete by August, 2015.

CSHS continued to collaborate with Parents Let's Unite for Kids, Montana's Family-to-Family Information Center, and other Montana programs serving CYSHCN, to ensure that all families have access to transition information and available resources.

## Future Activities: Medical Home and Transition Services

CSHS has identified two priorities to focus on in the coming year and over the next five-year period: NPM 12 - Percent of children with and without special health care needs who received services necessary to make transitions to adult healthcare; and SPM 5 - Percent of CYSHCN ages 0-18 who have a medical home.

Programs implemented through the Integrated Community Systems for CSHCN Grant in Montana have worked to promote medical homes and care transition for CYSHCN. Montana will continue the parent partner project, the medical home portal, and the transition to adult care projects through SFY 2016. CSHS also intends to facilitate sustainability planning, so these projects are able expand and continue.

CSHS will continue to support Cystic Fibrosis, Cleft/Craniofacial, and Metabolic Clinics in Montana. Contracts will include language requiring clinics to promote medical homes and transition assistance to CYSHCN who attend clinics. CSHS will collaborate with providers to define, implement and evaluate strategies in clinics.

CSHS is currently working with the Rural Institute of the University of Montana to perform a comprehensive program assessment. The assessment is using a Concerns Report Method which includes open-ended interviews with families, consumers, and providers; a review of current literature; and development of a concerns matrix to guide future strategic planning. A preliminary concerns matrix and recommendations are expected in late summer, 2015. CSHS will use this information to guide future planning for the section. An assessment design team met in June 2015 to guide this process. The team consists of CYSHCN health care providers, families, service providers and consumers.

## FFY 2015 Report Updates:

The FFY15 updates for the CYSHCN domain include the following performance measures:

- NPM 1 – Screen Positive Newborns
- NPM 2 – CYSHCN Families Partner in Decisions & Satisfied with Services
- NPM 3 – CYSHCN Medical Home
- NPM 4 – CYSHCN with Adequate Insurance
- NPM 5 – CYSHCN Community-Based Systems Ease-of-Use
- NPM 6 – CYSHCN Transition to Adulthood
- SPM 1 – Cleft Lip and/or Palate Clinical Care

### **NPM 1 – The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs:**

The Children's Special Health Services Section (CSHS) redesigned all educational materials and resources for medical providers and hospital staff on the required newborn screening conditions, including Critical Congenital Health Disease (CCHD) screening and reporting. Four workshops ("Safe, Sound, and Screened") were held in Bozeman, Libby, Missoula and Kalispell to offer direct-entry midwives coordinated information and training from bloodspot, hearing, and CCHD screening personnel. Additional trainings have been planned for FFY16.

Newborn screening rules were amended in June 2015 to add Severe Combined Immunodeficiency (SCID) to Montana's mandated screening panel. Universal screening for SCID began July 1, 2015.

Production began on a short training video about bloodspot collection, and how to complete the specimen requisition form. Final editing and distribution will be completed in FFY 2016.

CSHS partnered with the Montana Office of Vital Records to perform birth certificate matching for hearing screening within its existing Hi-Trak software. Filed Montana birth certificates are matched to hearing records each Monday, reducing the match time from one month of age to one week of age. Hearing screening records also include CCHD screening data.

Initial bloodspot timeliness reports to submitting facilities were disseminated in November 2014 and covered the 2<sup>nd</sup> quarter of 2014. Quality indicators included: (1) time from birth to collection of initial screening specimen (target 24 - 48 hours); (2) time from collection of initial screening specimen to delivery (target 3 days); (3) time from delivery to result (target 5 days); (4) percent of specimens missing critical information (target < 3%); and (5) percent of satisfactory specimens (target > 97%). As of September 2015, timeliness reports for all of 2014 and the first three quarters of 2015 were generated and disseminated to submitters.

CSHS now subcontracts with a biochemical geneticist from Colorado Children's Hospital in Denver to provide metabolic services for patients in Montana. Dr. Janet Thomas works with the Montana metabolic team members to provide metabolic team clinics and follow-up services to all patients with a metabolic diagnosis.

**NPM 02: The percent of children with special health care needs age 0 to 18 years whose families' partner in decision making at all levels and are satisfied with the services they receive:**

CSHS changed the way statewide Metabolic and Cystic Fibrosis multidisciplinary clinics are managed. Rather than paying three regional hospitals to host pediatric sub-specialists, multidisciplinary clinics, and provide care coordination to patients, CSHS awarded contracts through a competitive bidding process to three hospitals to provide the specialty clinic services and coordinate patient care. Benefis Healthcare in Great Falls, Community Medical Center in Missoula and St. Vincent's Healthcare in Billings make arrangements to provide services statewide. This new structure enabled CSHS to require the hospital teams to play an active role in family-centered care and quality improvement. The contracts for these hospital require that they provide family-centered care (to include partnering with families in decision making) and working with CSHS to determine a means to measure a family's level of engagement and satisfaction with services. Going forward, these contracts also require an annual survey of families.

The Cleft/Craniofacial Team Clinics continued to be managed regionally, through pediatric specialty clinics. There were 18 clinics held throughout the state where 257 individuals were seen. New contracts included formal language requiring family-centered care, family engagement and a means to measure these outcomes.

The HALI Project Parent Partners (PPs) continued to provide support to families of CYSHCN in three pediatric clinics and one community health center in Montana. The goal of the program is to help families navigate the 'non-medical' components of the medical home. Parent Partners are recruited at the practice level. They must be parents of CYSHCN and exhibit leadership and skills necessary to mentor other parents of CYSHCN as they navigate their child's care. A statewide training for eight PPs was held in June 2015, in Helena. Parts of the training focused on techniques to help families partner in decision-making regarding their child's care. CSHS continued to partner with the State of Wyoming Department of Health, and the HALI Project, to evaluate the program and measure family satisfaction.

CSHS also partnered with the University of Montana Rural Institute for Inclusive Communities to perform a comprehensive assessment of CSHS programs, and concerns for CYSHCN in Montana. The assessment was modeled after the concerns report method, and utilized an 'assessment design team' (ADT) to identify a matrix of concerns for CYSHCN in Montana. The concerns matrix was used to develop a statewide survey of providers and families. Parents, consumers, and Parent Partners were well represented on the ADT from the onset of the collaboration, In addition to being decision makers in the assessment design process, parents and CYSHCN were also interviewed to help inform the matrix. This project is ongoing, and results are expected by the summer of 2016.

The Medicaid State Plan Amendment (SPA), which included changes to Targeted Case Management (TCM) for CYSHCN, was very close to being approved by the end of FFY 2015. CSHS began to collaborate with Montana Medicaid, and local agencies, to discuss changes to the Administrative Rules of Montana to reflect the changes to the SPA. With these changes to TCM for CYSHCN, more types of agencies (not only public health departments) will be able to bill Medicaid for home visits to CYSHCN. TCM services will be family-centered and require family engagement, quality improvement and a means to measure family satisfaction with services. CSHS will be monitoring TCM for CYSHCN providers. This project began during FFY 2015, and will be ongoing.

**NPM 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home:**

CSHS changed the way statewide Metabolic and Cystic Fibrosis multidisciplinary clinics are managed. Rather than paying three regional hospitals to host pediatric sub-specialists, multidisciplinary clinics, and provide care coordination to patients, CSHS contracted with two hospitals to provide the specialty clinic services and coordinate patient care. The hospitals, in turn, make arrangements to provide services statewide. This new structure enabled CSHS to require the hospital teams to play an active role in family-centered care and quality improvement. The contracts for these hospital require that they provide family-centered care (to include partnering with families in decision making) and working with CSHS to determine a means to measure a family's level of engagement and satisfaction with services. Going forward, these contracts also require an annual survey of families.

The Cleft/Craniofacial Team Clinics continued to be managed regionally, through pediatric specialty clinics. However, new contracts included formal language requiring family-centered care, family engagement and a means to measure these outcomes.

The HALI Project Parent Partners (PPs) continued to provide support to families of CYSHCN in three pediatric clinics and one community health center in Montana. The goal of the program is to help families navigate the 'non-medical' components of the medical home. Parent Partners are recruited at the practice level. They must be parents of CYSHCN and exhibit leadership and skills necessary to mentor other parents of CYSHCN as they navigate their child's care. A statewide training for PPs was held in June 2015, in Helena. Parts of the training focused on techniques to help families partner in decision-making regarding their child's care. CSHS continued to partner with the State of Wyoming Department of Health, and the HALI Project, to evaluate the program and measure family satisfaction.

The Medicaid State Plan Amendment (SPA), which included changes to Targeted Case Management (TCM) for CYSHCN, was very close to being approved by the end of FFY 2015. CSHS began to collaborate with Montana Medicaid, and local agencies, to discuss changes to the Administrative Rules of Montana to reflect the changes to the SPA. With these changes to TCM for CYSHCN, more types of agencies (not just public health departments) will be able to bill Medicaid for home visits to CYSHCN. TCM services will be family-centered and require family engagement, quality improvement and a means to measure family satisfaction with services. CSHS will be monitoring TCM for CYSHCN providers. This project began during FFY2015, and will be ongoing.

The CSHS program logic model included the following desired outcome: "Medically complex children and youth with special healthcare needs receive coordinated care that links and supports care coordination at community, regional, and statewide levels." CSHS continued to collaborate with Montana Medicaid, to ensure that services not previously covered by Medicaid would be covered if they are deemed medically necessary, as required by the Early Periodic Screening, Diagnosis, and Treatment protocol.

The Hearing Conservation Program (HCP) audiologists provided follow-up hearing screenings for hospital births or initial and follow-up screenings for non-hospital births in their regions at no cost to the parents. This program is provided as a partnership with the Office of Public Instruction. They worked with preschool and school-aged children to evaluate and monitor hearing, and provided technical assistance for school-based amplification needs. The HCP audiologists continued to collaborate with other providers, teachers of the deaf and general school staff as part of a

team approach for each child's educational needs. They make medical referrals as needed for ear health concerns, such as otitis media. The UNHSI program screened 96% of all babies born in Montana during FFY15.

Newborn screening and Critical Congenital Heart Defects (CCHD) screening was added to the hearing screening reporting tool, HiTrack, so nurses can enter CCHD data in one database. In FFY2015 70.3% of babies born in Montana were screened for CCHD; .5% failed screening. CSHS can query the software and determine which babies need follow-up, so the information can be passed on to the primary care provider.

The Children's Special Health Services section provided statewide training on newborn screening (NBS) to midwives in Montana who deliver outside of a hospital setting. Historically, midwives have had low rates of NBS participation and reporting in Montana. The four regional trainings were attended by 34 midwives and apprentices. The training was very well received and NBS reporting from midwives rose by 19%. The result has been better coordination of services for babies with out-of-range results. Midwife NBS reporting tools were added to the CSHS website <http://dphhs.mt.gov/publichealth/cshs/NewbornScreeningPrograms.aspx>.

CSHS began contracting with the Rural Institute for Inclusive Communities (RI) to continue development of the Montana Medical Home Web Portal <https://mt.medicalhomeportal.org/>. The goal of the Web Portal is to provide current and reliable information to families and providers of CYSCHN regarding diagnosis, and medical and other services available to them locally. During this reporting period, the RI added service and contact information in many categories and conducted a statewide survey of providers to address the need to populate mental health services, for children and youth, on the portal. The survey asked mental health providers if they provided services to children. If so, they were added to the portal.

**NPM 04: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need:**

The Children's Special Health Services (CSHS) Program continued to provide minimal financial assistance to families who are primarily underinsured or uninsured and at or below 250% of poverty. In FFY15 CSHS covered periodic evaluations by specialists, lab tests, x-rays, orthodontia, surgeries, medications and helmet therapy to thirty individuals in the financial assistance program. CSHS also continued to provide financial assistance for all Montanans for genetic testing. CSHS uses state funding to cover the costs of genetic testing that is not covered by health insurance. In FFY15, 66 individuals were enrolled in the Montana genetics financial assistance program. 51 of those individuals were insured, but their insurance did not cover the genetic test recommended by their medical provider; 15 individuals were uninsured.

CSHS continued to bill for multidisciplinary team clinics for children and youth with Cleft/craniofacial conditions, Cystic Fibrosis and Metabolic conditions. Condition specific team clinics are provided in Missoula, Kalispell, Great Falls, Billings, Browning, Wolf Point, and Helena. CSHS bills insurance providers, however; if a child is uninsured or a plan does not reimburse for the service, the family is not balance billed. During this period CSHS began working with hospitals to transition clinic billing to the service providers.

CSHS continued to work with Medicaid to facilitate Early Periodic Screening Diagnosis and Treatment activities. CSHS nurse consultants met with the Medicaid Family and Maternal Health Nurse as necessary to discuss care issues and to promote understanding of Medicaid programs and the needs of CYSCHN.

CSHS continued to contract with the University of Montana Rural Institute (RI). RI updated the resource guide, *Planning Your Transition from Pediatric to Adult Health Care: A Workbook to Help You Take Charge of Your Health*, which includes information for CYSHCN about public and private coverage available in Montana. 470 hard copy and 150 DVDs of the guides were distributed to CYSHCN and their families, and to CYSCHN providers.

The Medicaid State Plan Amendment (SPA), which included changes to Targeted Case Management (TCM) for CYSHCN, was very close to being approved at the end of the reporting period. CSHS began to collaborate with Montana Medicaid and local agencies to discuss changes to the Administrative Rules of Montana to reflect the changes to the SPA. With these changes to TCM for CYSHCN, more agencies will be able to bill Medicaid for home visits to CYSHCN. TCM can be billed for care coordination to include coordinating with the patient's primary care provider and specialty providers, development of a care plan, referrals and ongoing monitoring and follow-up activities. This is an ongoing project which began during this performance period.

The CSHS program logic model included metrics for: 1) increasing the number of agencies which are billing Medicaid TCM for CYSHCN (baseline is seven), and 2) the number of CYSHCN that have identified healthcare coverage (part of contractors surveys).

**NPM 05: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily:**

CSHS changed the way statewide Metabolic and Cystic Fibrosis multidisciplinary clinics are managed. Rather than paying three regional hospitals to host pediatric sub-specialists, multidisciplinary clinics, and provide care coordination to patients, CSHS contracted with two hospitals to provide the specialty clinic services and coordinate patient care. The hospitals, in turn, make arrangements to provide services statewide. This new structure enabled CSHS to require the hospital teams to play an active role in family-centered care and quality improvement. The contracts for these hospital require that they provide family-centered care (to include partnering with families in decision making) and working with CSHS to determine a means to measure a family's level of engagement and satisfaction with services. Going forward, the contracts also require an annual survey of families.

The Cleft/Craniofacial Team Clinics continued to be managed regionally, through pediatric specialty clinics. However, new contracts included formal language requiring family-centered care, family engagement and a means to measure these outcomes.

The HALI Project Parent Partners (PPs) continued to provide support to families of CYSHCN in three pediatric clinics and one community health center in Montana. The goal of the program is to help families navigate the 'non-medical' components of the medical home. Parent Partners are recruited at the practice level. They must be parents of CYSHCN and exhibit leadership and skills necessary to mentor other parents of CYSHCN as they navigate their child's care. A statewide training for PPs was held in June 2015, in Helena. Parts of the training focused on techniques to help families partner in decision-making regarding their child's care. CSHS continued to partner with the State of Wyoming Department of Health, and the HALI Project, to evaluate the program and measure family satisfaction.

The Medicaid State Plan Amendment (SPA), which included changes to Targeted Case Management (TCM) for

CYSHCN, was very close to being approved by the end of FFY 2015. CSHS began to collaborate with Montana Medicaid, and local agencies, to discuss changes to the Administrative Rules of Montana to reflect the changes to the SPA. With these changes to TCM for CYSHCN, more agencies will be able to bill Medicaid for home visits to CYSHCN. TCM services will be family-centered and require family engagement, quality improvement and a means to measure family satisfaction with services. CSHS will be monitoring TCM for CYSHCN providers. This project began during FFY2015, and will be ongoing.

The Universal Newborn Hearing Screening Intervention program continued to support coordinated, comprehensive care for children who are diagnosed with or who have a potential hearing loss. The Hearing Conservation Program (HCP) audiologists provided follow-up hearing screenings for hospital births, or initial and follow-up screenings for non-hospital births in their regions at no cost to parents. They worked with preschool and school-aged children to evaluate and monitor hearing, and provided technical assistance for school-based amplification needs. The HCP audiologists continued to collaborate with other providers, teachers of the deaf and general school staff as part of a team approach for each child's educational needs. They made medical referrals as needed for ear health concerns, such as otitis media.

Newborn screening and Critical Congenital Heart Defects (CCHD) screening was added to the hearing screening reporting tool, HiTrack, so nurses can enter CCHD data in one database. CSHS can query the software and determine which babies need follow-up, so the information can be passed on to the primary care provider. In FY15 there were 17 babies reported to the CCHD database with a failed screening.

The Children's Special Health Services section provided statewide training on newborn screening (NBS) to midwives in Montana who deliver outside of a hospital setting. Historically, midwives have had low rates of NBS participation and reporting in Montana. The four regional trainings were attended by 34 midwives and apprentices. The training was very well received and NBS reporting from midwives rose by 19%. This, in-turn, has led to better coordination of services for babies with out-of-range results which are not born in a hospital.

CSHS began contracting with the Rural Institute for Inclusive Communities (RI) to continue development of the Montana Medical Home Web Portal. The goal of the Web Portal is to provide current and reliable information to families and providers of CYSCHN regarding diagnosis, and medical and other services available to them locally. During this reporting period, the RI added resources in many categories and conducted a statewide survey of providers to address the need to populate mental health services, for children and youth, on the portal.

**NPM 06: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence:**

CSHS continued to partner with the Rural Institute of the University of Montana (RI) to provide transition resources to CYSHCN in Montana. RI continued to convene the Consumer Advisory Council (CAC), a group of young adults who are in transition or who have recently gone through transition, to prioritize activities. The CAC met four times during the year, including one in-person meeting at the statewide transition conference. In addition to the four full CAC meetings, 9 additional conference call CAC work group meetings were held in FFY2015. Three of these meetings were to prepare for workshops CAC members would be presenting at the Montana Youth in Transition Conference; six of the meetings were to develop and administer the Community Investment Fund.

In addition to hosting a vendor table, CAC members presented at the following workshops during the 2014 Montana

Youth in Transition Conference:

- What's up, Doc? – Planning the Transition to Adult Health Care Services
- Youth Power - How We Can Help Lead Montana into the Future Today!
- Strategies for Managing Depression: Youth with Developmental Disabilities and Mental Health Diagnoses
- Show Me the Money! How to Earn, Save, Budget and Spend...Money!
- So You Want to Go to College? Finding Success with Post-Secondary Education
- Tools to Assist at Work
- Tools for College
- Turning 18: What Does Transfer of Rights Mean?
- How to Prepare Students with Asperger's for Successful Post-school Employment as Documented in an Awesome IEP
- Wanted: Parent Participation!

Project staff presented the workshop, "A Vision of Employment for All: Preparing Youth to Work" at the MCASE/MCEC Conference of Diverse Abilities in Bozeman on February 4, 2015.

The CAC consists of 18 members: 8 youth/young adults with disabilities and/or SHCN; 5 parents; and representatives from SSA, schools, OPI, CSHS, MT Autism Project, PLUK, DDP, MYLF.

There were 5 webinars during FFY2015. Topics/titles for the webinars were:

- "A Vision of Employment for All: Preparing Youth to Work" (tailored to VR)
- "A Vision of Employment for All: Preparing Youth to Work" (for wider audience)
- "Addressing Barriers to Employment"
- "Montana Vocational Rehabilitation & Blind Services and the Workforce Innovation and Opportunity Act"
- "So You Want to Go to College?"

At least one PLUK (Parent Training Information Center) representative is using the Health Care Transition Guide evaluation guide with families in their region as part of the Transition planning process. In addition, a Wyoming Transition Specialist requested and received permission to use the Planning for Your Transition from High School to Adult Life workbook to use with students in their state.

A registered nurse who works for Children's Special Health Services in Louisiana requested and received permission to post a link to the resource guide on her agency's website.

Additionally, RI updated and disseminated the guide, *Planning Your Transition from Pediatric to Adult Health Care: A Workbook to Help You Take Charge of Your Health*.

The HALI Project Parent Partners (PPs) continued to provide support to families of CYSHCN in three pediatric clinics and one community health center in Montana. The goal of the program is to help families navigate the 'non-medical' components of the medical home. A statewide training for eight PPs was held in June 2015, in Helena. Staff from the RI presented to the PPs about helping families and CYSHCN make the transition to adult care.

**State Performance Measure 1: The percent of children with cleft lip and/or palate receiving care in interdisciplinary clinics:**

The Children's Special Health Services (CSHS) program continued to support Cleft/Craniofacial team clinics through three regional sites, Missoula, Billings and Great Falls and five outreach locations; Helena, Browning, Wolf Point, Bozeman and Kalispell. 257 individuals attended 18 clinics held at these sites. New contracts for the regional sites included formal language requiring coordinated, ongoing, comprehensive care in partnership with the patient's medical home. They also required the sites to work with CSHS to determine a means to measure these outcomes. Providers must participate in one quality improvement project, in partnership with the state, during the contract period.

Nurse coordinators who staff Cleft/Craniofacial team clinics are now required to attend the annual American Cleft Palate Association meeting and to share the information they learn with team members who are unable to participate.

CSHS will continue to bill for Cleft/craniofacial team clinics. Under or uninsured children and youth with cleft/craniofacial anomalies can attend this clinic free of charge.

## Cross-Cutting/Life Course

### State Action Plan Table

#### State Action Plan Table - Cross-Cutting/Life Course - Entry 1

##### Priority Need

Oral Health

##### NPM

A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

##### Objectives

Increase the percent of women who have a dental visit during pregnancy to 60.5% by 2021, and the percent of children ages 1 through 17 who have an annual preventive dental visit to 79% by 2021.

##### Strategies

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

##### ESMs

ESM 13.1 - Pregnancy Care and Dental Access Integration

##### NOMs

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

NOM 19 - Percent of children in excellent or very good health

## State Action Plan Table - Cross-Cutting/Life Course - Entry 2

### Priority Need

Smoking During Pregnancy and Household Smoking

### NPM

A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

### Objectives

Decrease the percent of women who smoke during pregnancy to 14.4% by 2021, and the percent of children who live in a household where someone smokes to 24% by 2021.

### Strategies

Ongoing strategies in addition to new ESM are: 1) MTUPP is requiring local tobacco prevention specialists to provide outreach and education about their quit-line pregnancy program to the health clinics in their communities which serve pregnant women. 2) MECHV funded home visitors at implementing sites assess primary caregivers and pregnant enrollees for tobacco use, and refer to appropriate assessment programs if appropriate. The program will also collaborate with MTUPP on tobacco cessation efforts.

### ESMs

ESM 14.1 - County Public Health Department Tobacco Cessation Activities

## NOMs

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

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

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

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

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

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

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

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

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

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children in excellent or very good health

## State Action Plan Table - Cross-Cutting/Life Course - Entry 3

### Priority Need

Access to Care

### SPM

Access to Care and Public Health Services

### Objectives

For counties with frontier-level populations who choose this performance measure, support the public health department's ability to continue providing Enabling Services, Public Health Services, and Group Encounter activities to 20% of their MCH population through 2021.

### Strategies

Ongoing strategies in addition to new ESM are: 1) Six frontier-level population CPHDs are collaborating with the FCHB on a pilot project of this performance measure for SFY 2016. The main focus is to help provide support for all of the MCH services they provide. Although activities do not have to fit into any one performance measure, these partners have submitted plans and methods of evaluation. 2) Representatives of the different-size CPHDs will be meeting to address the funding formula, and provide input on the NPM and SPM State Action Plans.

## State Action Plan Table - Cross-Cutting/Life Course - Entry 4

### Priority Need

Family Support and Health Education

### SPM

Family Support and Health Education

### Objectives

County Public Health Departments who choose this performance measure will be providing family support referrals and health education, in the physical setting of their facilities, to 17% of their clients by 2021.

### Strategies

Ongoing strategy in addition to new ESM: Six CPHDs collaborated on a pilot of SPM 2 for SFY16. Four more have joined for SFY17 and one chose a different measure. These counties will provide baseline data for the measure. Three of these counties represent larger population counties in the state, two represent mid-size population counties, and there are four smaller population counties.

**Measures**

**NPM-13 A) Percent of women who had a dental visit during pregnancy**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	58.0	58.5	59.0	59.5	60.0	60.5

**FAD not available for this measure.**

**NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	76.6	77.0	77.5	78.0	78.5	79.0

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	76.6 %	1.4 %	159,134	207,659
2007	76.5 %	1.3 %	163,804	214,190

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**ESM 13.1 - Pregnancy Care and Dental Access Integration**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	40.0	50.0	60.0	70.0	80.0

**NPM-14 A) Percent of women who smoke during pregnancy**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	16.0	15.7	15.4	15.0	14.7	14.4

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2014	15.9 %	0.3 %	1,954	12,315	
2013	16.5 %	0.3 %	2,012	12,194	
2012	16.2 %	0.3 %	1,934	11,968	
2011	16.6 %	0.3 %	1,988	12,008	
2010	16.3 %	0.3 %	1,956	11,979	
2009	16.0 %	0.3 %	1,945	12,132	

**Legends:**

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NPM-14 B) Percent of children who live in households where someone smokes**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	26.4	26.0	25.5	25.0	24.5	24.0

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	26.4 %	1.5 %	57,783	218,543
2007	26.8 %	1.3 %	59,900	223,429
2003	26.3 %	1.3 %	49,838	189,394

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**ESM 14.1 - County Public Health Department Tobacco Cessation Activities**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	16.0	15.8	15.5	15.3	15.0

**Cross-Cutting/Life Course - Plan for the Application Year**

**Please see the FFY 2015 report section for background narrative on this domain through 9/30/15 -**

Montana's Cross-Cutting / Life Course domain performance measures for FFYs 2016 - 2020 are:

- NPM 13 – Oral Health
- NPM 14 – Smoking in Pregnancy and Household
- SPM 1 – Access to Care and Public Health Services
- SPM 2 – Family Support and Health Education

The following narratives contain current activities and upcoming plans –

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

Oral Health Program (OHP) staff at DPHHS have established many partnerships in recent years. Those partnerships will be leveraged in the coming year for activities related to National Performance Measure 13. One project is a collaboration with a community health center (CHC) site to increase the number of pregnant women receiving dental care during pregnancy.

The CHC site recently increased their number of pregnant patients as part of an obstetrical project. Also, during the last year, dental clinic services were incorporated into patient care on an informal basis. OHP staff are working with CHC/MCH staff to create a more formal referral system, and procedures to increase the number of women that are

assessed for dental needs prenatal care visits.

This will be a pilot project for local health department MCH staff and dental clinic staff, at sites that are co-located. The site will be developing quality improvement instruments to record: 1) how many pregnant women are assessed for dental care utilization and need during prenatal care visits, and 2) are then seen in the dental clinic and complete a dental treatment plan to ensure person-centered care and primary prevention. DPHHS will then be working with CHC staff to disseminate the quality improvement activities to other co-located sites.

American Indian populations in Montana experience significantly higher rates of dental disease. Building relationships with dental providers in tribal health and Indian Health Service locations has been a priority for the OHP. Also, monitoring of staffing levels and community-based dental care models has been a part of surveillance, and will continue if funding for the OHP can be maintained. OHP staff have noted that the number of dental hygiene providers has increased in recent years at IHS and tribal clinics, with a subsequent expansion of preventive care activities.

In order to increase the utilization of dental care, the OHP will continue to support alternate and community-based models of care. The OHP is helping to alleviate staffing challenges at two American Indian clinic sites through dental student rotations. Student rotations are dental workforce activities in Montana through HRSA 13-142 Grants to States to Support Oral Health Workforce Activities and offer an opportunity to increase capacity of the clinics, and introduce students to practice in tribal and IHS sites. To date, 18 students have served in Montana clinical rotations: four in sites that see a high proportion of American Indian patients (Hardin - private practice; Browning - IHS dental clinic). These were two 2nd year students and two 4th year students. Fourth year dental students performed a total of 1,253 dental procedures during the 2015-2016 rotations, with 286 of those completed at the Hardin and Browning sites.

Another focus of the OHP is to increase the number of primary care providers assessing and providing preventive care during well-child visits. During 2015, OHP staff increased the number of resources for primary care providers on the DPHHS website (<http://dphhs.mt.gov/publichealth/oralhealth/OHMedicalProviders.aspx>). Staff are currently developing and implementing a targeted communication plan to primary care providers, to increase the number using the resources.

Print materials distributed as part of the campaign will include the American Academy of Pediatrics Caries Risk Assessment and a one-page Montana specific document, *Montana Steps to Prevention*. This document outlines how to provide oral health services in a primary care setting, including reimbursement. The aim of this project is to utilize current State policies, to address disparities in areas with low numbers of dental providers and limited access for Medicaid enrollees. In 2013 and 2014 less than 30 Medicaid- enrolled children each year received dental care in primary medical settings based on CMS data.

Promotion of website resources will be targeted in the eastern and northern areas of the State. This is based on surveillance data, critical access and community assessments, and dental health professional shortage areas (HPSA). The print materials will be followed by phone calls to assess readiness or need for technical assistance. The OHP staff provided training to one urban clinic in January 2016 and will use this as a model for technical assistance.

Workforce and dental surveillance have been a foundational part of OHP work, and data are consistent with national surveillance indicators (<http://www.cste.org/group/OralHealth>). Data are being utilized in meetings, outreach, and

communications to identify disparities and support quality improvement activities. Controlled dental surveillance in the Head Start population was completed recently, and will be analyzed and disseminated by August 2016. Additionally, surveillance in the Kindergarten population to assess the prevalence of disease began during 2016 and will be completed in 2017.

A proposal for continued OHP resources was submitted in February 2016. If funded, it will offer an opportunity for community-based preventive care programming, and build on the relationships that have been established. Additionally, support will foster the development of an oral health surveillance plan for 2016-2025, with resources for Basic Screening Survey data collection on the 3<sup>rd</sup> grade population in 2017.

**NPM 14 - Pregnancy and Household Smoking: A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes.**

The Montana Healthy Families Program sites funded with state funding, and/or federal Maternal, Infant, and Early Childhood Home Visiting funding, continue to implement their selected home visiting model. Tobacco cessation is a component of all the models.

Home visitors assess primary caregivers and pregnant enrollees for tobacco use annually. Clients who use tobacco are referred to appropriate cessation services and receive support and follow-up from the home visitors about their cessation efforts. The program collects and reports on the percent of families with tobacco use in the home at the time of enrollment, and the percent of primary caregivers and pregnant participants who are current tobacco users (measured at enrollment and annually).

The program serves approximately 900 clients (children and pregnant women) annually. Approximately 20% of the clients are women who enroll while pregnant. Under several of the home visiting models children and families are served for multiple years: Parents as Teachers, Nurse-Family Partnership, and Family Spirit,.

In the plan through FFY 2020, home visitors at implementing sites will continue to assess the primary caregivers and pregnant enrollees for tobacco use at enrollment and refer to appropriate assessment programs if appropriate. The program will continue to collaborate with the Montana Tobacco Use Prevention Program (MTUPP) on tobacco cessation efforts.

During FFY16, the Montana Tobacco Quit-Line recently added a program for pregnant and postpartum smokers who wish to quit. It provides a dedicated female coach, extended coaching calls with cash incentives, a personalized quit plan, and Nicotine Replacement Therapy support. Women who are interested may call 1-800-784-8669 to enroll or visit the website. There is also a new Montana Tobacco Quit Line program for American Indian smokers, which connects them with Native Coaches. It offers 10 weeks of free counseling and free Nicotine Replacement Therapy. The service uses a dedicated toll-free number: 1-855-372-0037. During the first eight months of FFY 2016, the Quit Line received 3,024 calls, and had 2,904 referrals from 28 different types of sources.

**SPM 1 - Access to Care and Public Health Services: Number of clients ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 2,000 or less.**

Access to Care and Public Health Services was consistently identified as a continuing health care need on the 2015

Needs Assessment Surveys and Key Informant Interviews, as Montana faces a large geographic health disparity. Access to Care is a fundamental action area in five sections of Montana's State Health Improvement Plan, and one section is focused on strengthening the public health and health care system. It is also integral to a key results area of the Public Health & Safety Division Strategic Plan.

Recently, the County Public Health Department (CPHD) contracts have included increasing requirements for planning, reporting and evaluating their MCHBG activities. This transition has been accompanied by additional support at regional trainings and webinars. The large CPHDs take these requirements in stride; but many of the smaller ones have outdated record-keeping systems and problems aggregating enough county specific data to measure the results of their activities in the short term. As a result the number of counties accepting MCHBG funding decreased from 54 counties participating in fiscal year 2013, to 50 in fiscal year 2016.

This State Performance Measure was developed to address the unique challenges faced by counties with very small populations. Six frontier-level population CPHDs collaborated with the FCHB on a pilot project of this performance measure for FY 2016. The main focus was to help provide support for all of the MCH services they provide, and the activities not have to fit into any one performance measure. Below are examples from Sheridan County's first quarter report (MCH population 1,403):

**a. Women / Maternal Health (Ages 15 - 44)**

This quarter was marked by a positive case of mumps whose family members and immediate contacts included a pregnant woman. Staff worked with partners at a local clinic and the DPHHS CDEpi team to track contacts and ensure that appropriate education, treatment and preventative measures were provided. Immunizations (Tdap, HepA, HPV) were provided to a number of woman as appropriate. We collaborate with WIC to make referrals to Medicaid, dental & health care providers; also STD education and referrals to family planning.

**a. Perinatal / Infant Health (Age <1)**

We accepted a referral from Benefis Hospital (Great Falls) to follow a high risk newborn, tracking growth over several visits (1/week). We collaborated with WIC to identify newborns and provide education about immunizations. We also collaborate with Plentywood Clinic PC by entering immunization records into imMTrax for them and providing reminders to patients.

**a. Child Health (Ages 1 - 10)**

Along with our collaboration with Plentywood Clinic PC for immunization tracking and reminders, we also directly provide vaccinations to children age 6+. Staff tracked pertussis a outbreak for children from Sheridan County who attended a camp during the summer of 2015, and for children connected to the above mentioned case of mumps.

**a. Adolescent Health (Ages 11 - 19)**

We collaborate with all county schools to review immunization status of all new students and updates for Var & Tdap status. We also administer immunizations for adolescents (Tdap MCV4 & HPV Var & HepA). We also provided education regarding strep throat to school personnel, to be passed on to families.

**a. Children and Youth with Special Health Care Needs**

We referred a family to physical therapy resources and respite care options.

Having the ability to choose this SPM kept at least one CPHD from dropping out of participation in MCHBG activities. For FFY 2017 there are now ten counties choosing this measure.

**SPM 2 – Family Support and Health Education: Number of clients ages 0 – 21, and women ages 22 – 44 who are assessed for social service and health education needs; and then are placed into a referral and follow-up system, or provided with health education as needed.**

During the recent 5-Year Statewide Needs Assessment, inputs identified a strong emerging trend. Family support and parental education appeared as essentials which are increasingly unmet; and as having a major effect on the health of the whole MCH population, especially ages 0 to 19 years. This goes along with the increasing nationwide recognition of the social determinants of health.

Public health functions in Montana are decentralized, and the FCHB contracts with counties to provide a significant portion of MCH services. SPM 2 was created to support county public health departments with providing referrals and follow-up to community services, and health education to their clients. The initial focus was counties without MIECHV grant funding, and designed to help clients that come into the health department. Many of the counties with home visiting became interested as well though, as an extension to their programs.

The FCHB assisted with practical application of SPM 2 by creating standardized documents: 1) a simple and non-invasive family needs survey, 2) an informed-consent form, 3) a more in-depth interview assessment tool, and 4) a data collection and tracking form. Six counties of differing sizes started implementing this measure on July 1, 2015. They were included in finalizing the forms and processes, and were given training. The first year will provide baseline data. Quarterly conference calls help with support and sharing best practices.

Some of the smaller population counties have found a challenge with this performance measure, as they do not have a lot of public traffic into their facilities. During the conference calls, and then again during feedback at the March 2016 regional trainings, it became evident that medium-size counties are more particularly suited for SPM 2, but it also depends on the public health department's business processes, i.e. the number of clients who come into their building for services.

FFY 2016 will provide baseline data for the counties which are continuing into the upcoming year with this performance measure. Any year in which a county chooses SPM 2 for the first time will be its baseline year. Nine counties are working on it for FFY 2017, with four being new. Current counties continuing with this measure are Missoula, Powell, Lewis & Clark, Gallatin, and Richland. The new counties are Ravalli, Toole, Blaine, and Liberty.

## **Cross-Cutting/Life Course - Annual Report**

### **Background Narrative - Information Submitted for July 2015 Report:**

Performance Measures Included: (**P** designates performance measures for fiscal years 2011-2015, and **N** designates new performance measures for fiscal years 2016-2020)

Last Year's Accomplishments and Current Activities =

- **P**NPM 9 – 3<sup>rd</sup> Graders Oral Health Screening
- **P**NPM 13 – Health Insurance
- **P**NPM 15 – Smoking Last 3 Months Pregnancy
- **P**SPM 2 – Medicaid Clients Oral Health Screening (Ages 0 – 6)
- **P**SPM 5 – Smoking Entire Pregnancy

Plan for the Coming Year and for 5-Year Action Plan =

- **NNPM 13 – Oral Health Preventive Visits, Pregnancy and Ages 1-17**
- **NNPM 14 – Pregnancy and Household Smoking**
- **NSPM 1 – Access to Care**
- **NSPM 2 – Family Support & Health Education**

The main MCHBG categories of activity that fit into the Cross-Cutting / Life Course domain for Montana are: access to care, adequate insurance, family support and health education, smoking, and oral health. This narrative will report on past accomplishments and challenges, current effectiveness, and initiation of new efforts based on the needs assessment analysis.

Two of these categories contain performance measures which span the timeframes of two 5-Year Statewide Needs Assessments: oral health and smoking. Access to Care and Family Support & Health Education, are new state performance measures created to address top emerging needs identified in the 2015 Statewide 5-Year Needs Assessment. Adequate health insurance is a part of the reporting on last year's accomplishments and current activities, and while not one of the priorities in the upcoming state action plan, will continue to be of importance to the FCHB.

#### Access to Care

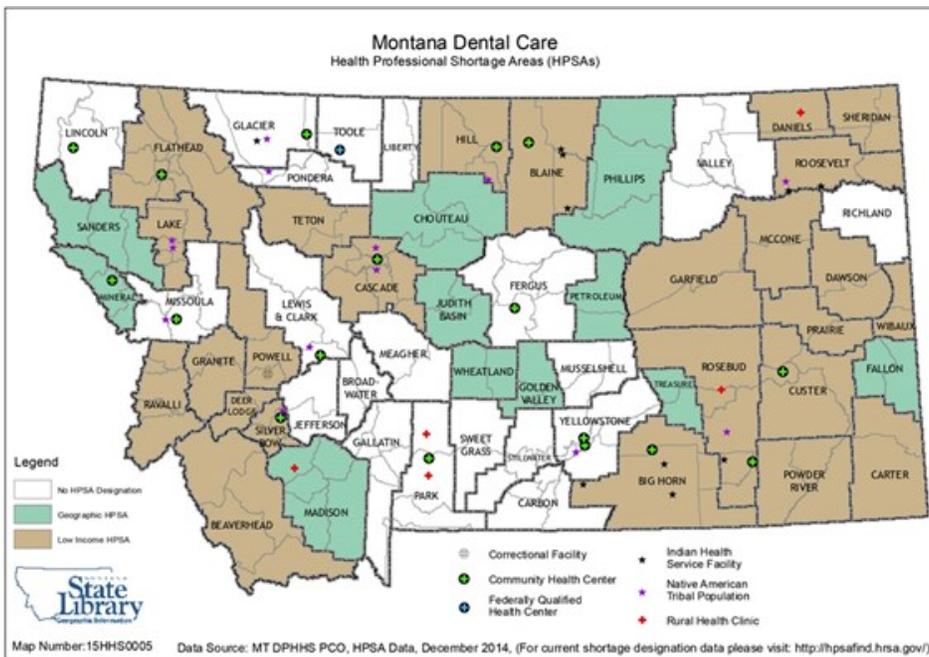
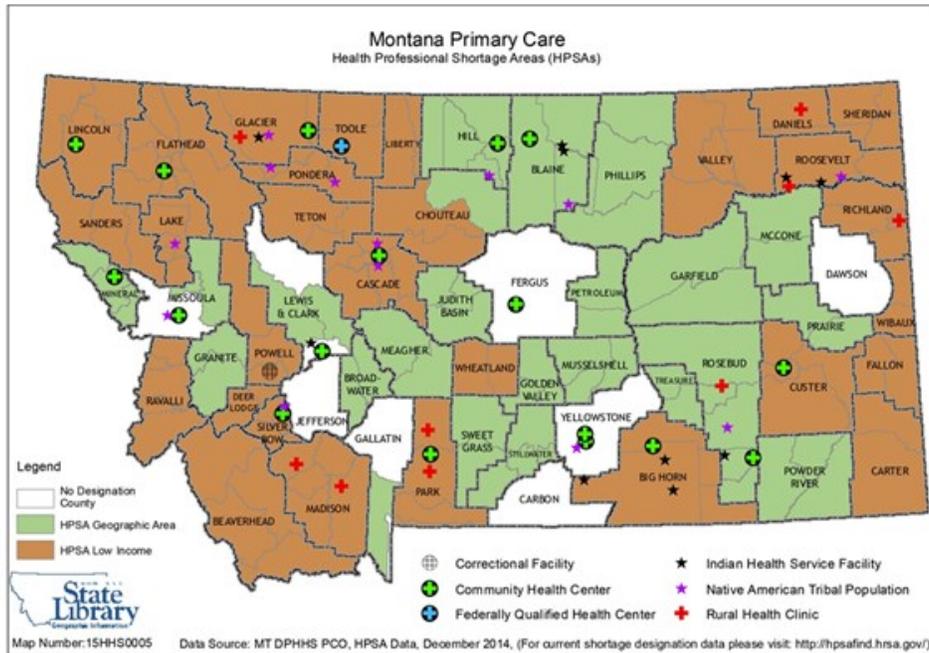
Access to Care is one of the main action-area categories in Montana's State Health Improvement Plan. In addition, the Public Health and Safety Division's Strategic Plan includes these goals:

- Improve the delivery of clinical preventive services, and
- Increase use of appropriate health services, particularly by underserved and at-risk populations.

Montana's public health services are delivered primarily through contracts with County Public Health Departments (CPHDs) and tribal public health departments in every county and reservation in Montana, as well as outpatient clinics, community health centers, hospitals and other community-based organizations statewide. Geographic disparities exist, however, in connection to enabling services. The very low population base in Montana's frontier counties creates a double challenge of decreased availability of health services, and lack of health care providers.

There is huge variation in the potential size of the maternal and child population served by Montana's counties. In 2015 the MCH population ranged from 197 individuals in Petroleum County, to 73,779 individuals in Yellowstone County. Of Montana's 56 counties, in state fiscal year 2015 the 10 counties eligible for minimum baseline funding accounted for less than 1% of the state's maternal and child population; 41 counties held only 20%; and the 6 largest counties accounted for 60% of the MCH population. The majority of the counties with low population are where the greatest geographic health disparities occur due to access-to-care issues.

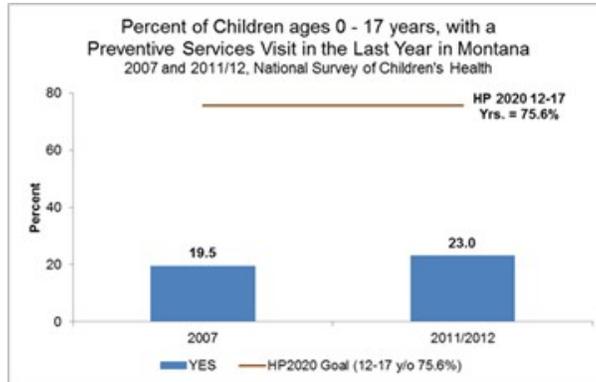
All 56 Montana counties have federally designated Health Professional Shortage Areas (HPSA) or Medically Underserved Areas or Populations (MUA/P). Many federal and state programs use these designations for eligibility and prioritization purposes. The following maps show the Health Professional Shortage Areas for primary care, dental health providers, which relates directly to access-to-care challenges:



Another area which can be classified as both an access- to-care health disparity and challenge is oral health. The rate of preventive visits for children ages 0-17 years has stayed constant at about 76.6 percent since 2007. The CPHDs identified oral health as the top children’s unmet health need, which pertains to the Life-Course domain.

The challenge of access to specialty care also remains a large obstacle for many children with special health care needs in Montana. For some specialty services, (i.e. some pediatric surgeries) families must travel out-of-state for care. In order to reduce the burden on families, the Children’s Special Health Section works with staff at tertiary care centers to ensure families have access to care when returning home.

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



In the past two years, the CPHD contracts have included increasing requirements for planning, reporting and evaluating their MCHBG activities. This transition has been accompanied by additional support at regional trainings and webinars. The large CPHDs take these requirements in stride; but many of the smaller ones have outdated record-keeping systems and problems aggregating enough county specific data to measure the results of their activities in the short term. As a result the number of counties accepting MCHBG funding has decreased from 54 counties participating in fiscal year 2013, to 50 in fiscal year 2016.

During this coming year a study group will be created with representatives of different sized CPHDs, to address the funding formula and provide input on the NPM and SPM State Action Plans. Two new State Performance Measures (SPMs) have also been developed to address priorities not covered by any of the National Performance Measures. SPM 1 was created as a result of the increasing access-to-care challenges identified in the 2015 Statewide 5-Year Needs Assessment:

**SPM 1 - Access to Public Health Services:** Number of clients' ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 2,000 or less. (County public health departments report data on a state provided form.)

*Rationale - Access to Care issues were consistently identified as a continuing health care need on the Needs Assessment Surveys and Key Informant Interviews. Montana faces a large geographic health disparity. Access to Care is a fundamental action area in five sections of the State Health Improvement Plan (SHIP), and one section is focused on strengthening the public health and health care system. It is also integral to Key Results Area 3 of the Public Health and Safety Division Strategic Plan (PHSDSP).*

Six frontier-level population CPHDs are collaborating with the FCHB on a pilot project of this performance measure for FY 2016. The main focus is to help provide support for *all* of the MCH services they provide. Although activities do not have to fit into any one performance measure, these partners have submitted plans and methods of evaluation.

### Adequate Health Insurance

At the end of September 2014, Montana had 103,538 children enrolled in the Healthy Montana Kids Plan (HMK), a combination of children's Medicaid and CHIP coverage. This was an increase of 1,147 children over the previous September. The Affordable Care Act had an effect on the comparative rates of enrollment however, and the ratio of change between children's Medicaid and CHIP. Children's Medicaid enrollment increased by 5,341, while CHIP decreased by 4,232.

The Census Bureau's March 2014 Current Population Survey, Annual Social and Economic Supplement, stated that the uninsured rate for children ages 0-18 in Montana was at 6%. Coverage equaled 44% for those with employer provided insurance, and children's Medicaid and CHIP covered 37%. All American Indian children in the state are also covered by the Indian Health Service, for medical and public health services.

Work continued on "family friendly" approaches for those seeking health care or who have questions about the Affordable Care Act (ACA). Montana:

- Launched an updated online application to coordinate with the federal streamlined application;
- Sent ACA related information to 75,000 current Medicaid and HMK households explaining that their current coverage met ACA compliance and there was no need to take further action;
- Established a toll-free number for callers with ACA, Medicaid, or HMK Plan related questions;
- Continued to target outreach to the state's seven tribal reservations; and,
- Updated the online self-service portal so applicants may check their benefits or application status.

The "Service First" initiative was established by DPHHS in December 2013 "to provide the right services at the right time in the best way possible for Montanans." The initiative's objectives include: a main street presence in most communities; friendly offices focused on customer service; efficient work processes and case handling; simplified notices, forms, and policies; utilizing technology to better support clients' needs; and workforce training.

Montana elected to facilitate Medicaid enrollment by extending the Medicaid renewal period. This allowed renewals that would otherwise have occurred during January 1 to March 31, 2014 to occur later, and avoided having to operate two sets of eligibility rules because of new household composition rules that went into effect after March 31<sup>st</sup>.

Children in families with income up to 250% of the Federal Poverty Level (FPL) continue to be eligible for the Healthy Montana Kids program. It is also expected that more uninsured children will be enrolled due to a ripple effect from recent Medicaid expansion, passed by the Montana legislature in April 2015.

#### Family Support and Health Education

State Performance Measure 2 was created as a result of the increasing need for enabling services and health education, which were identified in the 2015 Statewide 5-Year Needs Assessment. It also helps to address social determinants of health.

**SPM 2 – Family Support and Health Education:** Number of clients' ages 0 – 21, and women ages 22 – 44 who are assessed for social service and health education needs; and then are placed into a referral and follow-up system, or provided with health education as needed. (County public health departments report on state provided form)

*Rationale - During the needs assessment process, family support and parental education emerged as essentials which are increasingly unmet; and as a having a major effect on the health of the whole MCH population, especially ages 0 to 19. Numerous strategies in the SHIP and PHSDSP address working to improve outreach in this area.*

High-level guidance for this performance measure is also provided in the SHIP "Prevention and Health Promotion Efforts" section, and in the PHSDSP goals to "Promote health by providing information and education to help people make healthy choices."

The main goal of SPM 2 is to provide referrals to enabling services, some case management as needed, and requested health education *in the physical setting of the CPHD facility*. This model does not require as many resources in funding and personnel, and will help track and support work that is already provided by the CPHDs in a more comprehensive manner.

Six CPHDs are collaborating on a pilot of SPM 2 for FY16, and this will provide baseline data for the measure. Three of these counties represent larger population counties in the state: Gallatin, Lewis & Clark and Missoula. Richland County represents a mid-size population county, and sits in the epicenter of the Bakken oil boom area. The two smaller population counties, Madison and Powell, will also pilot the measure.

New forms to support the implementation of SPM 2 were created by the MCH section staff. First, the counties will use a "Family Needs Survey." When clients come into the health department they will be given the opportunity to complete a short survey. From this survey, clients can select from 15 topics commonly mentioned by families, as areas where they would like help in identifying resources or learning more information. At the end is a place to write down additional requests for services not mentioned on the list.

If a CPHD client indicates an interest to meet with a staff member to discuss the topics selected, then an appointment is made either immediately or as soon as possible. At that time a consent form is signed. The staff member then uses an assessment tool which was created to gather the information needed to provide the most effective assistance.

The counties will collect de-identified data on a standardized form to submit to the FCHB. The information covers: the main survey topics selected by the client, their MCH population category, the types of referrals made, and any health education topics - covered along with dates.

#### Smoking During Pregnancy & Household Smoking

At the beginning of FY 2014, nine sites provided home visiting services as part of the Montana Maternal and Early Childhood Home Visiting Program (MT MECHV), which includes state funding and federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding. They implemented the Parents as Teachers (PAT) or Nurse-Family Partnership (NFP) home visiting models. Tobacco use assessment, and referral to cessation resources, was provided under both models. Clients who used tobacco were referred to cessation services if appropriate. The Montana Tobacco Use Prevention Program (MTUPP) was a partner in providing cessation support for pregnant and post-partum women, and provided training as needed. In FY 2014, 137 of 452 (30.3%) primary caregivers reported smoking when they enrolled in the MT MECHV program

In the summer of 2014, ten new sites (and 15 new contractors) began implementing evidence-based home visiting using PAT, NFP, SafeCare Augmented or Family Spirit with federal MIECHV Expansion funds. The new models were added because SafeCare Augmented addressed child abuse and neglect and is a shorter curriculum, and Family Spirit is specifically developed for tribal communities. This increased the total program caseload to approximately 1,000 clients. Some sites provide more than one model. The total number sites implementing each model is: PAT = 18, SafeCare = 7, NFP = 5, and Family Spirit = 1. Approximately 20% of the clients are women who enroll while pregnant. Under several of the home visiting models they are served for multiple years: Parents as Teachers, Nurse-Family Partnership, and Family Spirit.

During FY 2015, sites funded with state funding and/or federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding continued to implement their selected home visiting model. Tobacco cessation is an ongoing

component. Clients receive support and follow-up from the home visitors about their cessation efforts. Women are referred to MTUPP as needed and the program provides training to the home visitors. For clients served between October 2011 and December 2014, 36% of primary caregivers who reported using tobacco at enrollment quit while enrolled.

MTUPP is requiring local tobacco prevention specialists to provide outreach and education about their quit-line pregnancy program to the health clinics in their communities which serve pregnant women. QUIT Line information is available at: <http://dphhs.mt.gov/publichealth/mtupp/quitline.aspx>

In FY 2016, home visitors will continue to assess primary caregivers and pregnant enrollees for tobacco use. Clients who use tobacco will be referred to appropriate cessation services and will receive support and follow-up from the home visitors about their cessation efforts. The program collects and reports on the percent of families with tobacco use in the home at the time of enrollment, and the percent of primary caregivers and pregnant participants who are current tobacco users (measured at enrollment and annually).

Over the next 5 years, home visitors at implementing sites will continue to assess the primary caregivers and pregnant enrollees for tobacco use, and refer to appropriate assessment programs if appropriate. The program will continue to collaborate with the Montana Tobacco Use Prevention Program (MTUPP) on tobacco cessation efforts.

In FY 2015, Toole CPHD selected SPM 5 (smoking during anytime during pregnancy) and developed these three activities and evaluation methods:

- Activity 1: All pregnant WIC participants will be screened for tobacco use and referred to the Quitline if they use tobacco.
  - Evaluation: Staff will maintain a log sheet of all pregnant WIC participants who report tobacco use and indicate whether they were referred to the Quitline.
- Activity 2: All pregnant WIC participants who report tobacco use will receive a tobacco cessation pamphlet.
  - Evaluation: Staff will maintain a log sheet of all pregnant WIC participants who report tobacco use and indicate whether they were given a tobacco cessation pamphlet.
- Activity 3: Tobacco cessation resources will be provided to local health care providers with information on the reasons to encourage women of child bearing age to not use tobacco and to quit if they already use.
  - Evaluation: The tobacco use prevention coordinator's catalyst reporting will indicate the tobacco cessation resources shared with local health care providers.

In FY 2016, Park CPHD has chosen to focus on NPM 14 as its performance measure. Park's activities and evaluation methods are:

- Activity 1: Identification of women smoking in the first trimester through provider referrals
  - Evaluation: Continual monitoring of number of referrals from providers
- Activity 2: Referral of women to the Quitline
  - Evaluation: Number of women receiving services will be tracked
- Activity 3: Education outreach for reproductive aged women currently smoking to increase cessation prior to conception
  - Evaluation: Number of women served by education services and number of Quitline referrals

## Oral Health

The Maternal and Child Health (MCH) Section Supervisor provided direct oversight of the Oral Health Program (OHP) until February 2014. Then, through funding provided by HRSA's Grants to States to Support Oral Health Workforce Activities, a full-time coordinator was hired to provide day-to-day oversight and administration of OHP activities, and to promote oral health assessments for children ages 0 to 6. The OH Coordinator, a dental hygienist with a Master's Degree in Community and Rural OH, serves as a resource for county public health departments (CPHD), public and private entities, and directly oversees the Grants to States to Support Oral Health Workforce Activities which include:

- Partnering with the University of Washington School of Dentistry for 27 dental student rotations in underserved areas;
- Collecting dental sealant surveillance data by partnering with the Montana Dental Association, Montana Dental Hygienists' Association and Sealants for Smiles, who conduct Basic Screening Survey (BSS) of 3rd grade children;
- Training 20 dental health providers on how to complete a BSS;
- Expanding the reach and scope of two Medicaid Programs: the Access to Baby Child Dentistry (ABCD) and fluoride varnish applications in primary care settings by physicians to include more dental and primary care practices;
- Promoting the Office of Rural Health/Area Health Education Center's (ORH/AHEC) efforts providing outreach for dental provider recruitment/retention in rural and underserved communities;
- Providing technical assistance to the ORH/AHEC Career Outreach Pipeline Program" aimed at fostering interest in dental careers among Montana's adolescents by providing dental career learning opportunities to 6,000 students;
- Collaborating with the Primary Care Office on a dental provider survey which is collecting data about the dental provider's future number of working years; and,
- Conducting outreach to foster inter-professional oral health activities among public health and primary medical providers for care collaboration and sharing the results with the ORH/AHEC, UW School of Dentistry, and MT Dental Association. The goal is to increase the number of health professionals which will help to increase the number of MT children receiving preventive care, including dental sealants.

The OH Coordinator offered technical assistance to a CPHD with a high percentage of Native American children, which had chosen NPM 9, through facilitation of open mouth screenings. Fifty-nine children were screened in grades kindergarten through 5 and among children with permanent molars, less than 15% had preventive sealants. The OH Coordinator provided the public health nurse with an OH Resource Guide outlining provisions for services, including travel reimbursement for Medicaid enrollees and the Sealants for Smiles (SFS) program contact information. Sealants for Smiles is a state-wide collaborative of dental professionals that provide school-based dental sealants in schools with over 50% free and reduced lunch populations.

The OHP will continue to build capacity, by increasing the awareness of the impact of oral health on overall health. Outreach during FY 2015 offered an opportunity to begin collaboration with other Montana DPHHS programs and public health stakeholders, to integrate oral health promotion. A communication plan was implemented and evaluation data is continuously being collected related to outreach. During previous outreach, a primary focus was on preventing the transmission and infection of decay-causing bacteria during infancy and early childhood - while emphasizing the importance of dental care during pregnancy.

The OH Coordinator continued work to develop an oral health surveillance system, and a draft burden of oral disease document called "Oral Health Surveillance, 2004-2013." The results indicated that during 2006 and 2014, 30 and 40 schools participated in the surveillance program, respectively. Approximately two-thirds of surveyed Montana 3rd graders in 2006 and 2014 had a history of dental decay. For both 2006 and 2014 the rate of untreated decay

remained higher than the Healthy People 2010 target of 21%. Among children identified with dental needs, less than 3% had urgent needs in 2014 compared with over 7% in 2006.

The percentage of children with the presence of preventive dental sealants increased nearly 10% since 2006 and is above the Healthy People 2010 objective for the percentage of children with dental sealants of 50%. In 2014, over 92% of children classified as AI/AN had a history of dental decay and over 56% had untreated decay, compared with 58% and 18% of children classified as white, respectively. The data collection will be utilized to foster program evaluation and future planning related to the oral health of MT children. The data is also being included in the Montana OH surveillance system, where analysis can help to address disparities in the 0 to 6 year old population. The full report is accessible at: <http://dphhs.mt.gov/publichealth/Montana-Public-Health>

The OH Coordinator is collaborating with Sealants for Smiles, and the Ronald McDonald Care Mobile, to establish a sustainable foundation for future school-based sealant activities. Additional outreach includes collaboration with the Montana Dental Hygienists' Association Public Health Committee, to conduct an assessment of 27 WIC Agencies to determine the knowledge level of WIC staff about oral health. The results will be utilized for assistance in training WIC staff, which was requested by the WIC Program.

The OH Coordinator conducted targeted trainings for MCHBG public health staff in 5 locations throughout MT during March 2015. Participants were provided an overview of the etiology of disease, and a laminated copy of the American Academy of Pediatrics oral health risk assessment tool. They were also given a demonstration of "knee-to-knee" dental screening practices including fluoride varnish applications for children identified as high-risk. Evaluation methods, which included a pre- and post-test during the trainings and a follow-up evaluation afterwards, were used to determine the utilization of materials presented.

During FY 2015, the OHP completed controlled dental surveillance on the third grade population which will continue to be disseminated during outreach. During FY 2016 the OHP will complete dental surveillance in the Head Start (HS) population to foster early preventive dental care in high-risk populations. Preliminary outreach and preparation for HS surveillance began during FY 2015 to engage HS staff and stakeholders, and data collection will begin early in FY 2016.

The recently developed Montana Oral Health Surveillance System includes data on the proportion of Medicaid-enrolled pregnant women that receive dental services. The OHP communication plan includes outreach to obstetric providers with Centers for Medicare and Medicaid Services (CMS) print materials to increase the proportion from the FY 2014 baseline of 20%. The surveillance system also includes CMS Form-416 data, related to utilization of dental care among Montana children. Outreach will continue to foster early initiation of dental care to determine risk and reduce the prevalence of disease.

Surveillance assessment of primary care settings was made to ascertain how many were providing preventive dental care. A Medicaid query during SFY 2013 determined that only 2 physicians in Montana were reimbursed for fluoride varnish applications. Those providers indicated that there were no significant barriers to the delivery of oral health services in this setting, so outreach activities on this subject were included in conjunction with other work activities.

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### **FFY 2015 Report Updates:**

The FFY15 updates for the Cross-Cutting/Life-Course domain include the following performance measures:

- NPM 9 – Oral Health
- NPM 13 – Children’s Health Insurance
- NPM 15 – Smoking During Last 3 Months Pregnancy
- SPM 2 – Dental Screening, Medicaid Ages 0-6
- SPM 5 – Smoking During Entire Pregnancy

**Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth:**

The Oral Health Program (OHP) continued to collaborate with other oral health stakeholders to address NPM 9. The University Of Washington School Of Dentistry (UWSOD) continued to build capacity for dental student rotations by identifying rotation sites, and preceptors, to increase the number of dentists in underserved communities. During FY15 nine dentist students served in 4 week rotations in rural and community health center sites in Montana at the following locations: RiverStone CHC (Billings), Partnership CHC (Missoula), Browning Indian Health Service Dental Clinic, Community Health Partners (Bozeman) and a private dental practice in Hardin.

The Area Health Education Center (AHEC) continued to provide outreach for dental provider recruitment/retention in rural and underserved communities. The center recruited 4 dentists in FY15 through direct contact with Montana CHC sites and a robust 3RNet utilization. The dentists were placed at Flathead CHC (Kalispell), Southwest Montana CHC (Butte), Seeley satellite CHC, and Bullhook CHC (Havre). AHEC staff also offered opportunities for 3480 adolescents to explore careers in dentistry through ‘grow your own’ programming in high school science classes, career fairs, and mentoring programs.

The OHP conducted outreach to foster inter-professional oral health services, to increase the number of MT children receiving preventive care, including dental sealants. Seventy-two MCH public health providers from 46 counties received oral health training at five regional locations: Bozeman, Glasgow, Great Falls, Miles City and Polson. Sixty WIC staff also received oral health training in Helena. As part of the training over 500 items of print material from the National Maternal and Child Oral Health Resource Center and CMS were distributed, as well as American Academy of Pediatrics caries risk assessment guides.

Through the Sealants for Smiles and Ronald McDonald Care Mobile 10,855 children in 96 schools received dental screenings and 15,911 sealants were placed. Both programs also participated in Basic Screening Survey (BSS) data collection on the third grade population which was completed during FY15. The BSS data was submitted to the National Oral Health Surveillance System, to update the prevalence of decay and dental sealants among Montana third grade children. [A data brief](#) was disseminated to over 90 school nurses, state nutrition staff, and numerous other oral health stakeholders. BSS data was also included in the Montana OHP surveillance system which program staff continued to maintain.

The OHP also continued to offer support for the Primary Care Office dentist survey. Data collection began in FY15 and will be utilized in establishing dental health professional shortage areas. Data will also be utilized by the OHP to evaluate dentist workforce activities. The OHP also completed a survey of dental hygiene providers during FY15. Data of respondents with a public health endorsement as part of [MCA 37-4-405](#) were collected in both August 2014 and August 2015, and combined with Medicaid claims data, to monitor community-based activities by dental hygienists practicing in public health settings. Several of these provider types are placing sealants in school-based settings as part of mobile dental clinics.

**Performance Measure 13: Percent of children without health insurance:**

In April 2015, the Montana State Legislature passed Senate Bill 405, expanding Medicaid eligibility to about 70,000 low-income residents. The legislation requires enrollees to pay premiums and copays for services, and includes provisions to help with job training and placement. The State received federal approval of waivers needed for the unique provisions in October 2015. This cleared the way for residents to receive healthcare under what is called the Montana [Health and Economic Livelihood Plan](#) (HELP), and they were able to begin signing up for coverage that took effect in early January 2016.

The new plan is open to individuals who earn less than \$16,000 a year (or \$33,000 for a family of four), most of whom work in businesses that traditionally do not offer health care coverage like construction, food service, farming, cleaning services, and childcare.

Numerous informational resources regarding health insurance and enrollment were made available at <http://dphhs.mt.gov/healthcare/healthcareresources>. Also, Montanans who go to [healthcare.gov](http://healthcare.gov) to find information about health insurance may be determined eligible for the expanded Medicaid coverage.

All the essentials are covered, including:

- Doctor, hospital, and emergency services
- Prescription drugs
- Dental care
- Vision care
- Laboratory and x-ray services
- Maternity and newborn care
- Mental health and substance abuse treatment
- Rehabilitative services and supplies
- Transportation to appointments

Details concerning affordability:

- No or low monthly premiums, depending on income
- Small co-pays for doctor visits, with no co-pays for preventive services such as health screenings, smoking cessation, or flu shots
- No out-of-pocket above 5% of total income

Children in families with income up to 250% of the Federal Poverty Level (FPL) still continue to be eligible for the Healthy Montana Kids (CHIP) program. Also, a good resource for selecting a Montana health insurance plan that meets health needs, and fits into a monthly budget, can be found at [CoverMT.org](http://CoverMT.org).

#### **Performance Measure 15: Percentage of women who smoke in the last three months of pregnancy:**

The Montana Healthy Families Program sites, funded by the Maternal and Early Childhood Home Visiting Program, continued to implement four selected home visiting models. Support for tobacco cessation is a component of each.

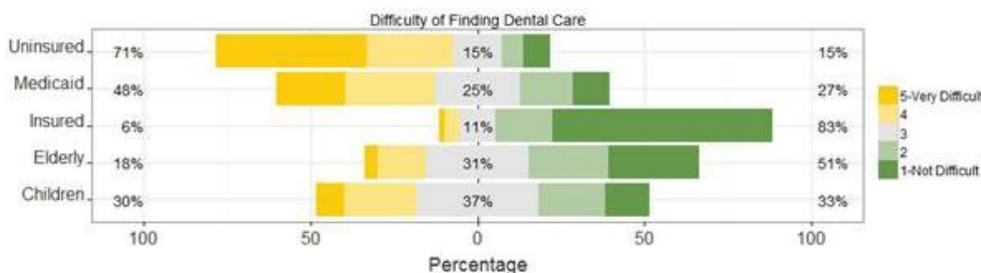
Home visitors assessed the primary caregivers and pregnant enrollees for tobacco use annually. In 2015, over 60 clients who used tobacco were referred to appropriate cessation services, and received support and follow-up from the home visitors for their cessation efforts. The Montana Tobacco Use Prevention Program (MTUPP) is a partner in providing cessation support for pregnant and post-partum women. Women were referred to MTUPP as needed and the program provided training to the home visitors as needed. MTUPP made it a requirement for tobacco prevention specialists at the local level to provide outreach and education, about the quit-line pregnancy program, to health clinics in their communities serving pregnant women.

Nineteen new sites (and 15 new contractors) implemented evidence-based home visiting with state and federal MIECHV Expansion funds. These new sites followed the same guidelines and provided the same level of service as the existing sites. The total caseload capacity for the existing and new contractors was approximately 1000 clients. Programs implementing Nurse-Family Partnership (5 sites) enrolled women during pregnancy. Parents as Teachers (17 sites), SafeCare Augmented (6 sites) and Family Spirit (1 site) enrolled families with young children in addition to pregnant women. Even when clients enrolled while they were pregnant, the majority of clients enrolled after the first trimester of pregnancy.

If caregivers were already enrolled as a client and became pregnant while enrolled, the home visitor asked whether they wanted to enroll as a pregnant client and focus home visits on the pregnancy. Prior to providing services, sites were trained in the home visiting model, as well as in the Montana program components, such as: screening requirements, assessment tools, continuous quality improvement, and the program forms and data system. All client data were entered into the MTmechv data system or, in the case of NFP sites, downloaded to Montana's program from the NFP ETO data system. As of May of 2016, over 2,000 clients have been served and 23,000 home visits have been completed since the program began offering services. 79 pregnant women were enrolled in the program as of May 2016.

**State Performance Measure 2: The percent of Medicaid clients 0 through 6 years of age who have had a dental screening during the year:**

Through HRSA Grants to Support Oral Health Workforce Activities, the Oral Health Program (OHP) provided technical assistance and expertise to increase oral health activities throughout MT. The OHP monitored outreach through communication plan data, to examine activities and improve program quality. The data collection includes outreach to medical, public health, dental and school-based providers. Formal outreach activities included 10 events with a reach to 284 MCH, WIC, Head Start, elderly care and dental providers. MCH Block grant evaluation data included perceptions of access to dental care (see below):



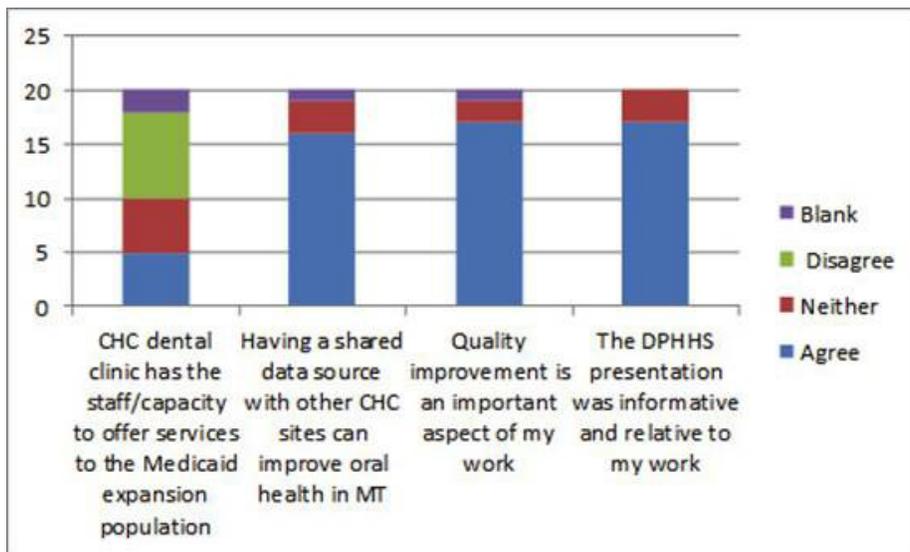
During 5 regional meetings, 72 MCH public health staff received training on transmission of decay-causing bacteria, etiology of disease, and best practices in preventing dental decay. Participants were provided a laminated copy of the American Academy of Pediatrics oral health risk assessment tool and knee-to-knee dental screening techniques were demonstrated. Evaluation data exhibited that many attendees did not think of dental decay as an infectious disease prior to the training. The training also offered an overview of the OHP website which was updated in October 2014. Over 64% of attendees had not utilized the OHP website prior to the training.

Oral health training was also provided to 63 WIC staff members following an assessment of the 27 WIC sites. Over 70% of the sites reported they had not had any prior dental training. OHP staff continues to work with dental providers, to increase the number of collaborations between WIC sites and providers conducting on-site preventive programming during early childhood. During FY15, one CHC site implemented programming with a dental hygiene

provider.

Medicaid claim data, on the number of fluoride varnish applications by medical providers during well-child visits, were included in the oral health surveillance system to monitor outreach activities. During FY15 OHP staff developed a [one-page document](#) outlining how to implement caries risk assessments and fluoride varnish applications in medical settings, including assessment and risk coding for Medicaid enrollees. A dissemination plan is being developed to communicate with medical providers. OHP staff continued to seek funding opportunities to support programming for this preventive strategy.

OHP staff also presented to 20 dental staff members of community health center (CHC) sites throughout Montana, to introduce national and state measures related to oral health. Attendees were asked to review metrics and identify several that CHC sites could monitor as a group to promote health. Two Uniform Data System (UDS) metrics were selected as well as MCH National Performance Measure 13A. Only two clinics were able to accurately identify their dental Uniform Data System (UDS) data on utilization of dental care, but 17 agreed shared data metrics is important for quality improvement (see graph below). OHP staff will continue to collaborate with the Montana Primary Care Association and CHC staff to implement the measures.



Planning for BSS data collection in Head Start and Kindergarten began in FY15. Data will be collected in collaboration with mobile dental clinics, Indian Health Service, and CHC sites during the 2015-2016 school year.

**State Performance Measure 5: The percent of women who smoke during pregnancy:**

The Montana Healthy Families Program sites, funded by the Maternal and Early Childhood Home Visiting Program, continued to implement four selected home visiting models. Support for tobacco cessation is a component of each.

Home visitors assessed the primary caregivers and pregnant enrollees for tobacco use annually. Clients who used tobacco were referred to appropriate cessation services, and received support and follow-up from the home visitors for their cessation efforts. The Montana Tobacco Use Prevention Program (MTUPP) is a partner in providing cessation support for pregnant and post-partum women. Women were referred to MTUPP as needed and the program provided training to the home visitors as needed. MTUPP made it a requirement for tobacco prevention specialists at the local level to provide outreach and education, about the quit-line pregnancy program, to health

clinics in their communities serving pregnant women.

Clients who used tobacco were referred to appropriate cessation services and received support and follow-up from the home visitors about their cessation efforts. The program outcome measure related to tobacco cessation is: Percent of primary caregivers and pregnant MIECHV participants who are current tobacco users.

Nineteen sites implemented evidence-based home visiting with state and federal MIECHV Expansion funds. The new sites followed the same guidelines and provided the same level of service as the existing sites. The total caseload capacity for the existing and new contractors was approximately 1000 clients. Programs implementing Nurse-Family Partnership (NFP) enrolled women during pregnancy. Parents as Teachers, SafeCare Augmented and Family Spirit enrolled families with young children in addition to pregnant women. Even when clients enrolled while they were pregnant, the majority of clients enrolled after the first trimester of pregnancy.

If caregivers were already enrolled as a client and became pregnant while enrolled, the home visitor asked whether they wanted to enroll as a pregnant client and focus home visits on the pregnancy. Prior to providing services, sites were trained in the home visiting model, as well as in the Montana program components, such as: screening requirements, assessment tools, continuous quality improvement, and the program forms and data system. All client data were entered into the MTmechv data system or, in the case of NFP sites, downloaded to Montana's program from the NFP ETO data system.

Two County Public Health Departments focused their MCHBG funding on activities to inform women of the importance of smoking cessation during pregnancy:

- Toole County's MCH and WIC staff collaborated to encourage women enrolled in WIC to quit smoking while pregnant. At certification, the Competent Professional Authority (CPA) asks about smoking within the family. Pregnant women are educated on the negative effects of smoking during pregnancy. They are given "The Power to Quit" brochure, and referred to the Quitline. All Women enrolled in WIC are asked about their tobacco use during their certification, or their child's certification, and referred to the Quitline if they use tobacco.
- Park County's Tobacco Outreach Specialist met with local OB and Family Practice providers to educate on the QUIT line for adults, and the additional services offered for pregnant patients. The training included information on the harmful effects of smoking while pregnant, and of second and third hand smoke after baby arrives. Laminated educational pamphlets were given to hang up in their offices and clinic rooms. This service was well received by providers.

The Tobacco Outreach Specialist also received referrals for all OB patients. To the smokers she provided: education on the harmful effects of smoking while pregnant, support for quitting, and information about the QUIT line. Postnatally, she met with all referrals: providing education on second and third hand smoke, and encouraged mothers and partners to quit smoking or continue cessation as relevant.

### **Other Programmatic Activities**

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

### **II.F.2 MCH Workforce Development and Capacity**

**The following narrative is an update on information initially submitted for the July 2015 Report:**

#### **Workforce Development and Capacity -**

Workforce development and capacity building continues to be a PHSD priority. The PHSD Workforce Development Plan (WDP), released in November 2014, was reviewed in September 2015 during the PHAB Site Visit Team's review of Domain 8's four requirements. The WDP specifically addressed Domain 8.2.1, which received a PHAB rating of Largely Demonstrated.

The PHSD Training and Development Specialist, and management team, are assessing the PHSD WDP. Several components of the Workforce Training Model and Curricula and Training Schedules have been implemented. For example: the Public Health System Business Analyst has instituted monthly Integrated Performance Management System trainings, and new PHSD employees are briefed on the SHIP and Strategic Plan. Plans are in place to engage a professional workforce development consultant to assist with updating the WDP by the Spring of 2017.

By March of 2017, all PHSD staff's current and needed skill sets will be assessed using the same tools as in 2013. These results will be incorporated into the revised WDP and the Strategic Plan.

PHSD is completing the final year of a contract with the Northwest Center for Public Health Practice at the University of Washington to provide a 12-month distance-based Public Health Management Certificate (PHMC) training program for public health workers at the state, local and tribal level. The CSHS Supervisor, a WIC Retailer Services Program Specialist, and Health Education Specialists working in the Women's and Men's Health and Maternal & Early Childhood Home Visiting Sections will be completing their PHMC studies in July, 2016.

PHSD is finalizing a Certificate of Public Health (CPH) Program beginning in 2017 with the University of Montana, for approximately 20 to 30 participants. A bachelor's degree is a prerequisite. The PHC Program consists of four classes, three of which will be required and completed as a cohort. The remaining class may be selected from a list of electives.

Fourteen FCHB staff participated in the Fall 2015 Quality Improvement Training, which reviewed how to use the Plan, Do, Study, Act (PDSA) method for program evaluation. PDSA is the preferred approach for PHSD programs to determine if their public health program's activities are meeting their goals. Staff who completed the training continue to update management on the status of their PDSA projects, at their programs biannual Integrated Performance Management System's presentation.

The PHSD week long Summer Institute continues to provide targeted training to local health department and state level staff. This summer's classes includes courses in Emergency Planning; Epi-Ready Team Training; Foodborne Illness Response Strategies; MT Public Health Law and Statutes; Introduction to Epidemiology and Data Basics, and public health communication and response. The plenary workshop is titled: Building a Cohesive Leadership Team. Information about the Summer Institute is accessible at:

<http://dphhs.mt.gov/publichealth/PHEPTraining/SummerInstitute>

The PHSD used survey results of CPHDs and Tribal health departments for understanding the board of health function, and to drive trainings and professional development for the lead local health officials. Topics included: stakeholder engagement; primary data collection; secondary data sources; survey design; meeting facilitation; strategic planning; and introduction to Epi Info. The evaluations showed the topics were useful to the participants. More training topics will be identified from the 2016 Lead Local Survey. PHSD management have also traveled the state providing in-person training on topics such as public health law to county and tribal boards of health.

The PHSD is also working with the Rocky Mountain Public Health Training Institute to deliver trainings for strategic planning and Quality Improvement. In addition, the PHSD is working with a consultant to deliver a workforce assessment training for local and tribal health departments training in SFY 2017.

The Director of DPHHS has prioritized trauma informed care and adverse childhood experiences (ACEs) training in the Department. The Director's goal is that every DPHHS employee in the state will receive ACEs training. In order to achieve this goal, three Department employees are considered Master Trainers and within each Division there are two to three trained Facilitators who deliver short ACEs presentations and facilitate discussion. In PHSD, the CSHS supervisor and WIC nutritionist are trained Facilitators. ACEs trainings are ongoing within the Department.

All DPHHS staff are encouraged to attend Suicide Awareness and Prevention Training. The training is co-taught by Karl Rosston, LCSW, a certified master trainer for suicide awareness and prevention and the state's suicide prevention coordinator, and Dennis Nyland, the Governor's mental health ombudsman.

In February 2016, CSHS and the Montana Rural Institute for Inclusive Communities convened an Assessment Design Team, to plan survey strategies for CSHS assessment. Family Engagement training, with then AMCHP President-elect Eileen Forlenza, was presented on the first day on how to best engage families at all levels of advocacy and ability. The day included brainstorming, reflection and team-building exercises. The group consisted of parent, providers, staff, and individuals with a special health care needs.

The MCH Section provides yearly training to the MCHBG contractors and FICMMR Leads. The March 2016 training was held in five Montana communities and featured Teri Covington, Executive Director of the National Center for Child Death Review at the Michigan Public Health Institute and Abby Collier, Senior Project Manager, Children's Health Alliance of Wisconsin.

The FICMMR training was tailored based on feedback from the attendees at the five communities, and covered a host of topics, i.e. Developing a Prevention Action Plan; How to Facilitate an Effective Review; and How to Make An Inclusive Prevention Plan. The State FICMMR Coordinator also briefed the attendees on the Quality Improvement project for the data reported on the Child Death Review Case Reporting Form.

The MCHBG portion of the March 2016 training included a presentation on evidence-based or informed strategy measures and their relationship to the State Action Plans. The training was deemed a success based on the survey results which indicated that 98% that either agreed or strongly agreed that the training enhanced their knowledge, and that they would be able to apply the information to their jobs.

The FCHB sent two staff members, the MCH Supervisor and the MCHBG Coordinator, to the HRSA ESM Technical Assistance training in April 2016. They also attended the AMCHP Conference which followed, with the CSHS Supervisor, CSHS Family Delegate, and the MCH Epidemiologist. The Title V Coordinator attended the Return on Investment workshop. Throughout this past year, the MCHBG Coordinator also attended many of the ESM specific, and TVIS training webinars provided by HRSA.

Since 2010, several FCHB and PHSD staff members have been involved with the Montana Health Care Workforce Advisory Committee (MHWAC). The MHWAC is an active group with about 100 members from a wide range of healthcare-related entities around the state. It is charged with providing guidance to the state on how to assure a well-trained healthcare workforce sufficient in number, breadth and quality to meet the needs of all regions of the state.

Office of Rural Health/Area Health Education Center (ORH/AHEC) received a State Health Care Workforce Development Grant from HRSA. ORH/AHECs are involved in several project areas involving Health Information Technology, Allied Health, Oral Health, Community Health Workers and Care Coordination. The FCHB works closely with the Office of Public Instruction to assure students are exposed to healthcare careers early, through pipeline programs for K-12 students.

A recent MHWAC effort is updating the 2011 Strategic Plan, which is utilized extensively to advise workforce efforts across healthcare sectors and the state. Healthcare is undergoing a dramatic transformation and the Plan must be updated to address current issues. The update is expected in the summer of 2016.

The MHWAC continues to meet monthly and address workforce issues at both the community and state level. The public health perspective is provided by the FCHB and PHSD at the meetings, which are now focused on the MT HealthCARE Grant. HealthCARE (Creating Access to Rural Education) Montana is a partnership between the Montana Department of Labor and Industry and many of Montana's two-year colleges. The partnership builds a pathway to training programs that will meet the current and future needs of healthcare organizations. HealthCARE helps train, recruit, and retain healthcare professionals in rural and frontier Montana by:

- Helping prospective students identify and access pathways toward a healthcare certificate or 2-year degree, as well as supporting them throughout their healthcare education to ensure academic success;
- Developing an accelerated nursing curriculum to guide healthcare providers toward higher levels of practice and to ease the nursing shortage in Montana;
- Increasing opportunities for on-the-job training by developing healthcare apprenticeships; and
- Building and sustaining a rural, "home-grown" healthcare workforce that serves the smallest communities in the farthest regions of Montana.

For more information about the MT HealthCARE Grant, go to: <http://healthcaremontana.org/>

### **II.F.3. Family Consumer Partnership**

**The following narrative is an update on information initially submitted for the July 2015 Report:**

#### **Family/Consumer Partnership -**

Family and consumer engagement is gathered in a number of methods.

#### **Advisory Committees**

The WIC Futures Study Group was active as a collaborative between local lead health officials and the WIC state office up until May 2016, however this group was not considered “advisory”. WIC is planning a new group, which has yet to be established, made up of representatives of local clinics. This group will be working with the state on quality improvement activities.

WIC is engaging with WIC retailers throughout a new Electronic Benefit Transfer (EBT) implementation process, by hosting quarterly conference calls. The transition to the EBT system does impact families, and the calls focus on the WIC State Office and retailers providing updates, answers to questions, and troubleshooting solutions for issues that may present themselves during the transition period.

CSHS is working with the Consumer Advisory Council (CAC) of the Montana Rural Institute for Inclusive Communities (RIIC), to assess the needs of CYSHCN in Montana by performing a statewide survey. Part of the process has been to establish an assessment design team to inform design, identify the sample group and, when the survey is complete, to analyze the data and recommend strategies to address issues that emerge. The group includes specialty providers, parents, young adult CYSHCN, representatives from agencies that work with CYSHCN, pediatricians, and CSHS staff. When the assessment is complete (early 2017) CSHS plans to continue to convene this group as a Stakeholders Group for CSHS MCHBG activities.

In addition to advising the RIIC, members of the CAC plan and present webinars throughout the year on topics related to transitioning to adulthood. CAC young adults and parents also present several sessions at the annual Montana Youth in Transition Conference. Topics included secondary education, employment, healthcare, and empowerment.

CSHS ‘s American Cleft Palate Association Standards’ Cleft/Craniofacial application was approved in the spring of 2016. Work on establishing a Stakeholders Group is anticipated to begin in the fall of 2016.

The WMH Section continued their work with the Information & Education Committee (IEC). In the past year, the IEC met 4 times to review health education materials and toolkits focused on prevention of Domestic Violence, HIV, Sexually Transmitted Infections, and Teen Pregnancy. Based on the information provided in the toolkit, local health educators were able to conduct over 100 outreach events, almost 500 educational presentations, reaching approximately 33,000 individuals statewide.

In September 2015, the MCHBG Coordinator gave a presentation to the PHSITF on the Evidence Based/Informed Strategy Measures (ESMs) and their relationship to the State Action Plans. The PHSITF were also asked to identify

potential subject matter experts for the NPMs and SPMs, and will be advising on the final MCHBG submission.

The MCH Supervisor is creating a MCHBG Interested Parties list. The PHSITF members, the lead local health department directors, and CSHS contractors are included.

### **Strategic and Program Planning, and Quality Improvement**

A complete review and testing of all links in the Transition Guide was completed by a CAC member. In April 2015, project staff updated all links and contact information. The updated guide was posted on the Transition and Employment Projects website and advertised via the Montana Transition E-Mail List, the Rural Institute and Transition & Employment Project's Facebook pages, Parents Let's Unite for Kids, and Montana Youth Transitions (website and Facebook page). The Transition Guide includes a request for feedback, including changes, corrections, or information readers would like to see added. In FFY2015, only positive feedback (with no suggested changes) was received.

WIC is currently completing a review and update to the WIC local agency monitoring process. Monitoring occurs every two years and is time-intensive. WIC staff revisit criteria, forms and processes at the end of each 2-year cycle, to look for opportunities for improvement. The improved monitoring process includes clarifications to the chart reviews for administration and nutrition services and additions to the scoring matrix to quantify on-site observations, which may or may not result in a corrective action plan for non-compliance observations. These changes are included in the WIC state plan that will be submitted on August 15, 2016, with implementation anticipated to begin October 1st.

The Integrated Performance Management System (IPMS) continues to be the PHSD operationalized method for programs to record their program's action plans and goals. IPMS also reports core activities, tasks and metric outcomes. Progress reviews provide help for achieving the program goals. In the past year, the PHSD Office of System Improvement has overseen development of and training on IPMS enhancements. To review the PHSD Strategic Plan September 2015 update go to: <http://dphhs.mt.gov/publichealth.aspx>

### **Materials Development**

The CAC members continue to provide input on publications and materials. In the coming year, it is anticipated that new materials will be developed using lessons learned from the HALI Project.

## **II.F.4. Health Reform**

**The following narrative is an update on information initially submitted for the July 2015 Report:**

### **Health Reform -**

In April of 2015, the Montana legislature passed the Montana [Health and Economic Livelihood Plan](#) (HELP), and coverage took effect in January 2016. HELP expanded Medicaid to adults up to age 64 earning up to 138% of the federal poverty level (FPL). The new plan is open to individuals who earn less than \$16,000 a year (or \$33,000 for a family of four), most of whom work in businesses that traditionally do not offer health care coverage.

The Montana Budget and Policy Center estimates that 70,000 Montanans will be eligible for Medicaid under the plan, including 20,000 American Indians. It is administered by Blue Cross/Blue Shield and includes premiums and co-pays (not to be more than 5% of an individual's income total), personal asset limits, and a voluntary workforce development component. Following passage of MT HELP, the DPHHS communication plan shifted to activities

related to Medicaid Expansion. As of May 1, 2016, 45,799 adults have enrolled.

HELP covers the following essential services:

- Doctor, hospital, and emergency services
- Prescription drugs
- Dental care
- Vision care
- Laboratory and x-ray services
- Maternity and newborn care
- Mental health and substance abuse treatment
- Rehabilitative services and supplies
- Transportation to appointments

Details concerning affordability:

- No or low monthly premiums, depending on income
- Small co-pays for doctor visits, with no co-pays for preventive services such as health screenings, smoking cessation, or flu shots
- No out-of-pocket above 5% of total income

Numerous informational resources regarding health insurance and enrollment are available at <http://dphhs.mt.gov/healthcare/healthcareresources>. Also, Montanans who go to [healthcare.gov](http://healthcare.gov) to find information about health insurance may be determined eligible for the expanded Medicaid coverage. Children in families with income up to 250% of FPL continue to be eligible for Healthy Montana Kids (CHIP and Children's Medicaid).

At the request of Tribal Health Directors, Governor Bullock created the Office of American Indian Health to help address their health disparities. The position resides in the Director's Office at DPHHS. Mary Lynne Billy-Old Coyote, an enrolled member of the Chippewa Cree Tribe, began her tenure as the Director in April 2016. Billy-Old Coyote is coordinating work with Tribal health stakeholders and DPHHS staff, to identify key health-related issues and develop strategies to address them. She is also helping to identify existing state resources that may assist Tribes.

WMHS remains involved with the ongoing activities supporting ACA and Medicaid expansion in Montana. These activities include outreach, referrals, direct enrollment assistance, resource sharing, developing and maintaining partnerships, and training. In addition, the WMHS section supervisor represents the FCHB in DPHHS HELP Plan Health Assessment/Wellness meetings. This group works with Blue Cross/Blue Shield on developing health risk assessments, completed by individuals enrolling in the MT HELP Plan.

WMHS received a second year of funding for Title X Outreach and Enrollment (O/E) activities. It contracts with Planned Parenthood of Montana (PPMT) in Great Falls, Billings and Missoula, with Hill County Public Health Department, and in Bozeman with *Bridgercare*. The focus of the grant is to provide in-reach and direct enrollment assistance to current Title X clients, with targeted outreach to prospective Title X clients. This helps to increase both the number that are insured and overall clinic revenue.

There are currently 12 individuals trained through the O/E grant as insurance navigators or certified assistance counselors to provide assistance to individuals wanting to enroll in: the marketplace, Medicaid, MT HELP, and Medicaid Waiver Plan First. Title X clinics that do not have trained personnel refer clients to organizations with trained O/E workers such as Community Health Centers.

## Outreach

WMHS collaborated with the Montana Primary Care Association to market the brand “Covermt.org”. Four billboards each were posted in Great Falls, Billings and Missoula. A specific billboard was created for American Indian outreach in Hill County. WMHS is also working with PPMT and Hill County, as each often travel to reservations for events such as Pow Wow’s to staff a table and provide enrollment services.

### **Direct Enrollment Assistance and Education:**

WMHS is the sole Title X grantee in Montana. During the second open enrollment period, WMHS received funding under the Title X Outreach and Enrollment Project, to provide direct enrollment assistance to current and prospective family planning clients at five service sites in the state.

- August 1, 2015-April 30, 2016
  - 2,685 clients assisted
  - 1,480 clients received an eligibility determination with the assistance of an O/E worker
  - 902 clients enrolled
  - 260 outreach events
  - 9,349 participated reached at outreach events
  - 81 Facebook posts related to outreach and enrollment

### **Referrals:**

Parent Partners (PP), Montana’s parent mentoring program for families of CYSHCN, are required to assess each family/child’s insurance status as well as other social services, i.e. SNAP, at each encounter. If a family/child is eligible for Medicaid or CHIP, the PP refers the family to the Office of Public Assistance and assists the family in completing the enrollment paperwork. By December 2016, CHRIS functionality will allow the PP to enter referral information, and will be able to CSHS to track the number of families referred.

Montana WIC clinics screen over 18,000 participants annually to ensure they have access to healthcare. Access to health care coverage is a mandatory question of all participants during the WIC certification process. Participants who report they do not receive primary care are referred to local providers. Additionally, anyone who reports that they do not have Medicaid, or healthcare coverage, are referred to Medicaid to seek coverage.

Families enrolled in the Healthy Montana Families Program (Home Visiting) are provided referrals to Medicaid, presumptive eligibility, Offices of Public Assistance, navigators, certified application counselors, and primary care providers as needed. Home visitors follow-up with clients on their access to and contact with providers. The programs also work extensively with health care providers in their communities, so the providers refer potential clients to home visiting. In calendar year 2015, home visiting programs received over 130 referrals from health clinics, 120 referrals from Medicaid, and over 25 referrals from individual physicians.

### **Resource Sharing:**

WMHS participates in conference call and webinar meetings hosted by HHS Region VIII, the three Navigator grant recipients in the state, and the Montana Primary Care Association to share resources and best practices. These webinars have included the following topics: Insurance and health literacy; coverage options for those who are justice-involved; special enrollment periods; finding local enrollment help; and insurance for American Indians. The PCA includes information on successes and challenges with the Montana HELP plan, how to work with tribes, tax credits, and how to find a local enrollment specialist.

Marketplace resources are accessible at [www.covermt.org](http://www.covermt.org) and MT HELP resources are accessible at <http://healthcare.mt.gov>.

### **Partnerships:**

The WMHS has developed and maintained strong partnerships with organizations outside of DPHHS including the three Navigator grant recipients; the Montana PCA, and the MT CSI. The PCA provides training and technical

assistance to health centers and advocates for policies and programs that improve access to health care for all, especially for underserved and vulnerable populations. The MPCA Outreach and Enrollment Manager oversees over 45 CACs and Navigators, established at most of the Federally Qualified Health Centers throughout the state. Partnership activities included the co-planning of the MPCA Outreach and Enrollment Summit, trainings for MT CACs and Navigators and for Title X clinic staff.

Within DPHHS, WMHS has partnered with the Office of Intergovernmental Affairs, the Office of Indian Affairs, and Medicaid. Local agencies maintain partnerships with hospitals, community health centers, and other social service agencies to partner on events and provide cross-referrals. With guidance from the MT DPHHS Tribal Relations Manager, and in collaboration with MPCA, WMHS has specifically reached out to Rocky Boy and Fort Belknap Reservations to build new relationships. These organizations collaborate to coordinate tribal meet-and-greet visits and O/E assistance to meet the significant need in tribal communities without duplicating efforts.

### **Training:**

WMHS participated in the planning team for the 2<sup>nd</sup> Annual Outreach and Enrollment Summit held October 2015. The Summit brought together ACA Navigators and CACs throughout the state and had attendees from each of the tribal reservations. Breakout sessions included: Health insurance literacy in Indian County; Outreach and enrollment 101; Digging into the details: a conversation with Montana insurance carriers; Preparing for Medicaid expansion and Preparing for Open Enrollment 3.

WMHS also hosted the Montana Family Planning Training in March 2016, which included staff from Medicaid to review the Medicaid HELP plan and answer technical questions from Title X local staff. There were 53 individuals in attendance.

In February 2016, the Montana Primary Care Association presented on Medicaid Expansion to members of the Best Beginnings/Early Childhood Advisory Council. There were over 50 statewide early childhood partners at this training.

## **II.F.5. Emerging Issues**

**The following narrative is an update on information initially submitted for the July 2015 Report:**

### **Emerging Issues -**

Montana's American Indians have the greatest health disparities. In April 2016, Mary Lynne Billy-Old Coyote, an enrolled member of the Chippewa Cree Tribe, began her tenure as the Director of the State Office of American Indian Health. Billy-Old Coyote is coordinating with Tribal health stakeholders and DPHHS staff to identify key health-related issues and develop strategies to address them.

CMS approved the Montana Medicaid targeted case management (TCM) state plan amendment (SPA) for High Risk Pregnant Women (HRPW) and children and youth with special healthcare needs (CYSHCN) in January, 2016. The SPA assured Medicaid members freedom when choosing their provider. It also lessens the burden on agencies to hold cooperative agreements with specialists, which was a huge barrier, particularly in rural communities. CSHS and the Healthy MT Families sections have taken the lead in offering technical assistance, training and materials to new and existing TCM providers for CYSHCN and HRPW. The goal is to establish a solid network of TCM providers throughout the state to offer support to families of CYSHCN. TCM for CYSHCN will remain a priority for CSHS in the coming years.

CSHS staff and contractors continue to hear concerns from families of CYSHCN regarding lack of specialty care in Montana, travelling for healthcare (both in and out of state), and adequate insurance coverage for medically complex children. CSHS continues to address these issues by supporting several programs including: specialty clinics for cleft/craniofacial anomalies, cystic fibrosis, metabolic and genetic disorders; the HALI Project Parent Partners; and continuing to work with the Montana Medicaid EPSDT Program to ensure necessary medical services are covered for children in Montana.

Over the last five years, WIC participation has been declining nationwide. Outreach is necessary to encourage enrollment of the eligible population, especially among children over one, where there has been the steepest decline. Also, breastfeeding remains challenging for many women, and the drop-off in rates between 0-3 months is significant. WIC determined that staff training to promote and support breastfeeding will help to address this disparity among WIC participants.

WIC received two Infrastructure grants in 2015 to address these two concerns. These grants, which end 9/30/16, cover the following:

- Outreach/Participant Education Grant: A grant for \$153,670 funded an outreach campaign and a tool (video) for participant training on how to use their WIC benefits. Remaining money will be used to purchase TVs and computer kiosks for WIC clinic waiting areas, which will be used for education. For the outreach campaign, the program had messages developed to target non-traditional families (such as grandparents and single dads), native populations, and older children to be placed at gas stations (pump toppers and video screens over the pumps) and on mobile billboards (delivery trucks and buses) across the whole state including all reservations.
- Breastfeeding Grant: A grant for \$158,975 funded staff training in the area of breastfeeding. It also was used to certify CLCs and IBCLCs, provide Loving Support training, and send local and state staff to breastfeeding related conferences.

Through two HRSA grants, the Oral Health Program (OHP) has increased capacity in the past six years. These grants allowed for broader collaboration between MCH and OHP staff, for addressing disparities in dental care among low-income families. University of Washington dental student rotations have allowed for increased workforce capacity at six Community Health Center sites, one Indian Health Service Clinic, and one private practice setting in a high-need area. Fourth year dental students provided 1253 procedures during the rotations. This provided potential for recruiting providers in high-need areas, where disparities exist for low-income populations. In messaging, OHP staff have emphasized the need for sites to begin oral health services earlier and integrate oral health in the broader healthcare setting to promote prevention.

Both grants have also addressed the dental health workforce needs by educating over 6500 Montana students on dental health careers. Eighty-six percent of the students that attended events during the 2014-2015 school year indicated they were not interested in a dental career in pre-surveys, and following the programming 43 percent reported they were interested or somewhat interested, with 98 percent saying the programming increased their knowledge of dental career options.

The OHP Coordinator has established a partnership with one CHC, co-located with a county public health department. Beginning 7/1/16, a pilot project addressing NPM 14 was launched. These two entities, with monthly assessment by the OHP Coordinator, will initiate a formal referral process to the dental clinic for pregnant women accessing other MCH programs, such as WIC, Home Visiting and obstetric care. The pilot aims to increase the number of pregnant women that initiate and complete dental treatment to support primary prevention and will serve as a demonstration to other sites serving low-income families.

MT's Health Professional Shortage Area (HPSA) designations for primary care, dental and mental healthcare providers indicate the workforce deficit Montana faces for healthcare professionals across the state. The HPSA designations and scores influence incentive programs used for recruiting and retaining healthcare providers. In the Spring of 2017, the Primary Care Office, as required and overseen by the Bureau of Health Workforce at the HRSA, will have updated each current HPSA designation in the state of Montana. The PCO, in collaboration with contractors, is in the process of surveying approximately 1200 primary care providers, 630 dental providers, and 1200 mental health professionals in hopes of providing actual numbers to the healthcare workforce shortage.

The impact of the 2017 update to the HPSA designations and scores is unknown, which is an on-going discussion in the 2016 PCO Needs Assessment. Re-evaluating each designation may result in some areas not qualifying for the HPSA status according to the current federal regulations. HPSA scores also may vary after the re-evaluation. Programs influenced by HPSA designations are the: National Health Service Corp (NHSC) programs, Montana State Loan Repayment Program, CMS Medicare Incentive Payment, CMS Rural Health Clinic Program, and J-1

waiver program.

The 2016 PCO Needs Assessment explored the various relationships between HPSA scores, poverty and health indicators. The first section of the 2016 Needs Assessment begins with a description of vulnerable populations followed by a description of key factors influencing the delivery and utilization of primary healthcare services in Montana. The second section explores whether high HPSA scores align with counties that have the highest rates or percentages of poor health outcomes or lowest rates or percentages of primary care utilization. The third section describes existing programs and partners that assist in the implementation of activities that reduce healthcare barriers in Montana. The final section provides recommendations for how to better support the primary health care workforce. The 2016 Montana Primary Care Needs Assessment can be viewed at: <http://dphhs.mt.gov/Portals/85/publichealth/documents/PrimaryCare/March2016PCOneedsAssessment.pdf>.

Building on the success of the IM CoIIN team's August 2015 Coming of the Blessing training, the IM CoIIN Team, partnering with the March of Dimes and the Children's Trust Fund is hosting the Promising Pregnancy Care (PPC) Conference July 21 and 22, 2016. The PPC Conference agenda was developed for prenatal care providers (OB doctors, nurses, midwives, etc.) with a special emphasis for those who provide direct services to American Indian women.

The Medicaid Hospital Section Supervisor and the FCHB Bureau Chief have been developing a group pregnancy care model that is evidence-based and can be modified to work best for Montana's population. This model, Promising Pregnancy Care (PPC), will be introduced at the PPC Conference. Attendees will learn how to use the PPC model and blend in culturally appropriate care. Providers may submit their completed care model to the department, and once approved it can be sustained through Medicaid reimbursement. Also included at the PPC Conference is training in Neonatal Abstinence Syndrome (NAS) and Finnegan scoring standardization. Montana providers are reporting an increase in the number of infants born with NAS. Information about the PPC Conference can be found at: <http://dphhs.mt.gov/publichealth/MCH.aspx>

The MCHC Supervisor and the Montana Injury Prevention Program Coordinator (MIPP) collaborated on a CDC grant, which if funded, will support and promote safe sleep procedures and evaluate, educate and promote occupant protection policies including primary seat belt enforcement and proper car seat utilization. Unintentional injury is the leading cause of death for Montanan's aged 1-44 and greatly contributes to the morbidity and mortality of people of all ages. In 2014, 634 people died from unintentional injury in Montana (2014 Vital Stats). Additionally 6259 were admitted to the hospital and 58546 were seen in emergency departments with a primary or secondary diagnosis of injury (2014 Montana Hospital Discharge Data). Montana has the 6th worst age-adjusted fatality rate for all injury deaths, with a rate of 83.10 per 100,000. This is much higher than the national injury fatality rate of 59.92 deaths per 100,000 people (WISQARS 2014).

## II.F.6. Public Input

**The following narrative is an update of information initially submitted for the July 2015 Report:**

### **Public Input -**

The county public health departments (CPHD) are the primary providers of maternal and child health services in Montana. Therefore, the MCHBG Coordinator has organized annual MCHBG training, providing training on the MCHBG transformation and the corresponding new reporting requirements. The annual 2016 MCHBG training was held in five communities in March and was attended by 65 representatives representing 50 county public health departments. Ninety-eight percent of the attendees indicated that they either agree or strongly agreed that the training enhanced their knowledge, and that they would be able to apply the information to their jobs.

The annual MCHBG Pre-Contract Survey (PCS) serves multiple purposes. It is used to create the CPHD Operational Plan for the coming year. The Operational Plan serves as the CPHD's framework for addressing their NPM or SPM and their activities and activities' evaluation plans for achieving their NPM/SPM goal. The PCS also asks for CPHD feedback on how the FCHB can improve its services and what areas they may need technical

assistance. In the April 2016 open comment section, there were 27 replies. Most (19) were complementing the assistance they receive. The other eight covered a range of suggestions and/or process change requests. This input, combined with comments gained from personal technical assistance provided to the CPHD on their quarterly MCHBG reports, are included in the MCHBG application.

As was reported last year, State Performance Measure 2 was developed in response to feedback from the MCHBG stakeholders. The six counties that selected SPM 2, will be submitting their final MCHBG reports in August 2016, which will provide information about how this SPM met their county's needs and possibly how to improve services in the future.

In the coming year, the MCHBG Future Study Group will be convened. The group will be reviewing the MCHBG funding formula, identifying essential maternal and child health services provided by the CPHD, and in the process offering input on maternal and child health services in Montana.

The portion of the MCHBG Annual Application and Report which specifically addresses CYSHCN includes a family input process. The remainder of this narrative provides more information on these details.

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CSHS amended the Montana newborn screening (NBS) administrative rules to add Severe Combined Immunodeficiency (SCID) to the NBS panel. Montana healthcare providers and some hospital administrators attended the administrative rules hearing. One provider gave testimony in support of the rule change, explaining the life-or-death nature early detection of SCID. The rule was changed and screening implemented in July, 2015.

Children's Special Health Services (CSHS) supports the Consumer Advisory Council (CAC) of the Montana Rural Institute for Inclusive Communities (RIIC) in planning strategies to educate families about CYSHCN transition to adult services. The CAC is made up of 18 members. There are eight young adults with special healthcare needs, five parents, and representatives from several agencies including the Social Security Administration, Montana Autism Project, CSHS, and the Montana Developmental Disabilities Program.

CSHS is also working with the Montana Rural Institute for Inclusive Communities to assess the needs of CYSHCN in Montana by performing a statewide survey. Part of the process for the assessment has been to establish an assessment design team (ADT) to provide input regarding survey design, identify the sample group and, when the survey is complete, to analyze the survey data and recommend strategies to address emerging issues. The group includes specialty providers, parents, young adult CYSHCN, representatives from agencies that work with CYSHCN, pediatricians, and CSHS staff. When the assessment is complete (early 2017) CSHS plans to continue to convene this group to act as a Stakeholders Group for CSHS MCHBG activities.

CSHS awarded a contract to Brad Thompson and The HALI Project to continue and expand their work with the Montana Parent Partner Program (MPPP). Parent Partners are currently located in three pediatric practices and one FQHC in Montana. The program will expand to an additional practice during the first year of the contract. The goal of the MPPP is to support and empower families of CYSHCN when making decisions about their child's care and accessing services.

CSHS 's American Cleft Palate Association (ACPA) Standards' Cleft/Craniofacial application was approved in the spring of 2016. Work on establishing the Cleft/Craniofacial Clinic Stakeholders Group is anticipated to begin in the fall of 2016.

A new approach for gathering public input will be launched with the MCHBG 2017 Application and 2015 Annual Report. The email addresses of over 110 individuals and organizations that have expressed an interest in the MCHBG have been compiled into a distribution list. After the July 2016 submission, the application and annual

report will be posted to the Maternal and Child Health section's webpage. Individuals, such as pediatric specialists and organizations, such as Community Medical Center, will be asked to provide their comments on the draft documents via a specific link at the MCH website. Creating the interested parties list is viewed as a low-cost approach to gather additional information and partners. The MCH and CSHS Supervisors are responsible for updating the interested parties list and completing any follow up to comments. To access the MCH website go to: <http://dphhs.mt.gov/publichealth/MCH.aspx#148431283-mchbg-2016-application--2014-annual-report>

## **II.F.7. Technical Assistance**

### **Technical Assistance**

The Montana Title V Program requests technical assistance for developing the capacity and knowledge of the Maternal Mortality Review (MMR) Workgroup. In May 2016, Julie Zaharatos, Senior Project Coordinator, reached out to MT's MMR Workgroup with information about their CDC/MMR Initiative and Maternal Mortality Review Data System (MMRDS).

This information was shared at the May 2016 MMR Workgroup meeting. The MMR Workgroup expressed an interest in learning more about these topics.

MT Title V has partnered with MT Medicaid to develop Promising Pregnancy Care (PPC), a reimbursable prenatal care and education program for MT Medicaid members. On July 21 and 22, 2016 an introductory PPC training is scheduled for prenatal care providers interested in implementing PPC in their practice. Additional trainings will be needed to support these practices ability to successfully implement a group pregnancy care model. We request TA on how to facilitate group pregnancy care for clinician staff, i.e. physicians and nurses. We have contacted the March of Dimes to identify names of trainer(s) experienced in adapting the group pregnancy care model for American Indians.

### III. Budget Narrative

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$2,292,158	\$2,236,161	\$2,154,629	\$2,284,817
<b>Unobligated Balance</b>	\$0	\$0	\$0	\$0
<b>State Funds</b>	\$2,305,719	\$1,828,948	\$2,012,550	\$1,828,951
<b>Local Funds</b>	\$3,698,449	\$3,667,846	\$3,698,449	\$3,645,934
<b>Other Funds</b>	\$0	\$0	\$0	\$0
<b>Program Funds</b>	\$1,788,920	\$1,812,882	\$1,912,489	\$1,888,322
<b>SubTotal</b>	\$10,085,246	\$9,545,837	\$9,778,117	\$9,648,024
<b>Other Federal Funds</b>	\$26,178,702	\$23,262,107	\$25,302,717	
<b>Total</b>	\$36,263,948	\$32,807,944	\$35,080,834	\$9,648,024

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$2,219,096	\$2,281,321	\$2,284,817	
<b>Unobligated Balance</b>	\$0	\$0	\$0	
<b>State Funds</b>	\$2,536,688	\$2,536,688	\$2,538,188	
<b>Local Funds</b>	\$3,667,846	\$5,158,958	\$3,755,312	
<b>Other Funds</b>	\$0	\$0	\$0	
<b>Program Funds</b>	\$1,845,771	\$1,605,274	\$1,933,508	
<b>SubTotal</b>	\$10,269,401	\$11,582,241	\$10,511,825	
<b>Other Federal Funds</b>	\$29,368,223	\$27,655,571	\$28,072,980	
<b>Total</b>	\$39,637,624	\$39,237,812	\$38,584,805	

	2017	
	Budgeted	Expended
<b>Federal Allocation</b>	\$2,323,181	
<b>Unobligated Balance</b>	\$0	
<b>State Funds</b>	\$2,532,524	
<b>Local Funds</b>	\$3,755,312	
<b>Other Funds</b>	\$0	
<b>Program Funds</b>	\$1,564,889	
<b>SubTotal</b>	\$10,175,906	
<b>Other Federal Funds</b>	\$26,793,715	
<b>Total</b>	\$36,969,621	

### III.A. Expenditures

#### Expenditures

The Family and Community Health Bureau (FCHB) Financial Specialist, the Maternal and Child Health Coordination Supervisor and the Public Health and Safety Division's Fiscal Budget Analyst maintain the budget documentation for Montana's Maternal and Child Health Block Grants, including assuring compliance with state and federal regulations and completion of the Financial Status Reports.

Montana's MCH Block Grant instituted the use of Quarterly County Progress Reports in 2015, submitted by the local health departments to the MCH Block Grant Coordinator. These progress reports provide a snapshot of the health departments' challenges or issues working towards their selected NPM or SPM. Technical assistance has been provided to these health departments as needed.

Montana's 2017 Application reflects the importance of local partners for providing MCH Services to the population. County progress reports have been adjusted to reflect new information to be collected for reporting requirements as defined in the grant guidance. This reporting consists of Direct Service expenditures; specific to service type. These are defined as the following:

- Preventative and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age one;
- Preventative and Primary Care Services for Children;
- Services for CSHCN.

Approximately 45% of the MCHBG will be distributed through contracts with 51 of the state's 56 city-county health departments for the FY 2017 allocation. The MCHC staff has worked with the local health departments on their 2015 annual reports with a primary focus on new SPM's and NPM's and how they must align with the NOM's. The MCH Grant Coordinator has offered regional training to local health departments to address concerns such as Direct

Services and the new method of reporting these services. It has been communicated during these regional trainings that the MCHBG is the last resort payer of direct services and that detailed information will be needed for the reason for these services, i.e. services were not covered or reimbursed through another provider.

The FCHB receives state general funds. In FY 2017, these funds will support half of the State FICMMR Coordinator and Public Health Nurse Consultant salaries. State general funds support CPHDSs who were awarded Healthy Montana Families Project (HMFP) funds in FY 2016. These communities have implemented Nurse Family Partnership (NFP), Parents As Teachers (PAT), Safe Care Augmented and Family Spirit.

The following is a summary of forms 2, 3a, and 3b –

**Form 2:**

Montana's state funds, local funds, and program income has decreased 5 percent since 2015. Decreases in these categories can be contributed to CSHS Clinic attendant's shortage and a shortage in State authority from the previous year. Montana continues an ongoing commitment of local funds to MCH services and remains stable. State funding will continue to support the newborn screening follow up program, genetic testing, contraceptive support, HMFP, and billing revenue to support Cystic Fibrosis, Cleft-craniofacial Assistance, and metabolic clinics for children with special health care needs.

**Form 3a:**

Montana's expenditures by population group had a slight difference from 2014 to 2015, as reported to the state office by the local county health departments. We Project increases in services to pregnant women; infants < 1 year; and children 1-22 years of age, whereas revenue to CSHCN services are projected to decline. The decline in the CSHCN revenue is due to the State agency transferring billing services to regional clinic sites.

**Form 3b:**

Expenditures for direct health care, enabling, population-based, and infrastructure building services vary from year to year, due to the local MCH contractor's yearly reporting. State staff has worked diligently in the past year to explain what direct services can be defined as to local partners through regional training. Montana does not collect data on the following categories for direct services: pharmacy, physician/office services, hospital charges, dental care, durable medical equipment and supplies, and laboratory services. Estimates based off of expenditures reported from our local contractors as well as state office level expenses have been used to report this information. State MCH staff is enhancing current reporting documentation for the local contractors to include these categories. By doing so, this will benefit the state staff when reporting information for 2016.

### **III.B. Budget**

#### **Budget**

Montana's proposed Maternal and Child Health (MCH) Block Grant budget for FFY 2017, as reflected on Form 2, includes the following budget items:

**Preventative and Primary Care for Children:** This budget item includes the anticipated amount to be spent for infants, children and their families. At the state level, this line item reflects the Maternal Child Health Coordination Section and the county level MCH contractors who are responsible for providing these services. The FFY 2017 amount is \$696,954.00.

Children with Special Health Care Needs: This budget item includes the Children with Special Health Services Section budget of \$696,954.

Title V Administrative Costs: This budget item includes the state indirect estimate of \$165,070, plus an estimate of \$67,248 from the county level MCH contractors. They are allowed to use up to 10% of their award for administrative costs per the MCH Administrative Rule **37.57.1001**. The FFY 2017 amount is \$232,318.

The unobligated FY 2017 balance is \$0. Montana continues to budget and expend to the level of the annual award.

State MCH Funds: This budget amount for FFY 2017 is \$2,532,524 which includes state general funds for Healthy Montana Families Home Visiting (\$713,406); the state special revenue funds for the genetics program (\$1,284,466); the state general funds for the family planning program (\$499,999); the state special revenue for the Montana WIC farmer's market program (\$9,000), and the state special revenue for support to the Children with Special Health Care Needs clinics, (\$25,658).

Local MCH Funds: This budget amount for FFY 2017 is \$3,755,312 which is an anticipated projection based off of past years. The MCH contractors historically over-match the required amount needed for this funding source.

Program Income: This budget amount for FFY 2017 is \$1,564,889. This amount is compiled from income that is reported to the local MCH contractors through donations and Medicaid billing. The additional amount for this budget is from CYSHCN specialty clinics. These clinics support Cystic Fibrosis, Cleft-cranio-facial and metabolic disorders. Revenue is generated at the state level for offering Cleft-cranio-facial clinics from clinic billing.

Montana's FFY 2017 Maintenance of Effort remains at \$485,480, resulting in the Federal-State Title V Block Grant Partnership as \$10,175,906.

Montana receives additional federal funding to support the common goals of the MCHBG. These additional funding sources include SSDI, Emergency Medical Services (EMSC), WIC, HIV Prevention, Oral Health Workforce Development, Immunization, ACA-MIECHV Expansion, ACA-MIECHV Formula, WIC-Farmers Market, PRAMS, Rape Prevention & Education (RPE), WIC-Breastfeeding Peer Counseling, Universal Newborn Hearing Screening Intervention, Early Hearing Detection Intervention, and Title X. All of these funding sources total \$26,793,715.

#### IV. Title V-Medicaid IAA/MOU

Available at:

[http://dphhs.mt.gov/Portals/85/publichealth/documents/MCH/MT\\_TitleV\\_HRD\\_HCSD\\_InteragencyAgreement2016.pdf?ver=2016-07-18-142310-743](http://dphhs.mt.gov/Portals/85/publichealth/documents/MCH/MT_TitleV_HRD_HCSD_InteragencyAgreement2016.pdf?ver=2016-07-18-142310-743)

## V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [MT\\_ExecSummarySupportDocs.pdf](#)

Supporting Document #02 - [MT\\_GestationalDiabetesProgramStudyPoster.pdf](#)

Supporting Document #03 - [MT\\_BFlearningCollaborativeFlyer.pdf](#)

Supporting Document #04 - [MT\\_MCHBGnewsletterMay2016.pdf](#)

Supporting Document #05 - [MT\\_NewImmunizationSchoolRules100115\\_FAQ.pdf](#)

## VI. Appendix

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**Form 2**  
**MCH Budget/Expenditure Details**

**State: Montana**

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 2,323,181	
A. Preventive and Primary Care for Children	\$ 696,954	(30%)
B. Children with Special Health Care Needs	\$ 696,954	(30%)
C. Title V Administrative Costs	\$ 232,318	(10%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 2,532,524	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 3,755,312	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 1,564,889	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 7,852,725	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 485,480		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 10,175,906	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 26,793,715	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 36,969,621	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 7,643
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 161,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 22,123
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 226,434
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 5,315,889
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Emergency Medical Services for Children (EMSC)	\$ 130,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	\$ 523,925
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 246,591
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 1,977,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 16,164,076
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	\$ 170,959
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Comprehensive HIV Prevention Programs for Health Departments	\$ 930,420
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	\$ 512,499
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 250,000

OTHER FEDERAL FUNDS	FY17 Application Budgeted
US Department of Agriculture (USDA) > Food and Nutrition Services > Farmers Market	\$ 59,782

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 2,219,096		\$ 2,281,321	
A. Preventive and Primary Care for Children	\$ 901,399	(40.6%)	\$ 695,380	(30.5%)
B. Children with Special Health Care Needs	\$ 824,992	(37.2%)	\$ 769,883	(33.7%)
C. Title V Administrative Costs	\$ 219,518	(9.9%)	\$ 204,545	(9%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0		\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 2,536,688		\$ 2,536,688	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 3,667,846		\$ 5,158,958	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 1,845,771		\$ 1,605,274	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 8,050,305		\$ 9,300,920	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 485,480				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 10,269,401		\$ 11,582,241	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 29,368,223		\$ 27,655,571	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 39,637,624		\$ 39,237,812	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 7,724
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	\$ 847,717
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 7,231,569
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	\$ 500,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Implementation Grants for Systems of Services for CYSHCN	\$ 344,335
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 271,012
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 1,976,100
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	\$ 172,710
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 14,646,275
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Emergency Medical Services for Children (EMSC)	\$ 130,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Comprehensive HIV Prevention Programs for Health Departments	\$ 1,130,251
US Department of Agriculture (USDA) > Food and Nutrition Services > Farmers Market	\$ 52,504
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > SSDI	\$ 95,374

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

1.	<b>Field Name:</b>	<b>Federal Allocation, A. Preventive and Primary Care for Children:</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The amount of funds that went towards Preventative and Primary Care for Children is based off of the amount that was expended as reported to the State office by our County Contractors for the year.
2.	<b>Field Name:</b>	<b>4. LOCAL MCH FUNDS</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The amount expended is what was reported to the State office from the local County level. The Counties report actual expenses towards MCH populations which usually exceed the budgeted amount for the year.
3.	<b>Field Name:</b>	<b>6. PROGRAM INCOME</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The Program income is reported based off of what the local counties report for bringing in towards MCH Populations for fees, donations, and billing income. The state office also receives billing income for regional clinics with CSHS.

**Data Alerts: None**

**Form 3a**  
**Budget and Expenditure Details by Types of Individuals Served**  
**State: Montana**

**I. TYPES OF INDIVIDUALS SERVED**

IA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	\$ 156,938	\$ 135,211
2. Infants < 1 year	\$ 385,250	\$ 266,098
3. Children 1-22 years	\$ 696,954	\$ 695,380
4. CSHCN	\$ 696,954	\$ 769,883
5. All Others	\$ 337,085	\$ 380,999
Federal Total of Individuals Served	\$ 2,273,181	\$ 2,247,571

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	\$ 1,386,000	\$ 1,469,156
2. Infants < 1 year	\$ 1,194,409	\$ 1,149,745
3. Children 1-22 years	\$ 2,465,008	\$ 3,510,382
4. CSHCN	\$ 1,373,861	\$ 1,508,801
5. All Others	\$ 1,456,892	\$ 2,134,869
Non Federal Total of Individuals Served	\$ 7,876,170	\$ 9,772,953
Federal State MCH Block Grant Partnership Total	\$ 10,149,351	\$ 12,020,524

**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

None

**Data Alerts: None**

**Form 3b**  
**Budget and Expenditure Details by Types of Services**  
**State: Montana**

**II. TYPES OF SERVICES**

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	\$ 270,572	\$ 250,970
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 54,114	\$ 50,194
B. Preventive and Primary Care Services for Children	\$ 135,286	\$ 125,485
C. Services for CSHCN	\$ 81,172	\$ 75,291
2. Enabling Services	\$ 843,133	\$ 765,723
3. Public Health Services and Systems	\$ 1,209,476	\$ 1,264,628
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 5,721
Physician/Office Services		\$ 12,119
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 28,000
Durable Medical Equipment and Supplies		\$ 40,000
Laboratory Services		\$ 165,130
Direct Services Line 4 Expended Total		\$ 250,970
<b>Federal Total</b>	<b>\$ 2,323,181</b>	<b>\$ 2,281,321</b>

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	\$ 2,392,232	\$ 4,637,765
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 478,446	\$ 927,552
B. Preventive and Primary Care Services for Children	\$ 1,196,116	\$ 2,318,883
C. Services for CSHCN	\$ 717,670	\$ 1,391,330
2. Enabling Services	\$ 1,633,750	\$ 1,837,045
3. Public Health Services and Systems	\$ 2,644,885	\$ 2,670,375
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 695,665
Physician/Office Services		\$ 1,159,441
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 1,159,441
Durable Medical Equipment and Supplies		\$ 927,553
Laboratory Services		\$ 695,665
Direct Services Line 4 Expended Total		\$ 4,637,765
<b>Non-Federal Total</b>	\$ 6,670,867	\$ 9,145,185

**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

None

**Form 4**  
**Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated**  
**State: Montana**

**Total Births by Occurrence: 12,529**

**1. Core RUSP Conditions**

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	12,494 (99.7%)	96	14	14 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methylglutaric aciduria	β-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect	Medium-chain acyl-CoA dehydrogenase deficiency
Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria	Maple syrup urine disease
Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I	Primary congenital hypothyroidism	Congenital adrenal hyperplasia
S,S disease (Sickle cell anemia)	S, β-thalassemia	S,C disease	Biotinidase deficiency	Critical congenital heart disease
Cystic fibrosis	Severe combined immunodeficiencies	Classic galactosemia		

## 2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Carnitine palmitoytransferase deficiency type 1A	12,494 (99.7%)	1	1	1 (100.0%)

## 3. Screening Programs for Older Children & Women

None

## 4. Long-Term Follow-Up

Montana's Newborn Screening Program does not directly monitor long-term follow-up of infants with confirmed diagnosis. Short-term follow-up contracts do require contracted providers to report confirmed diagnosis to the program. While the program does not directly monitor long-term follow-up, Children's Special Health Services does contract with specialty providers throughout the state to provide care for certain conditions identified through newborn screening. Contracts are in place to offer statewide multi-disciplinary clinic services to children and youth diagnosed with Cystic Fibrosis, Metabolic and Genetic Disorders. Contracts require provider teams to engage in annual quality improvement projects and report patient demographics quarterly.

**Form Notes for Form 4:**

None

**Field Level Notes for Form 4:**

1.	<b>Field Name:</b>	<b>Total Births by Occurrence</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Total Births by Occurrence Notes</b>
	<b>Field Note:</b>	Not Final 2015 Birth Data
2.	<b>Field Name:</b>	<b>Core RUSP Conditions - Receiving At Lease One Screen</b>
	<b>Fiscal Year:</b>	<b>2015</b>
	<b>Column Name:</b>	<b>Core RUSP Conditions</b>
	<b>Field Note:</b>	Hearing Loss information entered separately here, because number referred for treatment is not available yet: Number receiving at least one screen = 12,219 Number presumptive positive screens = 66 Number confirmed cases = 19  For Critical Congenital Heart Disease the number receiving at least one screen = 10,651

**Data Alerts: None**

**Form 5a  
Unduplicated Count of Individuals Served under Title V**

**State: Montana**

**Reporting Year 2015**

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	4,083	34.0	1.0	4.0	2.0	59.0
2. Infants < 1 Year of Age	6,688	41.0	4.0	11.0	3.0	41.0
3. Children 1 to 22 Years of Age	34,839	21.0	4.0	20.0	4.0	51.0
4. Children with Special Health Care Needs	6,763	42.0	1.0	2.0	1.0	54.0
5. Others	55,296	11.0	1.0	24.0	8.0	56.0
<b>Total</b>	<b>107,669</b>					

**Form Notes for Form 5a:**

None

**Field Level Notes for Form 5a:**

None

**Form 5b**  
**Total Recipient Count of Individuals Served by Title V**  
**State: Montana**

**Reporting Year 2015**

<b>Types Of Individuals Served</b>	<b>Total Served</b>
1. Pregnant Women	4,083
2. Infants < 1 Year of Age	12,529
3. Children 1 to 22 Years of Age	28,998
4. Children with Special Health Care Needs	6,763
5. Others	55,296
<b>Total</b>	<b>107,669</b>

**Form Notes for Form 5b:**

None

**Field Level Notes for Form 5b:**

None

**Form 6**  
**Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX**

**State: Montana**

**Reporting Year 2015**

**I. Unduplicated Count by Race**

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	12,523	10,385	62	1,433	123	13	292	215
Title V Served	12,523	10,385	62	1,433	123	13	292	215
Eligible for Title XIX	4,940	3,011	21	988	11	8	83	818
2. Total Infants in State	12,269	10,431	224	1,421	193	0	0	0
Title V Served	12,269	10,431	224	1,421	193	0	0	0
Eligible for Title XIX	7,358	2,831	36	998	13	13	49	3,418

**II. Unduplicated Count by Ethnicity**

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	11,918	566	39	12,523
Title V Served	11,918	566	39	12,523
Eligible for Title XIX	4,782	158	0	4,940
2. Total Infants in State	11,625	644	0	12,269
Title V Served	11,625	644	0	12,269

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
Eligible for Title XIX	7,173	185	0	7,358

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

1.	<b>Field Name:</b>	<b>1. Total Deliveries in State</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b>	Provisional 2015 Birth Data
2.	<b>Field Name:</b>	<b>1. Title V Served</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b>	Provisional 2015 Birth Data
3.	<b>Field Name:</b>	<b>1. Eligible for Title XIX</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b>	2015 Medicaid Data
4.	<b>Field Name:</b>	<b>2. Total Infants in State</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b>	Final 2014 Census Data
5.	<b>Field Name:</b>	<b>2. Title V Served</b>
	<b>Fiscal Year:</b>	<b>2014</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b>	Final 2014 Data
6.	<b>Field Name:</b>	<b>2. Eligible for Title XIX</b>

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**Fiscal Year:** 2014

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**Column Name:** Total All Races

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**Field Note:**

2015 Medicaid Data; Other and Unknown: a lot of babies in 2015 without any race identification in the Medicaid data.

**Form 7**  
**State MCH Toll-Free Telephone Line and Other Appropriate Methods Data**

**State: Montana**

<b>A. State MCH Toll-Free Telephone Lines</b>	<b>2017 Application Year</b>	<b>2015 Reporting Year</b>
1. State MCH Toll-Free "Hotline" Telephone Number	(877) 543-7669	(877) 543-7669
2. State MCH Toll-Free "Hotline" Name	Public Assistance Help Line	Public Assistance Help Line
3. Name of Contact Person for State MCH "Hotline"	David Crowson	David Crowson
4. Contact Person's Telephone Number	(406) 444-7887	(406) 444-7887
5. Number of Calls Received on the State MCH "Hotline"		45,937

<b>B. Other Appropriate Methods</b>	<b>2017 Application Year</b>	<b>2015 Reporting Year</b>
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	apply.mt.gov	apply.mt.gov
4. Number of Hits to the State Title V Program Website		112,916
5. State Title V Social Media Websites	https://www.facebook.com/MTDPHHS	http://facebook.com/mtdp phs
6. Number of Hits to the State Title V Program Social Media Websites		1,547

**Form Notes for Form 7:**

For the Facebook hits, what we have available for statistics is actually the number of "likes." The timeframe is for 7/1/15 - 6/28/16, and the number of posts during this time was 157. Additional information on the people who liked the DPHHS page: 79% are women, and 56% are under the age of 45.

**Form 8**  
**State MCH and CSHCN Directors Contact Information**  
**State: Montana**

1. Title V Maternal and Child Health (MCH) Director	
Name	Denise Higgins
Title	Family & Community Health Bureau Chief
Address 1	1400 East Broadway, Room 116-A
Address 2	PO Box 202951
City/State/Zip	Helena / MT / 59620
Telephone	(406) 444-4743
Extension	
Email	dehiggins@mt.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Rachel Donahoe
Title	Children's Special Health Services Supervisor
Address 1	1400 East Broadway, Room A-116
Address 2	PO Box 202951
City/State/Zip	Helena / MT / 59620
Telephone	(406) 444-3617
Extension	
Email	rdonahoe@mt.gov

### 3. State Family or Youth Leader (Optional)

Name	Tarra Thomas
Title	HALI Project Parent Partner & State Coordinator
Address 1	229 Avenue D
Address 2	
City/State/Zip	Billings / MT / 59101
Telephone	(406) 697-4631
Extension	
Email	tarrathomasfa@outlook.com

**Form Notes for Form 8:**

None

**Form 9**  
**List of MCH Priority Needs**  
**State: Montana**

**Application Year 2017**

No.	Priority Need
1.	Family Support and Health Education
2.	Access to Care
3.	Immunization Rates
4.	Child Injuries
5.	Smoking During Pregnancy and Household Smoking
6.	Breastfeeding Rates
7.	Oral Health
8.	Teen Pregnancy Prevention
9.	Low-Risk Cesarean Deliveries
10.	Infant Safe Sleep

**Form 9 State Priorities-Needs Assessment Year - Application Year 2016**

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Family Support and Health Education	New	
2.	Access to Care	Continued	
3.	Immunization Rates	Continued	
4.	Child Injuries	Continued	
5.	Smoking During Pregnancy and Household Smoking	Continued	
6.	Breastfeeding Rates	New	
7.	Oral Health	Continued	
8.	Teen Pregnancy Prevention	New	
9.	Low-Risk Cesarean Deliveries	New	
10.	Infant Safe Sleep	New	

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

None

**Form 10a  
National Outcome Measures (NOMs)**

**State: Montana**

**Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.**

None

**NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester**

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	75.2 %	0.4 %	9,258	12,317
2013	71.1 %	0.4 %	8,700	12,235
2012	73.5 %	0.4 %	8,774	11,941
2011	73.4 %	0.4 %	8,757	11,928
2010	73.9 %	0.4 %	8,654	11,718
2009	73.4 % ⚡	0.4 % ⚡	8,074 ⚡	10,996 ⚡

**Legends:**  
 🚩 Indicator has a numerator <10 and is not reportable  
 ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 1 - Notes:**

None

**Data Alerts: None**

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	164.0	12.6 %	171	10,428
2012	152.4	12.3 %	155	10,172
2011	147.9	12.0 %	154	10,415
2010	166.0	12.5 %	180	10,844
2009	131.0	11.0 %	144	10,996

**Legends:**  
 Indicator has a numerator ≤10 and is not reportable  
 Indicator has a numerator <20 and should be interpreted with caution

**NOM 2 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2010_2014	24.6 ⚡	6.3 % ⚡	15 ⚡	61,056 ⚡
2009_2013	27.9 ⚡	6.8 % ⚡	17 ⚡	60,881 ⚡
2008_2012	21.3 ⚡	5.9 % ⚡	13 ⚡	61,098 ⚡
2007_2011	24.4 ⚡	6.3 % ⚡	15 ⚡	61,419 ⚡
2006_2010	16.2 ⚡	5.1 % ⚡	10 ⚡	61,858 ⚡
2005_2009	16.3 ⚡	5.2 % ⚡	10 ⚡	61,381 ⚡

**Legends:**  
 📄 Indicator has a numerator <10 and is not reportable  
 ⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 3 - Notes:**

None

**Data Alerts: None**

**NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)**

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	7.4 %	0.2 %	920	12,429
2013	7.4 %	0.2 %	913	12,370
2012	7.4 %	0.2 %	891	12,109
2011	7.2 %	0.2 %	867	12,061
2010	7.5 %	0.2 %	901	12,054
2009	7.1 %	0.2 %	865	12,247

**Legends:**

- 📄 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.1 - Notes:**

None

**Data Alerts: None**

**NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)**

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.2 %	0.1 %	152	12,429
2013	0.9 %	0.1 %	110	12,370
2012	1.1 %	0.1 %	129	12,109
2011	1.0 %	0.1 %	118	12,061
2010	1.3 %	0.1 %	154	12,054
2009	1.0 %	0.1 %	125	12,247

**Legends:**

- 📄 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.2 - Notes:**

None

**Data Alerts: None**

**NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)**

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.2 %	0.2 %	768	12,429
2013	6.5 %	0.2 %	803	12,370
2012	6.3 %	0.2 %	762	12,109
2011	6.2 %	0.2 %	749	12,061
2010	6.2 %	0.2 %	747	12,054
2009	6.0 %	0.2 %	740	12,247

**Legends:**

- 📄 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.3 - Notes:**

None

**Data Alerts: None**

## NOM 5.1 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	9.3 %	0.3 %	1,157	12,423
2013	9.0 %	0.3 %	1,111	12,356
2012	9.4 %	0.3 %	1,136	12,099
2011	8.8 %	0.3 %	1,065	12,052
2010	10.2 %	0.3 %	1,222	12,042
2009	9.0 %	0.3 %	1,101	12,225

**Legends:**

- 📄 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

### NOM 5.1 - Notes:

None

**Data Alerts: None**

## NOM 5.2 - Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

### Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	2.4 %	0.1 %	302	12,423
2013	2.2 %	0.1 %	270	12,356
2012	2.5 %	0.1 %	297	12,099
2011	2.3 %	0.1 %	273	12,052
2010	2.7 %	0.2 %	320	12,042
2009	2.3 %	0.1 %	280	12,225

#### Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

#### NOM 5.2 - Notes:

None

Data Alerts: None

**NOM 5.3 - Percent of late preterm births (34-36 weeks)**

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.9 %	0.2 %	855	12,423
2013	6.8 %	0.2 %	841	12,356
2012	6.9 %	0.2 %	839	12,099
2011	6.6 %	0.2 %	792	12,052
2010	7.5 %	0.2 %	902	12,042
2009	6.7 %	0.2 %	821	12,225

**Legends:**

- 📄 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 5.3 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

### Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	22.9 %	0.4 %	2,849	12,423
2013	23.0 %	0.4 %	2,837	12,356
2012	23.8 %	0.4 %	2,879	12,099
2011	24.5 %	0.4 %	2,953	12,052
2010	25.0 %	0.4 %	3,008	12,042
2009	26.2 %	0.4 %	3,197	12,225

#### Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

#### NOM 6 - Notes:

None

Data Alerts: None

## NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	7.0 %			
2013/Q2-2014/Q1	8.0 %			

**Legends:**  
📅 Indicator results were based on a shorter time period than required for reporting

### NOM 7 - Notes:

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.3	0.7 %	66	12,415
2012	6.4	0.7 %	78	12,158
2011	6.0	0.7 %	72	12,103
2010	5.5	0.7 %	66	12,094
2009	5.5	0.7 %	68	12,294

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 8 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.6	0.7 %	69	12,377
2012	5.9	0.7 %	72	12,118
2011	6.0	0.7 %	72	12,069
2010	6.0	0.7 %	72	12,060
2009	6.2	0.7 %	76	12,257

**Legends:**  
 Indicator has a numerator <10 and is not reportable  
 Indicator has a numerator <20 and should be interpreted with caution

#### NOM 9.1 - Notes:

None

**Data Alerts: None**

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.9	0.5 %	36	12,377
2012	3.5	0.5 %	42	12,118
2011	4.4	0.6 %	53	12,069
2010	3.5	0.5 %	42	12,060
2009	3.4	0.5 %	41	12,257

**Legends:**

- 🚩 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20 and should be interpreted with caution

### NOM 9.2 - Notes:

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.7	0.5 %	33	12,377
2012	2.5	0.5 %	30	12,118
2011	1.6 ⚡	0.4 % ⚡	19 ⚡	12,069 ⚡
2010	2.5	0.5 %	30	12,060
2009	2.9	0.5 %	35	12,257

**Legends:**  
 🚩 Indicator has a numerator <10 and is not reportable  
 ⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.3 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	113.1 ⚡	30.3 % ⚡	14 ⚡	12,377 ⚡
2012	132.0 ⚡	33.0 % ⚡	16 ⚡	12,118 ⚡
2011	124.3 ⚡	32.1 % ⚡	15 ⚡	12,069 ⚡
2010	141.0 ⚡	34.2 % ⚡	17 ⚡	12,060 ⚡
2009	146.9 ⚡	34.6 % ⚡	18 ⚡	12,257 ⚡

**Legends:**  
 📄 Indicator has a numerator <10 and is not reportable  
 ⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.4 - Notes:**

None

**Data Alerts: None**

**NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	129.3 ⚡	32.3 % ⚡	16 ⚡	12,377 ⚡
2012	165.0	36.9 %	20	12,118
2011	132.6 ⚡	33.2 % ⚡	16 ⚡	12,069 ⚡
2010	165.8	37.1 %	20	12,060
2009	228.4	43.2 %	28	12,257

**Legends:**  
 📌 Indicator has a numerator <10 and is not reportable  
 ⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.5 - Notes:**

None

**Data Alerts: None**

**NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy**

**FAD Not Available for this measure.**

**NOM 10 - Notes:**

None

**Data Alerts: None**

**NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations**

Data Source: State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	12.6	1.1 %	131	10,429
2012	8.3	0.9 %	84	10,172
2011	7.1	0.8 %	74	10,415
2010	5.8	0.7 %	63	10,844
2009	7.0	0.8 %	77	10,996

**Legends:**  
🚩 Indicator has a numerator  $\leq 10$  and is not reportable  
⚡ Indicator has a numerator  $< 20$  and should be interpreted with caution

**NOM 11 - Notes:**

None

**Data Alerts: None**

**NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)**

**FAD Not Available for this measure.**

**NOM 12 - Notes:**

None

**Data Alerts: None**

**NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)**

**FAD Not Available for this measure.**

**NOM 13 - Notes:**

None

**Data Alerts: None**

**NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.7 %	1.4 %	41,011	207,814

**Legends:**  
🚩 Indicator has an unweighted denominator <30 and is not reportable  
⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 14 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	13.3 ⚡	3.4 % ⚡	15 ⚡	112,885 ⚡
2013	18.7	4.1 %	21	112,420
2012	25.2	4.8 %	28	111,151
2011	28.9	5.1 %	32	110,879
2010	29.7	5.2 %	33	111,031
2009	30.0	5.2 %	33	109,878

**Legends:**  
📄 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 15 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	43.6	5.9 %	55	126,045
2013	48.4	6.2 %	61	125,995
2012	35.7	5.3 %	45	126,186
2011	46.9	6.1 %	60	127,899
2010	58.7	6.8 %	75	127,848
2009	51.7	6.3 %	67	129,656

**Legends:**  
📄 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.1 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	28.0	3.8 %	54	193,188
2011_2013	25.0	3.6 %	49	196,016
2010_2012	26.2	3.6 %	52	198,457
2009_2011	31.3	3.9 %	63	201,589
2008_2010	33.3	4.0 %	68	204,191
2007_2009	33.7	4.0 %	70	207,573

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.2 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	19.2	3.2 %	37	193,188
2011_2013	19.9	3.2 %	39	196,016
2010_2012	17.1	2.9 %	34	198,457
2009_2011	18.9	3.1 %	38	201,589
2008_2010	17.1	2.9 %	35	204,191
2007_2009	13.5	2.6 %	28	207,573

**Legends:**  
🚩 Indicator has a numerator <10 and is not reportable  
⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.1 - Percent of children with special health care needs**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	20.2 %	1.4 %	44,515	220,046
2007	18.0 %	1.2 %	40,975	227,966
2003	15.1 %	0.9 %	32,448	214,360

**Legends:**

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 17.1 - Notes:**

None

**Data Alerts: None**

**NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system**

**Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	13.1 %	1.9 %	3,585	27,424

**Legends:**

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 17.2 - Notes:**

None

**Data Alerts: None**

**NOM 17.3 - Percent of children diagnosed with an autism spectrum disorder**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	2.5 %	0.6 %	4,748	187,371
2007	1.1 %	0.4 %	2,104	190,565

**Legends:**  
🚩 Indicator has an unweighted denominator <30 and is not reportable  
⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 17.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.4 - Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	8.4 %	1.1 %	15,731	186,642
2007	6.1 %	0.8 %	11,539	190,707

**Legends:**

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 17.4 - Notes:**

None

**Data Alerts: None**

**NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	59.9 % ⚡	5.7 % ⚡	12,195 ⚡	20,366 ⚡
2007	67.9 %	5.1 %	11,477	16,903
2003	69.0 %	5.0 %	10,043	14,555

**Legends:**  
 🚩 Indicator has an unweighted denominator <30 and is not reportable  
 ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 18 - Notes:**

None

**Data Alerts: None**

**NOM 19 - Percent of children in excellent or very good health**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	89.7 %	1.0 %	197,292	220,046
2007	88.3 %	1.0 %	201,191	227,806
2003	90.1 %	0.8 %	193,141	214,360

**Legends:**

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 19 - Notes:**

None

**Data Alerts: None**

**NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	29.0 %	2.2 %	27,468	94,620
2007	25.6 %	1.9 %	26,668	103,994
2003	27.3 %	1.7 %	28,305	103,610

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Data Source: WIC**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	27.1 %	0.5 %	2,139	7,892

**Legends:**  
 Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	22.4 %	0.9 %	9,188	41,112
2011	21.3 %	0.9 %	9,020	42,261
2009	22.1 %	1.4 %	9,595	43,345
2007	23.4 %	0.7 %	10,728	45,914
2005	22.1 %	0.9 %	10,223	46,302

**Legends:**

 Indicator has an unweighted denominator <100 and is not reportable

 Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 20 - Notes:**

None

**Data Alerts: None**

## NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	8.6 %	1.2 %	19,239	224,105
2013	10.3 %	1.5 %	23,082	223,805
2012	10.9 %	1.3 %	24,004	219,888
2011	12.7 %	1.3 %	28,123	220,707
2010	12.7 %	1.2 %	28,315	222,903
2009	13.3 %	1.2 %	29,339	220,142

**Legends:**

- 📄 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

### NOM 21 - Notes:

None

Data Alerts: None

**NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3\*:3:1:4)**

**Data Source: National Immunization Survey (NIS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	67.1 %	4.2 %	11,407	16,994
2013	65.4 %	4.2 %	11,245	17,205
2012	66.5 %	3.6 %	11,335	17,053
2011	59.6 %	4.5 %	10,492	17,599
2010	50.0 %	3.6 %	8,781	17,573
2009	38.7 %	3.9 %	7,012	18,121

**Legends:**

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
-  Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.1 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2015	45.3 %	2.5 %	95,231	210,363
2013_2014	50.4 %	2.2 %	106,072	210,648
2012_2013	45.8 %	2.2 %	96,850	211,476
2011_2012	42.4 %	2.3 %	87,608	206,624
2010_2011	37.3 %	4.0 %	77,543	207,890
2009_2010	33.9 %	2.4 %	69,998	206,484

**Legends:**

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
-  Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.2 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Immunization Survey (NIS) - Female**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	57.2 %	4.7 %	17,321	30,294
2013	45.8 %	4.9 %	13,602	29,724
2012	55.1 %	5.0 %	16,627	30,188
2011	52.9 % ⚡	6.1 % ⚡	16,174 ⚡	30,596 ⚡
2010	45.5 %	4.5 %	14,226	31,240
2009	35.0 %	4.5 %	11,078	31,660

**Legends:**  
 🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6  
 ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**Data Source: National Immunization Survey (NIS) - Male**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	33.4 %	4.7 %	10,718	32,142
2013	23.8 %	4.1 %	7,564	31,846
2012	16.8 %	3.6 %	5,374	32,002
2011	NR 🚩	NR 🚩	NR 🚩	NR 🚩

**Legends:**  
 🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6  
 ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.3 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Immunization Survey (NIS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	84.7 %	2.4 %	52,910	62,436
2013	84.3 %	2.6 %	51,921	61,570
2012	90.2 %	1.9 %	56,070	62,190
2011	85.0 %	3.1 %	53,577	63,063
2010	76.1 %	2.6 %	49,007	64,401
2009	63.8 %	3.1 %	41,526	65,085

**Legends:**

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
-  Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.4 - Notes:**

None

**Data Alerts: None**

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	60.3 %	3.3 %	37,615	62,436
2013	51.6 %	3.4 %	31,763	61,570
2012	58.7 %	3.4 %	36,472	62,190
2011	39.8 %	4.3 %	25,114	63,063
2010	40.2 %	3.0 %	25,884	64,401
2009	26.9 %	2.9 %	17,524	65,085

**Legends:**

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
-  Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.5 - Notes:**

None

**Data Alerts: None**

**Form 10a**  
**National Performance Measures (NPMs)**  
**State: Montana**

**NPM 2 - Percent of cesarean deliveries among low-risk first births**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	24.0	23.5	23.0	22.5	22.0	21.5

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	26.4 %	0.7 %	1,060	4,019
2013	24.9 %	0.7 %	1,013	4,066
2012	26.1 %	0.7 %	1,081	4,136
2011	24.9 %	0.7 %	1,013	4,066
2010	25.3 %	0.7 %	1,021	4,030
2009	24.2 %	0.7 %	1,034	4,277

**Legends:**

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1. **Field Name:** 2016

**Field Note:**  
 FAD for 2014 shows 26.4%

**NPM 4 - A) Percent of infants who are ever breastfed**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	91.5	91.8	92.0	92.3	92.6	93.0

**Data Source: National Immunization Survey (NIS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	86.2 %	3.4 %	8,494	9,852
2011	91.2 %	2.3 %		
2010	90.3 %	1.9 %		
2009	85.1 %	2.9 %		
2008	82.2 %	2.4 %		
2007	84.9 %	2.3 %		

**Legends:**

-  Indicator has an unweighted denominator <50 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1. **Field Name:** 2016

**Field Note:**

2014 breastfeeding report states 91.2

**NPM 4 - B) Percent of infants breastfed exclusively through 6 months**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	19.6	20.0	20.3	20.6	21.0	21.3

**Data Source: National Immunization Survey (NIS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	26.7 %	4.1 %	2,593	9,701
2011	19.3 %	3.1 %		
2010	21.6 %	3.3 %		
2009	23.6 %	3.3 %		
2008	21.1 %	2.4 %		
2007	21.4 %	2.4 %		

**Legends:**

-  Indicator has an unweighted denominator <50 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1. **Field Name:** 2016

**Field Note:**

2014 breastfeeding report states 19.3

**NPM 5 - Percent of infants placed to sleep on their backs**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	50.0	55.0	60.0	65.0	70.0	75.0

**FAD not available for this measure.**

**Field Level Notes for Form 10a NPMs:**

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1. **Field Name:** 2016

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**Field Note:**

These numbers are placeholders, for data which will be soon be available from analysis of the 2015 Health Survey of Montana's Mothers and Babies.

**NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Child Health)**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	182.0	180.0	178.0	176.0	174.0	172.0

**Data Source: State Inpatient Databases (SID) - CHILD**

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2013	132.5	10.2 %	168	126,838	
2012	131.3	10.3 %	162	123,409	
2011	148.9	11.0 %	184	123,537	
2010	159.9	11.5 %	192	120,069	
2009	176.8	12.3 %	207	117,060	

**Legends:**  
 Indicator has a numerator ≤10 and is not reportable  
 Indicator has a numerator <20 and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	75.4	76.0	76.5	77.0	77.5	78.0

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	75.4 %	2.2 %	52,087	69,078
2007	79.0 %	1.9 %	65,286	82,664
2003	68.6 %	1.9 %	55,728	81,280

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
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**Field Note:**  
 2011-2012; Standard Error: 2.24; L: 70.76; U:79.53; The National Survey of Children's Health (NSCH) beginning in 2017. States can use data from the 2011-2012 NSCH as a baseline.

**NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	48.6	49.0	49.5	50.0	50.5	51.0

**Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	48.6 %	4.9 %	6,230	12,815
2005_2006	46.2 %	2.9 %	5,846	12,655

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Field Note:</b>	2009_2010 Federally Available Data

**NPM 13 - A) Percent of women who had a dental visit during pregnancy**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	58.0	58.5	59.0	59.5	60.0	60.5

**FAD not available for this measure.**

**Field Level Notes for Form 10a NPMs:**

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1. **Field Name:** 2016

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**Field Note:**

Studies by Cigna and Delta Dental in 2015 reported 57% utilization among pregnant women. MT PRAMS in 2002 was 59.2% (56.1-62.3). Updated data will soon be available from the 2015 Health Survey of Montana's Mothers and Babies.

**NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	76.6	77.0	77.5	78.0	78.5	79.0

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	76.6 %	1.4 %	159,134	207,659
2007	76.5 %	1.3 %	163,804	214,190

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1. **Field Name:** 2016

**Field Note:**  
 2011-2012 National Survey of Children's Health (NSCH)

**NPM 14 - A) Percent of women who smoke during pregnancy**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	16.0	15.7	15.4	15.0	14.7	14.4

**Data Source: National Vital Statistics System (NVSS)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	15.9 %	0.3 %	1,954	12,315
2013	16.5 %	0.3 %	2,012	12,194
2012	16.2 %	0.3 %	1,934	11,968
2011	16.6 %	0.3 %	1,988	12,008
2010	16.3 %	0.3 %	1,956	11,979
2009	16.0 %	0.3 %	1,945	12,132

**Legends:**

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1. **Field Name:** 2016

**Field Note:**

2015 birth data not yet finalized, as of June 30, 2016.

**NPM 14 - B) Percent of children who live in households where someone smokes**

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	26.4	26.0	25.5	25.0	24.5	24.0

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	26.4 %	1.5 %	57,783	218,543
2007	26.8 %	1.3 %	59,900	223,429
2003	26.3 %	1.3 %	49,838	189,394

**Legends:**  
 Indicator has an unweighted denominator <30 and is not reportable  
 Indicator has a confidence interval width >20% and should be interpreted with caution

**Field Level Notes for Form 10a NPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Field Note:</b>	2011-2012 National Survey of Children's Health (NSCH)

**Form 10a**  
**State Performance Measures (SPMs)**  
**State: Montana**

**SPM 1 - Access to Care and Public Health Services**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	19.3	19.5	19.5	19.7	20.0

**Field Level Notes for Form 10a SPMs:**

1.	<b>Field Name:</b>	<b>2017</b>			
	<b>Field Note:</b>	Baseline is percent of MCH population served SFY 2014. Objective is mainly to sustain and support levels of access in very rural areas, and keep it from decreasing.			

**SPM 2 - Family Support and Health Education**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	15.0	15.5	16.0	16.5	17.0

**Field Level Notes for Form 10a SPMs:**

1.	<b>Field Name:</b>	<b>2017</b>			
	<b>Field Note:</b>	Currently these are preliminary objectives. A more precise baseline will be established from SFY 2016 data reports, due 8/15/16.			

**SPM 3 - Immunization**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	69.0	70.0	71.0	72.0	73.0

**Field Level Notes for Form 10a SPMs:**

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1. **Field Name:** 2017

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**Field Note:**

Preliminary baselines from imMTrax Sept. 2015:

A) 74.2%

B) Tetanus = 87%, Meningococcal = 54%, HPV = 51%

**SPM 4 - CYSHCN Medical Home**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	40.0	41.0	42.0	43.0	44.0

**Field Level Notes for Form 10a SPMs:**

None

**SPM 5 - Teen Pregnancy Prevention**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	9.8	9.5	9.3	9.0

**Field Level Notes for Form 10a SPMs:**

None

**Form 10a  
Evidence-Based or-Informed Strategy Measures (ESMs)**

**State: Montana**

**ESM 2.1 - Understanding Pregnant Women's Cesarean Knowledge & Usage**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

**Field Level Notes for Form 10a ESMs:**

1. **Field Name:** 2018  
  
**Field Note:**  
May be one-year ESM, to be replaced with a different strategy in this fiscal year.

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2. **Field Name:** 2019  
  
**Field Note:**  
May be one-year ESM, to be replaced with a different strategy by this fiscal year.

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3. **Field Name:** 2020  
  
**Field Note:**  
May be one-year ESM, to be replaced with a different strategy by this fiscal year.

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4. **Field Name:** 2021  
  
**Field Note:**  
May be one-year ESM, to be replaced with a different strategy by this fiscal year.

**ESM 4.1 - County Public Health Department's MCHBG Breastfeeding Collaborative**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	80.0	82.0	84.0	86.0	88.0

**Field Level Notes for Form 10a ESMs:**

None

## ESM 5.1 - Understanding Caregiver's Infant Safe Sleep Knowledge & Practices

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

### Field Level Notes for Form 10a ESMs:

1.	<b>Field Name:</b>	<b>2018</b>
	<b>Field Note:</b>	May be one-year ESM, to be replaced with a different strategy in this fiscal year.
2.	<b>Field Name:</b>	<b>2019</b>
	<b>Field Note:</b>	May be one-year ESM, to be replaced with a different strategy by this fiscal year.
3.	<b>Field Name:</b>	<b>2020</b>
	<b>Field Note:</b>	May be one-year ESM, to be replaced with a different strategy by this fiscal year.
4.	<b>Field Name:</b>	<b>2021</b>
	<b>Field Note:</b>	May be one-year ESM, to be replaced with a different strategy by this fiscal year.

## ESM 7.1 - Analyze Hospital Discharge Data for County-Level Child Injury Causes

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1.0	1.0	1.0	1.0	1.0

### Field Level Notes for Form 10a ESMs:

1.	<b>Field Name:</b>	<b>2018</b>
	<b>Field Note:</b>	May be one-year ESM, to be replaced with a different strategy in this fiscal year.
2.	<b>Field Name:</b>	<b>2019</b>
	<b>Field Note:</b>	May be one-year ESM, to be replaced with a different strategy by this fiscal year.

3. **Field Name:** 2020

**Field Note:**

May be one-year ESM, to be replaced with a different strategy by this fiscal year.

4. **Field Name:** 2021

**Field Note:**

May be one-year ESM, to be replaced with a different strategy by this fiscal year.

**ESM 10.1 - Adolescent Preventive Care Advocates Survey**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	60.0	60.0	60.0	60.0	60.0

**Field Level Notes for Form 10a ESMs:**

1. **Field Name:** 2018

**Field Note:**

May be one-year ESM, to be replaced with a different strategy in this fiscal year.

2. **Field Name:** 2019

**Field Note:**

May be one-year ESM, to be replaced with a different strategy by this fiscal year.

3. **Field Name:** 2020

**Field Note:**

May be one-year ESM, to be replaced with a different strategy by this fiscal year.

4. **Field Name:** 2021

**Field Note:**

May be one-year ESM, to be replaced with a different strategy by this fiscal year.

**ESM 12.1 - Transition Services Survey of CYSHCN Families**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	80.0	80.0	80.0	80.0	80.0

**Field Level Notes for Form 10a ESMs:**

1. **Field Name:** 2018  
**Field Note:**  
May be one-year ESM, to be replaced with a different strategy in this fiscal year.

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2. **Field Name:** 2019  
**Field Note:**  
May be one-year ESM, to be replaced with a different strategy by this fiscal year.

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3. **Field Name:** 2020  
**Field Note:**  
May be one-year ESM, to be replaced with a different strategy by this fiscal year.

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4. **Field Name:** 2021  
**Field Note:**  
May be one-year ESM, to be replaced with a different strategy by this fiscal year.

**ESM 13.1 - Pregnancy Care and Dental Access Integration**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	40.0	50.0	60.0	70.0	80.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 14.1 - County Public Health Department Tobacco Cessation Activities**

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	16.0	15.8	15.5	15.3	15.0

**Field Level Notes for Form 10a ESMs:**

None

**Form 10b  
State Performance Measure (SPM) Detail Sheets**

**State: Montana**

**SPM 1 - Access to Care and Public Health Services  
Population Domain(s) – Cross-Cutting/Life Course**

<b>Goal:</b>	Support and sustain the public health system in counties with small population bases, and the ability of their health departments to serve the MCH population.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of clients' ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 2,000 or less who choose SPM 1.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Total population ages 0 – 21, and women ages 22 – 44 in counties with a corresponding population of 2,000 or less who choose SPM 1.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of clients' ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 2,000 or less who choose SPM 1.	<b>Denominator:</b>	Total population ages 0 – 21, and women ages 22 – 44 in counties with a corresponding population of 2,000 or less who choose SPM 1.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	
<b>Numerator:</b>	Number of clients' ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 2,000 or less who choose SPM 1.									
<b>Denominator:</b>	Total population ages 0 – 21, and women ages 22 – 44 in counties with a corresponding population of 2,000 or less who choose SPM 1.									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Healthy People 2020 Objective:</b>	ECBP-10.1, ECBP-10.4, ECBP-10.6, ECBP-10.7, ECBP-10.8									
<b>Data Sources and Data Issues:</b>	MCHBG County Public Health Department Annual Data Reports									
<b>Significance:</b>	Access to care was consistently identified as a continuing health care need on the Needs Assessment Surveys and Key Informant Interviews. Montana faces a large geographic health disparity. Access to Care is a fundamental action area in five sections of the State Health Improvement Plan, and one section is focused on strengthening the public health and health care system. It is also integral to a key results area of the Public Health & Safety Division Strategic Plan.									

**SPM 2 - Family Support and Health Education**  
**Population Domain(s) – Cross-Cutting/Life Course**

<b>Goal:</b>	Address the social determinants of health by supporting County Public Health Department's ability to provide referrals to social services and health education to their clients.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Annual number of MCH clients referred to social services or provided health education by County Public Health Departments choosing SPM 2</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Annual number of County Public Health Department MCH clients in counties choosing SPM 2</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Annual number of MCH clients referred to social services or provided health education by County Public Health Departments choosing SPM 2	<b>Denominator:</b>	Annual number of County Public Health Department MCH clients in counties choosing SPM 2	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	
<b>Numerator:</b>	Annual number of MCH clients referred to social services or provided health education by County Public Health Departments choosing SPM 2									
<b>Denominator:</b>	Annual number of County Public Health Department MCH clients in counties choosing SPM 2									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Healthy People 2020 Objective:</b>	NWS-12, SDOH-1, SDOH-3.2									
<b>Data Sources and Data Issues:</b>	MCHBG County Public Health Department Annual Data Reports									
<b>Significance:</b>	Family support and parental education have emerged as essentials which are increasingly unmet; and as having a major effect on the health of the whole MCH population, especially ages 0 to 19 years. Numerous strategies in the State Health Improvement Plan, and Public Health & Safety Division Strategic Plan address working to improve outreach in this area.									

**SPM 3 - Immunization**

**Population Domain(s) – Child Health, Adolescent Health**

<b>Goal:</b>	Increase the percentage of children and adolescents who are up-to-date with their age appropriate vaccinations, in the counties whose County Public Health Departments choose SPM 3.									
<b>Definition:</b>	<table border="1"> <tr> <td data-bbox="493 422 732 625"><b>Numerator:</b></td> <td data-bbox="732 422 1469 625">A) 19 to 35 month olds who have received full schedule of age appropriate immunizations in counties whose CPHDs choose SPM 3, and B) 13 to 17 year olds who have received full schedule of age appropriate immunizations in counties whose CPHDs choose SP</td> </tr> <tr> <td data-bbox="493 625 732 789"><b>Denominator:</b></td> <td data-bbox="732 625 1469 789">A) Total number of 19 to 35 month old children in counties whose CPHDs choose SPM 3, and B) total number of 13 to 17 year old adolescents in counties whose CPHDs choose SPM 3.</td> </tr> <tr> <td data-bbox="493 789 732 842"><b>Unit Type:</b></td> <td data-bbox="732 789 1469 842">Percentage</td> </tr> <tr> <td data-bbox="493 842 732 894"><b>Unit Number:</b></td> <td data-bbox="732 842 1469 894">100</td> </tr> </table>	<b>Numerator:</b>	A) 19 to 35 month olds who have received full schedule of age appropriate immunizations in counties whose CPHDs choose SPM 3, and B) 13 to 17 year olds who have received full schedule of age appropriate immunizations in counties whose CPHDs choose SP	<b>Denominator:</b>	A) Total number of 19 to 35 month old children in counties whose CPHDs choose SPM 3, and B) total number of 13 to 17 year old adolescents in counties whose CPHDs choose SPM 3.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	
<b>Numerator:</b>	A) 19 to 35 month olds who have received full schedule of age appropriate immunizations in counties whose CPHDs choose SPM 3, and B) 13 to 17 year olds who have received full schedule of age appropriate immunizations in counties whose CPHDs choose SP									
<b>Denominator:</b>	A) Total number of 19 to 35 month old children in counties whose CPHDs choose SPM 3, and B) total number of 13 to 17 year old adolescents in counties whose CPHDs choose SPM 3.									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Healthy People 2020 Objective:</b>	IID-1, IID-3, IID-4, IID-5, IID-8									
<b>Data Sources and Data Issues:</b>	Montana's immunization tracking system, imMTrax. Periodic challenges with up-to-date data entry by all vaccine providers in a county, and percentages in low population counties can experience wide variations from low actual numbers of change.									
<b>Significance:</b>	Immunization is an ongoing need and most health departments face challenges from parents with vaccine hesitancy. Montana has included the adolescent population to make the performance measure more comprehensive.									

**SPM 4 - CYSHCN Medical Home**

**Population Domain(s) – Children with Special Health Care Needs**

<b>Goal:</b>	Increase the percentage of children and youth with special health care needs who have a medical home.									
<b>Definition:</b>	<table border="1"> <tr> <td data-bbox="492 386 734 443"><b>Numerator:</b></td> <td data-bbox="734 386 1469 443">Number of CYSHCN in Montana with a medical home.</td> </tr> <tr> <td data-bbox="492 443 734 499"><b>Denominator:</b></td> <td data-bbox="734 443 1469 499">Total number of CYSHCN in Montana.</td> </tr> <tr> <td data-bbox="492 499 734 556"><b>Unit Type:</b></td> <td data-bbox="734 499 1469 556">Percentage</td> </tr> <tr> <td data-bbox="492 556 734 613"><b>Unit Number:</b></td> <td data-bbox="734 556 1469 613">100</td> </tr> </table>		<b>Numerator:</b>	Number of CYSHCN in Montana with a medical home.	<b>Denominator:</b>	Total number of CYSHCN in Montana.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of CYSHCN in Montana with a medical home.									
<b>Denominator:</b>	Total number of CYSHCN in Montana.									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Healthy People 2020 Objective:</b>	MICH-30.2, MICH-31									
<b>Data Sources and Data Issues:</b>	NSCH, and Montana specific data collected from DPHHS regional specialty clinics and from partners.									
<b>Significance:</b>	Vast distances create unique challenges to serving children and youth with special health care needs and their families, especially for rural residents. A performance measure that focused specifically on medical home solutions for this population was needed, along with the use of state generated data.									

**SPM 5 - Teen Pregnancy Prevention**  
**Population Domain(s) – Adolescent Health**

<b>Goal:</b>	Reduce the rate of birth to girls ages 15 to 17 years.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of births to girls ages 15 to 17 years in Montana.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of girls ages 15 to 17 years in Montana</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Rate</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1,000</td> </tr> </table>		<b>Numerator:</b>	Number of births to girls ages 15 to 17 years in Montana.	<b>Denominator:</b>	Number of girls ages 15 to 17 years in Montana	<b>Unit Type:</b>	Rate	<b>Unit Number:</b>	1,000
<b>Numerator:</b>	Number of births to girls ages 15 to 17 years in Montana.									
<b>Denominator:</b>	Number of girls ages 15 to 17 years in Montana									
<b>Unit Type:</b>	Rate									
<b>Unit Number:</b>	1,000									
<b>Healthy People 2020 Objective:</b>	NVSS-N, FP-8.1, ECBP-10.6									
<b>Data Sources and Data Issues:</b>	MT Vital Statistics									
<b>Significance:</b>	Addressing teen pregnancy is an ongoing health need in many parts of Montana, and teen pregnancy and birth rates in the U.S. continue to be among the highest when compared to other developed countries. Teen pregnancy and childbearing are closely linked to other social issues, including poverty and income disparity, overall child well-being, and low educational attainment for mothers.									

**Form 10b**  
**State Outcome Measure (SOM) Detail Sheets**  
**State: Montana**

No State Outcome Measures were created by the State.

**Form 10c**  
**Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheets**

**State: Montana**

**ESM 2.1 - Understanding Pregnant Women's Cesarean Knowledge & Usage**  
**NPM 2 – Percent of cesarean deliveries among low-risk first births**

<b>Goal:</b>	Produce a surveillance report from the 2015 Health Survey of Montana's Mothers and Babies data, to gain greater understanding of the knowledge level and behaviors of pregnant women regarding low-risk cesarean deliveries.									
<b>Definition:</b>	<table border="1" style="width: 100%;"> <tr> <td style="width: 25%;"><b>Numerator:</b></td> <td>One surveillance report</td> </tr> <tr> <td><b>Denominator:</b></td> <td>One surveillance report</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1</td> </tr> </table>		<b>Numerator:</b>	One surveillance report	<b>Denominator:</b>	One surveillance report	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1
<b>Numerator:</b>	One surveillance report									
<b>Denominator:</b>	One surveillance report									
<b>Unit Type:</b>	Count									
<b>Unit Number:</b>	1									
<b>Data Sources and Data Issues:</b>	<p>2015 Health Survey of Montana's Mothers and Babies -</p> <p>Until a recent award, Montana had not been funded for a CDC Pregnancy Risk Assessment Monitoring System (PRAMS) survey since 2001, so this data will provide a baseline.</p>									
<b>Significance:</b>	<p>In order to gain needed insight, Montana produced a state-funded survey of all mothers who delivered during calendar year 2015. Analysis will provide additional data on low-risk mothers having cesarean deliveries. A surveillance report from this work will provide baseline data for subsequent strategies. NOTE: This ESM will lead into subsequent year's ESM on targeted messages.</p>									

**ESM 4.1 - County Public Health Department's MCHBG Breastfeeding Collaborative**  
**NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months**

<b>Goal:</b>	To support and encourage local public health organizations who have identified increasing the rate of breastfeeding as a priority need in their communities.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Total number of counties choosing to use MCHBG funding for breastfeeding support activities which have met their activity goals.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Total number of counties choosing to use MCHBG funding for breastfeeding support activities.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Total number of counties choosing to use MCHBG funding for breastfeeding support activities which have met their activity goals.	<b>Denominator:</b>	Total number of counties choosing to use MCHBG funding for breastfeeding support activities.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	
<b>Numerator:</b>	Total number of counties choosing to use MCHBG funding for breastfeeding support activities which have met their activity goals.									
<b>Denominator:</b>	Total number of counties choosing to use MCHBG funding for breastfeeding support activities.									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	<p>Family &amp; Community Health Bureau -</p> <p>The number of counties choosing to use MCHBG funding in this way may change from year to year.</p>									
<b>Significance:</b>	<p>The FCHB will contract with CPHDs interested in increasing the rate of breastfeeding in their areas. These counties will implement and evaluate at least two community-level activities during the fiscal year. This will raise community-level understanding on the importance of breastfeeding and increase support for breastfeeding mothers.</p>									

**ESM 5.1 - Understanding Caregiver's Infant Safe Sleep Knowledge & Practices**

**NPM 5 – Percent of infants placed to sleep on their backs**

<b>Goal:</b>	To understand the knowledge level and behaviors of caregivers regarding infant safe sleep practices.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>One surveillance report</td> </tr> <tr> <td><b>Denominator:</b></td> <td>One surveillance report</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1</td> </tr> </table>		<b>Numerator:</b>	One surveillance report	<b>Denominator:</b>	One surveillance report	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1
<b>Numerator:</b>	One surveillance report									
<b>Denominator:</b>	One surveillance report									
<b>Unit Type:</b>	Count									
<b>Unit Number:</b>	1									
<b>Data Sources and Data Issues:</b>	<p>2015 Health Survey of Montana's Mothers and Babies -</p> <p>Until a recent award, Montana had not been funded for a CDC Pregnancy Risk Assessment Monitoring System (PRAMS) survey since 2001, so this data will provide a baseline.</p>									
<b>Significance:</b>	<p>In order to gain needed insight, Montana produced a state-funded survey of all mothers who delivered during calendar year 2015. Together with the data which is entered into the Child Death Review Reporting System, analysis will provide additional data on usual infant sleep environments and positioning. A surveillance report from this work will provide baseline data for subsequent strategies. NOTE: This ESM will lead into subsequent year's ESM on targeted messages.</p>									

**ESM 7.1 - Analyze Hospital Discharge Data for County-Level Child Injury Causes**

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

<b>Goal:</b>	Produce a report with county-level data on child injury trends, which will assist County Public Health Departments in targeting future injury-prevention activities.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>One report</td> </tr> <tr> <td><b>Denominator:</b></td> <td>One report</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1</td> </tr> </table>	<b>Numerator:</b>	One report	<b>Denominator:</b>	One report	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1
<b>Numerator:</b>	One report								
<b>Denominator:</b>	One report								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1								
<b>Data Sources and Data Issues:</b>	<p>Montana Hospital Association, and US Census Bureau -</p> <p>MHA Hospital Discharge Data usage is by permission under agreement parameters.</p>								
<b>Significance:</b>	The Hospital Discharge Data Epidemiologist will assess the primary causes of injury-related hospital admissions for children ages 0 - 19, with an emphasis in identifying county-level trends. This information will provide the basis for County Public Health Departments to implement targeted injury-prevention activities in subsequent years.								

**ESM 10.1 - Adolescent Preventive Care Advocates Survey**

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

<b>Goal:</b>	To identify organizations involved with adolescent wellness and health who are interested in collaborating to promote the importance of preventive care for this population.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of organizations which respond to a survey gauging interest in promoting adolescent preventive medical visits.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Total number of organizations identified in environmental scan as having an interest in adolescent health.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of organizations which respond to a survey gauging interest in promoting adolescent preventive medical visits.	<b>Denominator:</b>	Total number of organizations identified in environmental scan as having an interest in adolescent health.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	
<b>Numerator:</b>	Number of organizations which respond to a survey gauging interest in promoting adolescent preventive medical visits.									
<b>Denominator:</b>	Total number of organizations identified in environmental scan as having an interest in adolescent health.									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	Family & Community Health Bureau									
<b>Significance:</b>	The FCHB will do an environmental scan to identify organizations and programs across the state with a current interest in adolescent health. The FCHB will then conduct an outreach and information gathering survey to identify those interested in partnering with messaging and promotion on the importance and benefits of preventive care for adolescents. NOTE: This ESM will lead into a subsequent year's ESM on targeted activities.									

**ESM 12.1 - Transition Services Survey of CYSHCN Families**

**NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care**

<b>Goal:</b>	To use family partner input to increase the efficacy of CSHS transition services.	
<b>Definition:</b>	<b>Numerator:</b>	Number of CYSHCN families completing the survey
	<b>Denominator:</b>	All CYSHCN families served by CSHS
	<b>Unit Type:</b>	Percentage
	<b>Unit Number:</b>	100
<b>Data Sources and Data Issues:</b>	CSHS survey of CYSHCN families	
<b>Significance:</b>	As part of a comprehensive program assessment, the Children's Special Health Services Section will create a survey which includes questions about transition services for families of CYSHCNs. The first year will provide a baseline, and results will be used to plan a rapid PDSA cycle to improve how the section provides those services.	

**ESM 13.1 - Pregnancy Care and Dental Access Integration**

**NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year**

<b>Goal:</b>	Successful pilot project between a County Public Health Department and a co-located Community Health Center, to increase the dental visits of pregnant clients.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of FHCPHD's pregnant clients which are referred for dental care and are then seen by a dentist before delivery.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of FHCPHD's pregnant clients which are referred for dental care.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of FHCPHD's pregnant clients which are referred for dental care and are then seen by a dentist before delivery.	<b>Denominator:</b>	Number of FHCPHD's pregnant clients which are referred for dental care.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	
<b>Numerator:</b>	Number of FHCPHD's pregnant clients which are referred for dental care and are then seen by a dentist before delivery.									
<b>Denominator:</b>	Number of FHCPHD's pregnant clients which are referred for dental care.									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	FHCPHD and Flathead Community Health Center									
<b>Significance:</b>	The FCHB's Oral Health Program will create a pilot project with Flathead County's Public Health Department and Community Health Center, to increase the dental visits of its pregnant clients. The health department is co-located with the Community Health Center, which has a full-time dentist. Pregnant health department clients will be assessed for utilization of dental care when they come in for prenatal care. If they have not had a dental visit during their pregnancy, an attempt will be made to have them seen by the dentist before they leave that day.									

**ESM 14.1 - County Public Health Department Tobacco Cessation Activities**

**NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes**

<b>Goal:</b>	Pilot project to support tobacco cessation activities by a CPHD which has identified this as a priority need in their county.									
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of pregnant women in Park County receiving home visiting services who smoke</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of pregnant women in Park County receiving home visiting services</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of pregnant women in Park County receiving home visiting services who smoke	<b>Denominator:</b>	Number of pregnant women in Park County receiving home visiting services	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	
<b>Numerator:</b>	Number of pregnant women in Park County receiving home visiting services who smoke									
<b>Denominator:</b>	Number of pregnant women in Park County receiving home visiting services									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	MECHV Section									
<b>Significance:</b>	The FCHB will contract with Park County Health Department (PCHD) to support targeted tobacco cessation activities. PCHD will plan, implement and evaluate at least 2 community-level activities during the fiscal year. Information on the outcome of these efforts will be distributed to all the CPHDs participating with the MCHBG.									

**Form 10d  
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)**

**State: Montana**

**Form Notes for Form 10d NPMs and SPMs**

None

**NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.**

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	3	7	11	9	7
Denominator	3	7	11	9	7
Data Source	Mt Newborn Screening Program				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015

**Field Note:**

In January 2008, Montana began screening all newborns by bloodspot testing for the 28 metabolic, endocrine, hematologic, and genetic conditions recommended by the American College of Medical Genetics and the American Academy of Pediatrics.

2. **Field Name:** 2014

**Field Note:**

In January 2008, Montana began screening all newborns by bloodspot testing for the 28 metabolic, endocrine, hematologic, and genetic conditions recommended by the American College of Medical Genetics and the American Academy of Pediatrics.

3. **Field Name:** 2013

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**Field Note:**

In January 2008, Montana began screening all newborns by bloodspot testing for the 28 metabolic, endocrine, hematologic, and genetic conditions recommended by the American College of Medical Genetics and the American Academy of Pediatrics.

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4. **Field Name:** 2012

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**Field Note:**

In January 2008, Montana began screening all newborns by bloodspot testing for the 28 metabolic, endocrine, hematologic, and genetic conditions recommended by the American College of Medical Genetics and the American Academy of Pediatrics.

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5. **Field Name:** 2011

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**Field Note:**

In January 2008, Montana began screening all newborns by bloodspot testing for the 28 metabolic, endocrine, hematologic, and genetic conditions recommended by the American College of Medical Genetics and the American Academy of Pediatrics.

**Data Alerts: None**

**NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)**

	2011	2012	2013	2014	2015
Annual Objective	56.5	72.9	72.9	72.9	72.9
Annual Indicator	72.9	72.9	72.9	72.9	72.9
Numerator					
Denominator					
Data Source	CSHCN Survey				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

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**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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4. **Field Name:** **2012**

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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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5. **Field Name:** **2011**

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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Data Alerts: None**

**NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)**

	2011	2012	2013	2014	2015
Annual Objective	50.0	40.0	40.0	40.0	40.0
Annual Indicator	39.1	39.1	39.1	39.1	39.1
Numerator					
Denominator					
Data Source	CSHCN Survey				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

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**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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4. **Field Name:** **2012**

**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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5. **Field Name:** **2011**

**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Data Alerts: None**

**NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)**

	2011	2012	2013	2014	2015
Annual Objective	55.2	53.3	53.3	53.3	53.3
Annual Indicator	53.3	53.3	53.3	53.3	53.3
Numerator					
Denominator					
Data Source	CSHCN Survey				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** 2014

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** 2013

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**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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4. **Field Name:** **2012**

**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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5. **Field Name:** **2011**

**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Data Alerts: None**

**NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)**

	2011	2012	2013	2014	2015
Annual Objective	88.6	54.3	54.3	54.3	54.3
Annual Indicator	54.3	54.3	54.3	54.3	54.3
Numerator					
Denominator					
Data Source	CSHCN Survey				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

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**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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4. **Field Name:** **2012**

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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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5. **Field Name:** **2011**

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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Data Alerts: None**

**NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.**

	2011	2012	2013	2014	2015
Annual Objective	46.5	48.6	48.6	48.6	48.6
Annual Indicator	48.6	48.6	48.6	48.6	48.6
Numerator					
Denominator					
Data Source	CSHCN Survey				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** **2015**

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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3. **Field Name:** 2013

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**Field Note:**

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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4. **Field Name:** 2012

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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

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5. **Field Name:** 2011

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**Field Note:**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Data Alerts: None**



**NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.**

	2011	2012	2013	2014	2015
Annual Objective	65.0	65.0	70.0	70.0	70.0
Annual Indicator	67.0	67.0	74.2	75.0	75.0
Numerator					
Denominator					
Data Source	National Immunization Survey				
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015  
**Field Note:**  
The source of data is the National Immunization Survey (NIS), Data are from 2014, data for 2015 (4:3:1:3:3) are not yet available. The confidence interval is +/- 7.6.

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2. **Field Name:** 2014  
**Field Note:**  
The source of data is the National Immunization Survey (NIS), Data are from 2014. The confidence interval is +/- 7.6.

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3. **Field Name:** 2013  
**Field Note:**  
The source of data is the National Immunization Survey (NIS), Data are from 2013. The confidence interval is +/- 6.9.

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4. **Field Name:** 2012  
**Field Note:**  
The source of data is the National Immunization Survey (NIS), Data are from 2011, data for 2012 (4:3:1:3:3) are not yet available. The confidence interval is +/- 8.4.

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5. **Field Name:** 2011

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**Field Note:**

The source of data is the National Immunization Survey (NIS), Data are from 2011. The confidence interval is +/- 8.4..

**Data Alerts: None**

**NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.**

	2011	2012	2013	2014	2015
Annual Objective	17.0	17.0	12.0	12.0	11.0
Annual Indicator	12.4	12.6	12.6	13.0	9.9
Numerator	231	229	229	237	180
Denominator	18,584	18,234	18,135	18,239	18,239
Data Source	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015  
**Field Note:**  
2015 Provisional Birth Data. 2015 population estimates unavailable. 2014 population estimates used in denominator.

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2. **Field Name:** 2014  
**Field Note:**  
2014 Final Birth Data. 2014 population final estimates used in denominator.

---

3. **Field Name:** 2013  
**Field Note:**  
2013 Final Birth and Population Data. 2013 population estimates used in denominator.

---

4. **Field Name:** 2012  
**Field Note:**  
2012 Provisional Birth Data. 2012 population estimates unavailable. 2011 population estimates used in denominator.

---

5. **Field Name:** 2011  
**Field Note:**  
Finalized data reported for 2011.

**Data Alerts: None**

**NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.**

	2011	2012	2013	2014	2015
Annual Objective	46.0	46.0	46.0	46.0	46.0
Annual Indicator	45.9	45.0	49.7	55.2	55.2
Numerator	4,908	4,872	5,384	5,975	5,975
Denominator	10,693	10,825	10,825	10,825	10,825
Data Source	05 06 Statewide OH Study, OPI 3rd Grade Enrollment	11 12 Statewide OH Study, OPI 3rd Grade Enrollment	12-13 Statewide OH Study, OPI 3rd Grade Enrollment	14 Statewide OH Study, OPI 3rd GrPop	14 Statewide OH Study, OPI 3rd GrPop
Provisional Or Final ?				Provisional	Provisional

**Field Level Notes for Form 10d NPMs:**

- 
1. **Field Name:** 2014
- 
- Field Note:**  
 Numerator data are from a 2014 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2011-2012 school year from the Montana Office of Public Instruction.
- 
2. **Field Name:** 2013
- 
- Field Note:**  
 Numerator data are from a 2012-2013 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2011-2012 school year from the Montana Office of Public Instruction.
- 
3. **Field Name:** 2012
- 
- Field Note:**  
 Numerator data are from a 2011-2012 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2011-2012 school year from the Montana Office of Public Instruction.
- 
4. **Field Name:** 2011

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**Field Note:**

Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2010-2011 school year from the Montana Office of Public Instruction.

**Data Alerts: None**

**NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.**

	2011	2012	2013	2014	2015
Annual Objective	5.4	5.4	6.0	6.0	6.0
Annual Indicator	6.0	3.3	2.7	5.3	3.7
Numerator	11	6	5	10	7
Denominator	183,924	184,236	186,272	187,272	187,272
Data Source	MT Office of Vital Statistics & NCHS				
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015  
**Field Note:**  
Provisional 2015 death data. 2015 census estimates unavailable--2014 estimates used in denominator.

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2. **Field Name:** 2014  
**Field Note:**  
Final 2014 death data. 2014 census estimates used in denominator.

---

3. **Field Name:** 2013  
**Field Note:**  
Final 2013 death data. Final 2013 estimates used in denominator.

---

4. **Field Name:** 2012  
**Field Note:**  
Provisional 2012 birth data. 2012 census estimates unavailable--2011 estimates used in denominator.

---

5. **Field Name:** 2011  
**Field Note:**  
Finalized 2011 data.

**Data Alerts: None**

**NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.**

	2011	2012	2013	2014	2015
Annual Objective	57.0	57.0	58.0	58.0	58.0
Annual Indicator	61.1	45.4	59.3	50.7	50.7
Numerator					
Denominator					
Data Source	National Immunization Survey				
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015  
  
**Field Note:**  
No 2015 data available yet

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2. **Field Name:** 2014  
  
**Field Note:**  
The data reported for 2014 are from the CDC/National Immunization Survey Breastfeeding Report Card — United States, 2014. These data are reported as a percentage and numerator and demonator information is not available.

---

3. **Field Name:** 2013  
  
**Field Note:**  
The data reported for 2013 are from the CDC/National Immunization Survey Breastfeeding Report Card — United States, 2013. These data are reported as a percentage and numerator and demonator information is not available.

---

4. **Field Name:** 2012  
  
**Field Note:**  
The data reported for 2012 are from the CDC/National Immunization Survey Breastfeeding Report Card — United States, 2012. These data are reported as a percentage and numerator and demonator information is not available.

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5. **Field Name:** 2011

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**Field Note:**

The data reported for 2011 are from the CDC/National Immunization Survey 2011, for children born in 2008. The 2008 data is final.

**Data Alerts: None**

**NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.**

	2011	2012	2013	2014	2015
Annual Objective	98.5	98.5	98.2	98.5	98.6
Annual Indicator	98.0	98.5	99.0	98.7	98.4
Numerator	11,323	11,379	11,627	11,742	11,830
Denominator	11,553	11,557	11,739	11,892	12,021
Data Source	Newborn Hearing	Newborn Hearing Screening Program			
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015

**Field Note:**

The numerator data source for this measure is HI\*TRACK, the Newborn Hearing Screening Program software. The numerator includes hearing screenings for infants born in hospitals in Montana. The denominator is from the Montana Office of Vital Statistics and includes births that occurred in Montana hospitals in 2015. It does not include births to Montana residents that occurred in hospitals out of state or births that occurred outside hospitals..

2. **Field Name:** 2014

**Field Note:**

The numerator data source for this measure is HI\*TRACK, the Newborn Hearing Screening Program software. The numerator includes hearing screenings for infants born in hospitals in Montana. The denominator is from the Montana Office of Vital Statistics and includes births that occurred in Montana hospitals in 2014. It does not include births to Montana residents that occurred in hospitals out of state or births that occurred outside hospitals..

3. **Field Name:** 2013

**Field Note:**

The numerator data source for this measure is HI\*TRACK, the Newborn Hearing Screening Program software. The numerator includes hearing screenings for infants born in hospitals in Montana. The denominator is from the Montana Office of Vital Statistics and includes births that occurred in Montana hospitals in 2013. It does not include births to Montana residents that occurred in hospitals out of state or births that occurred outside hospitals..

4. **Field Name:** 2012

---

**Field Note:**

The numerator data source for this measure is HI\*TRACK, the Newborn Hearing Screening Program software. The numerator includes hearing screenings for infants born in hospitals in Montana. The denominator is from the Montana Office of Vital Statistics and includes births that occurred in Montana hospitals in 2012. It does not include births to Montana residents that occurred in hospitals out of state or births that occurred outside hospitals..

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5. **Field Name:** **2011**

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**Field Note:**

The numerator data source for this measure is HI\*TRACK, the Newborn Hearing Screening Program software. The numerator includes hearing screenings for infants born in hospitals in Montana. The denominator is from the Montana Office of Vital Statistics and includes births that occurred in Montana hospitals in 2011. It does not include births to Montana residents that occurred in hospitals out of state or births that occurred outside hospitals..

**Data Alerts: None**

**NPM 13 - Percent of children without health insurance.**

	2011	2012	2013	2014	2015
Annual Objective	11.0	11.0	12.1	12.1	12.1
Annual Indicator	10.2	13.7	7.6	7.7	7.7
Numerator	24,197	32,330	20,021	19,405	19,405
Denominator	237,267	236,440	265,081	250,632	250,632
Data Source	US Census; CPS II				
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2015</b>
	<b>Field Note:</b>	Current Population Survey Annual Social and Economic Supplement, conducted 2015 Refers to status in 2014
2.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	Current Population Survey Annual Social and Economic Supplement, Refers to status in 2014
3.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	Current Population Survey Annual Social and Economic Supplement, status for 2013
4.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	Current Population Survey Annual Social and Economic Supplement, conducted 2012 Refers to status in 2011
5.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	from Current Population Survey Annual Social and Economic Supplement, conducted 2011 Refers to status in 2010

**Data Alerts: None**

**NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.**

	2011	2012	2013	2014	2015
Annual Objective	31.0	31.0	31.0	31.0	31.0
Annual Indicator	40.6	31.7	32.5	32.5	33.5
Numerator	5,274	4,170	4,173	3,896	3,876
Denominator	12,978	13,174	12,840	11,976	11,562
Data Source	WIC Program Enrollment				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015  
  
**Field Note:**  
The source is the Montana State WIC Program. Data are for FFY 2015. MT WIC only has kids on until 4 years old, 5 year olds are not on MT WIC.

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2. **Field Name:** 2014  
  
**Field Note:**  
The source is the Montana State WIC Program. Data are for FFY 2014. MT WIC only has kids on until 4 years old, 5 year olds are not on MT WIC.

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3. **Field Name:** 2013  
  
**Field Note:**  
The source is the Montana State WIC Program. Data are for FFY 2013.

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4. **Field Name:** 2012  
  
**Field Note:**  
The source is the Montana State WIC Program. Data are for FFY 2012.

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5. **Field Name:** 2011  
  
**Field Note:**  
The source is the Montana State WIC Program. Data are for FFY 2011.

**Data Alerts: None**

**NPM 15 - Percentage of women who smoke in the last three months of pregnancy.**

	2011	2012	2013	2014	2015
Annual Objective	13.0	13.0	13.0	13.0	13.0
Annual Indicator	13.6	13.4	13.8	12.8	12.7
Numerator	1,634	1,593	1,685	1,582	1,593
Denominator	11,981	11,915	12,185	12,331	12,519
Data Source	Live birth data, MT Office of Vital Statistics				
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2015</b>
	<b>Field Note:</b>	2015 Provisional Birth Data.
2.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	2014 Final Birth Data.
3.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	2013 Final Birth Data.
4.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	2012 Final Birth Data.
5.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	Final 2011 data.

**Data Alerts: None**

**NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.**

	2011	2012	2013	2014	2015
Annual Objective	12.5	12.5	14.0	14.0	14.0
Annual Indicator	18.0	13.8	28.0	15.6	18.8
Numerator	12	9	18	10	12
Denominator	66,748	64,985	64,322	63,920	63,920
Data Source	MT Office of Vital Statistics and NCHS				
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2015  
  
**Field Note:**  
2015 Provisional Death data. 2015 census population estimates unavailable. 2014 estimates used in denominator.

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2. **Field Name:** 2014  
  
**Field Note:**  
2014 Final Death data. 2014 census population estimates used in denominator.

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3. **Field Name:** 2013  
  
**Field Note:**  
2013 Final Death and Population data. 2013 final population estimates used in denominator.

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4. **Field Name:** 2012  
  
**Field Note:**  
2012 Final Birth data. 2012 census estimates used in denominator.

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5. **Field Name:** 2011  
  
**Field Note:**  
2011 Final Data.

**Data Alerts: None**

**NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.**

	2011	2012	2013	2014	2015
Annual Objective	65.0	65.0	78.5	78.5	78.5
Annual Indicator	85.1	83.3	87.3	89.6	87.2
Numerator	114	120	96	146	95
Denominator	134	144	110	163	109
Data Source	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

- 
1. **Field Name:** 2015
- 
- Field Note:**  
2015 Provisional data. Facilities for high-risk deliveries are neonates in Montana: Benefis Health System in Great Falls, Community Medical Center in Missoula, St. Vincent Healthcare in Billings, and KALISPELL REGIONAL HOSP.
- 
2. **Field Name:** 2014
- 
- Field Note:**  
2014 Final data. Facilities for high-risk deliveries are neonates in Montana: Benefis Health System in Great Falls, Community Medical Center in Missoula, St. Vincent Healthcare in Billings, and KALISPELL REGIONAL HOSP.
- 
3. **Field Name:** 2013
- 
- Field Note:**  
2013 Final data. Facilities for high-risk deliveries are neonates in Montana: Benefis Health System in Great Falls, Community Medical Center in Missoula, St. Vincent Healthcare in Billings, and KALISPELL REGIONAL HOSP.
- 
4. **Field Name:** 2012
- 
- Field Note:**  
2012 Final data. Facilities for high-risk deliveries are neonates in Montana: Benefis Health System in Great Falls, Community Medical Center in Missoula, and St. Vincent Healthcare in Billings.

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5. **Field Name:** 2011

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**Field Note:**

2011 Finalized data. Facilities for high-risk deliveries are neonates in Montana: Benefis Health System in Great Falls, Community Medical Center in Missoula, and St. Vincent Healthcare in Billings.

**Data Alerts: None**

**NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.**

	2011	2012	2013	2014	2015
Annual Objective	75.0	75.0	75.0	75.0	75.0
Annual Indicator	71.1	71.3	69.2	69.6	69.8
Numerator	8,557	8,595	8,549	8,646	8,776
Denominator	12,039	12,052	12,351	12,431	12,581
Data Source	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d NPMs:**

1.	<b>Field Name:</b>	<b>2015</b>
	<b>Field Note:</b>	2015 Provisional Birth data.
2.	<b>Field Name:</b>	<b>2014</b>
	<b>Field Note:</b>	2014 Final Birth data.
3.	<b>Field Name:</b>	<b>2013</b>
	<b>Field Note:</b>	2013 Final data.
4.	<b>Field Name:</b>	<b>2012</b>
	<b>Field Note:</b>	2012 Final data.
5.	<b>Field Name:</b>	<b>2011</b>
	<b>Field Note:</b>	2011 Final data.

**Data Alerts: None**

**Form 10d**  
**State Performance Measures (SPMs) (Reporting Year 2014 & 2015)**  
**State: Montana**

**SPM 1 - The percent of children with cleft lip and/or palate receiving care in interdisciplinary clinics.**

	2011	2012	2013	2014	2015
Annual Objective	90.0	90.0	90.0	90.0	90.0
Annual Indicator	90.0	65.0	89.5	100.0	100.0
Numerator	18	13	17	27	25
Denominator	20	20	19	27	25
Data Source	CSHCN Program				
Provisional Or Final ?				Final	Final

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015

**Field Note:**

Data source: CSHCN Program.

The data reflect the number of infants born during \*\*\* Calender year 2015 \*\*\*\* and identified as having a cleft lip and/or palate by the Children's Special Health Services (CSHS) Section (the state CSHCN program), who were seen in a cleft/craniofacial clinic. MT does not have a birth defects registry.

2. **Field Name:** 2014

**Field Note:**

Data source: CSHCN Program.

The data reflect the number of infants born during \*\*\* Calender year 2014 \*\*\*\* and identified as having a cleft lip and/or palate by the Children's Special Health Services (CSHS) Section (the state CSHCN program), who were seen in a cleft/craniofacial clinic. MT does not have a birth defects registry.

3. **Field Name:** 2013

**Field Note:**

Data source: CSHCN Program.

The data reflect the number of infants born during \*\*\* Calender year 2013 \*\*\*\* and identified as having a cleft lip and/or palate by the Children's Special Health Services (CSHS) Section (the state CSHCN program), who were seen in a cleft/craniofacial clinic.

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4. **Field Name:** 2012

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**Field Note:**

Data source: CSHCN Program.

The data reflect the number of infants born during FFY 2012 and identified as having a cleft lip and/or palate by the Children's Special Health Services (CSHS) Section (the state CSHCN program), who were seen in a cleft/craniofacial clinic.

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5. **Field Name:** 2011

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**Field Note:**

The data reflect the number of infants born during FFY 2011 and identified as having a cleft lip and/or palate by the Children's Special Health Services (CSHS) Section (the state CSHCN program), who were seen in a cleft/craniofacial clinic.

**Data Alerts: None**

**SPM 2 - The percent of Medicaid clients 0 through 6 years of age who have had a dental screening during the year.**

	2011	2012	2013	2014	2015
Annual Objective	1.0	30.0	30.0	30.0	30.0
Annual Indicator	38.7	35.2	36.5	38.3	39.6
Numerator	13,101	15,460	17,087	19,871	20,523
Denominator	33,813	43,862	46,816	51,868	51,797
Data Source	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2014  
  
**Field Note:**  
Data are from the Montana Medicaid Program (HMK+) and include all children enrolled during July 1, 2013 through June 30, 2014 (SFFY 2014). Data include children who received an oral evaluation by a dentist.

---

2. **Field Name:** 2013  
  
**Field Note:**  
Data are from the Montana Medicaid Program (HMK+) and include all children enrolled during July 1, 2012 through June 30, 2013 (SFFY 2013). Data include children who received an oral evaluation by a dentist.

---

3. **Field Name:** 2012  
  
**Field Note:**  
Data are from the Montana Medicaid Program (HMK+) and include all children enrolled during July 1, 2011 through June 30, 2012 (SFFY 2012). Data include children who received an oral evaluation by a dentist.

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4. **Field Name:** 2011  
  
**Field Note:**  
Data are from the Montana Medicaid Program (HMK+) and include all children enrolled during July 1, 2010 through June 30, 2011 (SFFY 2011). Data include children who received an oral evaluation by a dentist.

NOTE: The 2011 indicator of 1 is an error and per the HRSA Call Center, it can not be corrected for the 9/12 submission. The 2011 indicator should have been 30, as it is for 2012 through 2016.

**Data Alerts: None**

**SPM 3 - The percent of Medicaid clients who have gestational diabetes and have their blood glucose measured during the time period of six weeks to six months postpartum.**

	2011	2012	2013	2014	2015
Annual Objective	12.0	12.0	12.0	12.0	12.0
Annual Indicator	8.0	9.0	14.7	10.9	13.3
Numerator	10	12	21	21	6
Denominator	125	133	143	193	45
Data Source	Linked Medicaid-birth certificate data.	Link Medicaid-birth certificate data			
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015

**Field Note:**

In fiscal years 2011 - 2014, all women whose births were covered by Medicaid were counted in the denominator. As an example, in 2015 there were 215 identified Medicaid mothers, and 17 had the relevant codes corresponding to blood glucose measurement (7.9%).

The problem with this is that most women lose their Medicaid coverage long before six months postpartum. A woman who loses her coverage two months postpartum could have her blood glucose tested at three months postpartum, but that wouldn't be entered into the Medicaid database.

The FCHB epidemiologist then analyzed the 2015 (provisional) data of only women who had Medicaid coverage through the complete six months postpartum. Of the 215 mothers, only 45 had coverage during the entire time period. Of those 45, six received a blood glucose test (13.3%).

2. **Field Name:** 2014

**Field Note:**

2014 Provisional Data. Data sources are the MT Office of Vital Statistics and Medicaid Information System. Data include the Montana occurring births to Montana resident mothers with Gestational Diabetes Indicated. Medicaid Claims Data include CPT codes: 82947, 82962, 82950, 82951, 83036, 82952. Linked within 42 And 180 days of birth on mother's birthdate and mother's maiden name, infants last name or father's name to recipient's last name.

3. **Field Name:** 2013

---

**Field Note:**

2013 Final Data. Data sources are the MT Office of Vital Statistics and Medicaid Information System. Data include the Montana occurring births to Montana resident mothers with Gestational Diabetes Indicated. Medicaid Claims Data include CPT codes: 82947, 82962, 82950, 82951, 83036, 82952. Linked within 42 And 180 days of birth on mother's birthdate and mother's maiden name, infants last name or father's name to recipient's last name.

---

4. **Field Name:** **2012**

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**Field Note:**

2012 Final Data. Data sources are the MT Office of Vital Statistics and Medicaid Information System. Data include the Montana occurring births to Montana resident mothers with Gestational Diabetes Indicated. Medicaid Claims Data include CPT codes: 82947, 82962, 82950, 82951, 83036, 82952. Linked within 42 And 180 days of birth on mother's birthdate and mother's maiden name, infants last name or father's name to recipient's last name.

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5. **Field Name:** **2011**

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**Field Note:**

The data reported are for 2010. Data for 2011 are not yet final. They are expected to be finalized later in 2012. Data source are the MT Office of Vital Statistics and Medicaid Information System. Data include the Montana occurring births to Montana resident mothers, and YEARFIRST to YEARMAX, With Gestational Diabetes Indicated. Medicaid Claims Data include CPT codes: 82947, 82962, 82950, 82951, 83036, 82952. Linked within 42 And 180 days of birth on mother's birthdate and mother's maiden name, infants last name or father's name to recipient's last name.

**Data Alerts: None**

**SPM 4 - The rate of death to children 0 through 17 years of age caused by unintentional injuries.**

	2011	2012	2013	2014	2015
Annual Objective	13.0	13.0	12.0	12.0	12.0
Annual Indicator	21.9	13.1	9.4	12.9	14.7
Numerator	49	29	21	29	33
Denominator	223,563	221,980	224,014	225,024	225,024
Data Source	MT Office of Vital Statistics & NCHS				
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015  
**Field Note:**  
2015 MT Death Provisional Data. No 2015 Population data yet, used 2014.

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2. **Field Name:** 2014  
**Field Note:**  
2014 MT Death Final Data. 2014 Population data used.

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3. **Field Name:** 2013  
**Field Note:**  
2013 Final Data

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4. **Field Name:** 2012  
**Field Note:**  
2012 Final Data

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5. **Field Name:** 2011  
**Field Note:**  
The data reported are for 2010. Data for 2011 are not yet final. They are expected to be finalized later in 2012.

**Data Alerts: None**

**SPM 5 - The percent of women who smoke during pregnancy**

	2011	2012	2013	2014	2015
Annual Objective	15.0	15.0	14.0	14.0	14.0
Annual Indicator	16.3	16.2	16.5	15.9	15.9
Numerator	1,954	1,927	2,010	1,965	1,991
Denominator	11,991	11,921	12,190	12,333	12,521
Data Source	Birth certificates	Birth certificates	MT VS Birth Data	MT VS Birth Data	MT VS Birth Data
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015  
**Field Note:**  
2015 Provisional Birth Data

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2. **Field Name:** 2014  
**Field Note:**  
2014 Final Birth Data

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3. **Field Name:** 2013  
**Field Note:**  
2013 Final Data

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4. **Field Name:** 2012  
**Field Note:**  
2012 Final Data

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5. **Field Name:** 2011  
**Field Note:**  
The data reported are for 2010. Data for 2011 are not yet final. They are expected to be finalized later in 2012.

**Data Alerts: None**

**SPM 6 - The percent of children 19-35 months of age who have received the 4th immunization in the diphtheria, tetanus, and pertussis (DTaP) series.**

	2011	2012	2013	2014	2015
Annual Objective	80.0	80.0	80.0	80.0	80.0
Annual Indicator	82.6	86.6	79.0	83.0	83.0
Numerator					
Denominator					
Data Source	National Immunization Survey				
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015  
  
**Field Note:**  
The source of data is the National Immunization Survey (NIS). The confidence interval for this indicator is +/- 7.0. The data for 2015 are unavailable at this time.

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2. **Field Name:** 2014  
  
**Field Note:**  
The source of data is the National Immunization Survey (NIS). The confidence interval for this indicator is +/- 6.4. The data for 2014.

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3. **Field Name:** 2013  
  
**Field Note:**  
The source of data is the National Immunization Survey (NIS), Q1/2013-Q4/2013. The confidence interval for this indicator is +/- 6.4.

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4. **Field Name:** 2012  
  
**Field Note:**  
The source of data is the National Immunization Survey (NIS), Q1/2012-Q4/2012. The confidence interval for this indicator is +/- 4.4.

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5. **Field Name:** 2011

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**Field Note:**

The source of data is the National Immunization Survey (NIS), Q3/2010-Q2/2011. The confidence interval for this indicator is +/- 5.1. The data for 2011 are not yet final.

**Data Alerts: None**

**SPM 7 - The percent of children 19-35 months of age who have received an immunization against varicella.**

	2011	2012	2013	2014	2015
Annual Objective	82.0	82.0	83.0	83.0	83.0
Annual Indicator	85.7	85.3	87.1	90.9	90.9
Numerator					
Denominator					
Data Source	National Immunization Survey				
Provisional Or Final ?				Final	Provisional

**Field Level Notes for Form 10d SPMs:**

1. **Field Name:** 2015  
**Field Note:**  
Data are from NIS. The confidence interval is +/- 4.8. The data for 2015 are unavailable at this time.

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2. **Field Name:** 2014  
**Field Note:**  
Data are from NIS. The confidence interval is +/- 4.8. The data for 2014.

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3. **Field Name:** 2013  
**Field Note:**  
Data are from the Q1/2013-Q4/2013, NIS. The confidence interval is +/- 5.2.

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4. **Field Name:** 2012  
**Field Note:**  
Data are from the Q1/2012-Q4/2012, NIS. The confidence interval is +/- 5.2. The data for 2012 are provisional.

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5. **Field Name:** 2011  
**Field Note:**  
Data are from the Q3/2010-Q2/2011, NIS. The confidence interval is +/- 4.4. The data are provisional.

**Data Alerts: None**

**Form 11**  
**Other State Data**  
**State: Montana**

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the current application/annual report.

## State Action Plan Table

State: Montana

Please click the link below to download a PDF of the full version of the State Action Plan Table.

[State Action Plan Table](#)

**Abbreviated State Action Plan Table**

**State: Montana**

**Women/Maternal Health**

State Priority Needs	NPMs	ESMs	SPMs
Low-Risk Cesarean Deliveries	NPM 2 - Low-Risk Cesarean Delivery	ESM 2.1	

**Perinatal/Infant Health**

State Priority Needs	NPMs	ESMs	SPMs
Infant Safe Sleep	NPM 5 - Safe Sleep	ESM 5.1	
Breastfeeding Rates	NPM 4 - Breastfeeding	ESM 4.1	

**Child Health**

State Priority Needs	NPMs	ESMs	SPMs
Child Injuries	NPM 7 - Injury Hospitalization	ESM 7.1	
Immunization Rates			SPM 3

**Adolescent Health**

State Priority Needs	NPMs	ESMs	SPMs
Teen Pregnancy Prevention	NPM 10 - Adolescent Well-Visit	ESM 10.1	
Immunization Rates			SPM 3
Teen Pregnancy Prevention			SPM 5

**Children with Special Health Care Needs**

State Priority Needs	NPMs	ESMs	SPMs
Access to Care			SPM 4
Access to Care	NPM 12 - Transition	ESM 12.1	

**Cross-Cutting/Life Course**

State Priority Needs	NPMs	ESMs	SPMs
Access to Care			SPM 1
Family Support and Health Education			SPM 2
Oral Health	NPM 13 - Preventive Dental Visit	ESM 13.1	
Smoking During Pregnancy and Household Smoking	NPM 14 - Smoking	ESM 14.1	