PublicHealth IN THE 406

MONTANA PUBLIC HEALTH DATA RESOURCE GUIDE

July 2020

MONTANA DPHHS

Healthy People. Healthy Communities.

Department of Public Health & Human Services

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Introduction

The implementation and evaluation of public health interventions and policy relies on the access of data from many different sources. This guide was designed to facilitate public health practitioners, stakeholders, and policymakers to find commonly requested data as well as to promote other sources that may not be as widely known. This is the first edition of Montana's Public Health Data Resource Guide. As capacity grows, the guide will be updated to reflect new sources of data.

This guide is organized by program area and the data they collect. Each of these programs describes the strengths and limitations of the data, the items collected, and the means to gain access to the data. Programs differ in the type of information collected and may restrict its release according to law and departmental policy. However, most data are available in summary form or as an existing report, and some programs can perform custom analysis for items not routinely available — fees may apply.

The Montana Public Health Data Resource Guide is a valuable resource for exploring the state's health. The Office of Epidemiology and Scientific Support welcomes recommendations of other data sources for future inclusion as well suggestions to make this guide more useful. Please send your suggestions to Laura Williamson, 406-444-0064 or lwilliamson@mt.gov.

Indicator Based Information System

Program Webpage for IBIS

Data Contact:

Isaiah Reed, Epidemiologist
Montana Department of Public Health and Human Services
(406) 444-6947
isaiah.reed@mt.gov

Sources of Information:

The Montana Indicator Based Information System (MT-IBIS) is an online tool which makes information from a number of public health topics and datasets publicly available.

Description of the Data:

MT-IBIS provides community snapshot reports, queries for health datasets, and topics pages. As of summer 2018, the community snapshot reports include demographics and health status indicator measures such as chronic conditions and behavioral health. Users may query public health surveillance systems such as inpatient hospital admissions, population, vital statistics birth and death, the Montana Behavioral Risk Factor Surveillance System, and the Montana Cancer Tumor Registry by year, geography, age, and race. Topics pages include information on health topics such as injury, maternal and child health, and behavioral health.

Strengths of the Data:

MT-IBIS provides an online, publicly available format for users to query health topics, indicators, and data. Data available on MT-IBIS are subject to the same strengths as the original data source. Please see data strengths of those data sources for more information.

Data Limitations:

Data available on MT-IBIS are subject to the same limitations as the original data source. Please see data limitations of those data sources for more information.

Specific Use of the Information:

MT-IBIS is used by epidemiologists, public health partners, and the public to get Montana statistics on public health topics of interest.

Dataset Available:

MT-IBIS is publicly available.

Data Release Policy:

MT-IBIS follows the data release and suppression guidelines of the original data source.

Adult Tobacco Survey

Program Webpage for the Adult Tobacco Survey

Data Contact:

Lisa Richidt, Senior Epidemiologist
Montana Department of Public Health and Human Services
(406) 444-0927
lisa.richidt@mt.gov

Sources of Information:

The Montana Adult Tobacco Survey (MT-ATS) is a telephone survey of noninstitutionalized Montana adults aged 18+. The survey is conducted every few years and data are currently available for 2012, 2015, and 2018. The survey questionnaire is a slightly modified version of the National Adult Tobacco Survey and is developed in collaboration with the Office of Smoking and Health at the Centers for Disease Control and Prevention and the University of Wyoming Survey and Analysis Center (WYSAC).

Description of the Data:

The MT-ATS assesses the prevalence of tobacco use, as well as the factors promoting and impeding tobacco use among adults. Data are collected on types of tobacco use (conventional cigarettes, smokeless tobacco, cigars, and electronic cigarettes), frequency of tobacco use, history of tobacco use, cessation attempts, Montana Quit Line awareness, secondhand smoke exposure, and tobacco-related policy issues. The survey also collects data on demographic characteristics, including age, race, education, sex, income, and select chronic conditions.

Strengths of the Data:

The MT-ATS is an overlap dual-frame random-digit-dial telephone survey. “Dual-frame” refers to sampling both the landline and cell phone frames. Enough data are collected to make precise estimates of various smoking-related health outcomes for the Montana state population as well as for three regions defined by groups of counties. Data are weighted and adjusted for nonresponse, household size, and number of landlines. A calibration adjustment is done to improve the accuracy of survey estimates. Weights are calibrated to age, sex, race/ethnicity, educational attainment, and phone usage totals within each region.

Data Limitations:

The MT-ATS has a few key limitations. Data are self-reported and are therefore susceptible to potential biases. Individuals who do not own a phone, as well as institutionalized adults are not included in the sample. The sample size is not large enough to produce county-level estimates. The survey is only conducted once every several years.

Specific Use of the Information:

As noted above, data are used to determine the prevalence of tobacco use as well as the factors promoting and impeding tobacco use among Montana adults. Data are used primarily to monitor and evaluate the Montana Tobacco Use Prevention Program rather than for surveillance. The survey questionnaire is built around key outcome indicators from the four goal areas provided by the Office of Smoking and Health, which align with national tobacco prevention efforts. The four goal areas are preventing initiation of tobacco use among young people, eliminating nonsmokers' exposure to secondhand smoke, promoting quitting among adults and young people, and identifying and eliminating tobacco-related disparities.

System Evaluation:

Data are collected and cleaned by WYSAC, the survey contractor. WYSAC adheres to quality control standards outlined by the CDC and receives guidance and technical assistance as needed.

Dataset Available:

SAS datasets are available for years 2012, 2015, and 2018. Data are available upon request. To obtain MT-ATS data, please contact Lisa Richidt, the MTUPP Epidemiologist.

Data Release Policy:

MTUPP will release data upon the receipt and review of a documented request. When analyzing MT-ATS data, users should follow DPHHS's Guidelines for the Release of Public Health Data. Additionally, county-level data should not be analyzed as the sample size is not large enough to produce reliable estimates.

Data Publications:

There are currently no ATS data publications.

Suggested Data Citation:

Montana Department of Public Health and Human Services. Montana Adult Tobacco Survey, [data years].

Behavioral Risk Factor Surveillance System

Program Webpage for the Behavioral Risk Factor Surveillance System

Data Contact:

Vacant, Epidemiologist
Montana Department of Public Health and Human Services
(406) 444-2973

Sources of Information:

The Behavioral Risk Factor Surveillance System (BRFSS) is a cross-sectional telephone survey conducted annually in all 50 states, as well as the District of Columbia and three U.S. territories. It is co-sponsored by the Centers for Disease Control and Prevention (CDC) and the Montana Department of Public Health and Human Services (MT DPHHS) and has been administered throughout Montana since 1984. Noninstitutionalized adults (aged 18+ years) are randomly selected using both cell phone and land line numbers. Participation is voluntary and personally identifiable information is not collected; furthermore, all responses are kept confidential. The survey data is collected and cleaned by a contractor, currently the University of Wyoming Survey and Analysis Center. The CDC performs some data analyses and provides a final dataset to MT DPHHS for further analyses.

Description of the Data:

The BRFSS survey collects prevalence data regarding health-related risk behaviors, chronic health conditions, and the use of preventive services. It also collects information on various demographic factors, including age, gender, race, household income, educational attainment, and more. To collect these data, the survey utilizes core questions that are asked by all states on an annual or bi-annual basis. In addition, each state is given the opportunity to select optional modules and to add individualized questions specific to their public health needs. In Montana, this allows for the collection of data that are insightful of and beneficial to our residents and their health. In previous years, Montana has selected modules to examine topics such as industry and occupation, arthritis management, diabetes, and childhood asthma prevalence, among others. In addition, we have added questions to address oral health, binge drinking, veteran's health, and more. The data gathered from the BRFSS survey are primarily utilized to obtain prevalence estimates that describe the health and health statuses of Montana residents. These data help inform program planning and implementation, as well as policy development, as appropriate. Ultimately, this assists MT DPHHS and other partner organizations in their efforts to both improve and protect the health of all Montanans.

Strengths of the Data:

In Montana, the BRFSS survey collects data on diverse public health topics from a large sample size (average 7,000 respondents). Furthermore, we have over 30 years of quality BRFSS data produced from questions that have been tested for validity and reliability. Because of these factors, we can obtain estimates that are highly representative of the Montana adult population and several sub-populations within that. Other notable strengths associated with the BRFSS survey and the data that it produces are their ability to, add questions that reflect high priority or high concern areas for Montana, compare Montana's prevalence estimates to other states and the U.S. as a whole, report data specific to each of Montana's five health planning regions, track Montana's state-level progress towards Healthy People 2020 goals and objectives, produce prevalence estimates for a wide range of chronic diseases and many of the risk factors associated with them (the BRFSS is the only source for chronic disease prevalence in the state of Montana), and obtain meaningful data on Montana's American Indian population through the BRFSS strategies employed to oversample this important population

Data Limitations:

As with any data source, the BRFSS data comes with a few key limitations. The data are self-reported and therefore susceptible to potential biases. Individuals who do not own a phone, as well as institutionalized adults such as those living in nursing homes, on military bases, or within prisons, are not included in the sample. The sample size is not large enough to produce annual county-level estimate. We cannot assess incidence or whether measured risk factors/behaviors contributed to specific health outcomes.

Specific Use of the Information:

As noted above, the BRFSS data is primarily used to obtain prevalence estimates of various health risk behaviors and chronic diseases, as well as the use of preventative health services. The Montana DPHHS then uses these estimates to report on the health of Montanans in multiple formats and through many strategic avenues. The results of the BRFSS data can be found in the State Health Assessment, county health profiles, surveillance reports, and grant applications. It can also be drawn on to help inform and guide program planning and public health policy development, as well the respective implementation of each.

System Evaluation:

Both the MT DPHHS and our Contractor adhere to quality control standards set forth by the CDC. These standards are evaluated through monthly and annual reports produced for quality assurance purposes.

Data Set Availability:

Yearly data sets from 1984-present are available upon request. Format availability, specifically with regards to SAS or SPSS, is dependent upon the year requested. Multiple formats are potentially available. The availability of the most recent year of data will be dependent on the time of year and whether the data set has been finalized and released to MT DPHHS from the CDC. Data sets from 2011 and on will be made publicly available on the Montana Indicator Based Information System (IBIS). Publicly available data can be obtained from MT IBIS and CDC. Requests for restricted files can be made with the MT BRFSS request form. Additional information regarding our data release policy is below. Analyzed data may also be requested through the BRFSS Coordinator. There are no fees associated with accessing or using the BRFSS data.

Data Release Policy:

The BRFSS Coordinator will release data upon the receipt and review of an appropriately documented data request form. In order to protect respondent identity, data released externally will not include county information or industry and occupational information. Data users are required to provide a copy of all printed and published materials that use Montana BRFSS data to the MT BRFSS program. Such materials can be delivered to the Data Coordinator listed above. Data users should not release unreliable data that is characterized by one or more of the following three attributes: (1) small sample size (n<50), (2) relative standard error >30%, (3) half-width confidence intervals >10%. It is highly recommended that data users report 95% Confidence Intervals or Standard Errors for all estimates obtained from BRFSS data. In addition, it is important for all data users to acknowledge that, due to methodological changes, any prevalence estimates calculated from 2011 onward cannot be directly compared to estimates from 2010 and earlier. More on this can be found at the CDC website.

Data Publications:

Annual, surveillance, and special reports can be found on the MT BRFSS website.

The Montana Chronic Disease Prevention and Health Promotion Bureau also commonly uses BRFSS data in their reports, many of which can be found at their website.

Suggested Data Citation:

Montana Department of Public Health and Human Services (MT DPHHS) and Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data*. Helena, MT: Montana Department of Public Health and Human Services, Public Health and Safety Division, [data years].

Board of Crime Control Data System

Program Webpage for the Montana Board of Crime Control Data System

Data Contact:

Kathy Wilkins, Statistical Analysis Center Director
Montana Board of Crime Control
(406) 444-4298
kwilkins@mt.gov

Sources of Information:

Montana Board of Crime Control data are voluntarily collected by most law enforcement agencies across the state. These data are generated electronically through police reports. The reports are submitted to the Federal Bureau of Investigation (FBI) as part of the National Incident-Based Reporting System (NIBRS). The Montana Statistical Analysis Center (SAC) also compiles, houses, and analyzes these data in the Montana Incident-Based Reporting System (MTIBRS) central repository. The MTIBRS houses data from 2005 onward.

Description of the Data:

The Montana Incident-Based Reporting System Online Reporting (MOR) tool provides in depth demographical, temporal, and circumstantial information about crime victims, arrestees/offenders, and property data and the incidents and offenses committed by or against them. Data are available for the number of drug (methamphetamine, cocaine, heroin/opiate, marijuana, etc.) related crimes and the number of arrests for drug related crime. These data are available at the state, county, and local (jurisdiction) level.

Strengths of the Data:

Montana Board of Crime Control data are generated electronically through police reports. While agency participation is voluntary, Montana is unique in that approximately 98% of the population is covered through agency participation. These data indicate the number of drug (methamphetamine, cocaine, heroin/opiate, marijuana, etc.) related crimes and the number of arrests made for drug related crime. Data are available at the state, county, and local level.

Data Limitations:

Agency participation is voluntary and therefore does not cover 100% of the population. These data do not indicate how drug use or drug presence is or is not related to the crime/arrest. Drugs may be present in the individual or at the scene but go undetected. The state does not receive data for tribal jurisdictions and is unable to report data for drug related offenses in these areas.

Specific Use of the Information:

Montana Board of Crime Control data can provide counts at the state, county, and local level for the number of drug (methamphetamine, cocaine, heroin/opiate, marijuana, other) related crimes and the number of arrests for drug related crimes. These data may be utilized to describe the burden of drug use according to location and drug type. Data may also be used to track trends over time. Data collected by the Montana Board of Crime Control are submitted to the Federal Bureau of Investigation (FBI) as part of the National Incident-Based Reporting System (NIBRS) for inclusion in a nationwide dataset.

System Evaluation:

The National Incident-Based Reporting System (NIBRS) Pre-Certification Tool (PCT) allows users to automatically validate NIBIRS data against the FBI's more current NIBRS specifications. Furthermore, MTIBIRS generates reports of agency import results. An average submission error rate of 4% or less is required for data accuracy.

Data Set Availability:

Montana Board of Crime Control data are housed on the Montana Incident-Based Reporting System (MTIBRS). Annual summaries of the major crime statistics are made available, in report format, by the Montana Board of Crime Control. Requests for specific data, beyond those data provided in the annual summaries, can be made at: http://mbcc.mt.gov/Data/CIM-Data-Request.

Data Release Policy:

Data may be requested by filling out the Crime in Montana Data Request Form.

Data Publications:

There are Annual Crime in Montana Reports, dating from 1972.

Suggested Data Citation:

Montana Board of Crime Control (MBCC). Montana Incident Based Reporting System Data. Helena, MT: Montana Board of Crime Control, Statistical Analysis Center, [data years].

Cardiac Arrest Registry for Enhanced Survival

Program Webpage for the Cardiac Arrest Registry for Enhanced Survival

Data Contact:

Janet Trethewey, Cardiac Ready Communities Program Manager
Montana Department of Public Health and Human Services
(406) 444-0442
jtrethewey@mt.gov

Sources of Information:

Cardiac Arrest Registry for Enhanced Survival (CARES) is a surveillance registry that tracks out-of-hospital cardiac arrests, or OHCA. Prehospital data is manually entered by EMS providers, and hospital-based providers enter outcome data. CARES software links data sources and creates a single de-identified record for each OHCA event. Montana has been participating in CARES since 2013.

Description of the Data:

CARES captures initial cardiac rhythm, patient outcomes, rates of bystander CPR, bystander AED use, law enforcement AED use, telephone/dispatcher CPR instruction provided, demographics, and location of arrest (home, public space, etc.). A description of these variables can be found in the CARES data dictionary.

Strengths of the Data:

When Montana first enrolled in CARES, only the large population centers were participating, but as of 2020, participation has expanded to cover approximately 95+% of the population of MT. With such a high level of participation, much of the data can be generalized to the entire state. CARES uses Utstein criteria, the recognized international standard for reporting OHCA to ensure standardized data that can be compared across similar communities as well as state and national levels. National data, representative of both rural and urban populations, are available on a yearly basis for comparison. All data in the registry are maintained by the CARES program – supported by CDC and Emory University – which helps to ensure data quality. Outcome data are very complete as the loss to follow-up rate is very low. Local EMS services and hospitals have ownership of their own data and can pull their data at any time and search for any specific data point. The linkage of EMS to hospital data is a strength of CARES because it allows EMS services to look at survival rates and neurological outcomes rather than just the short-term outcome in the field (such as return of circulation).

Data Limitations:

Input is manually done by each EMS service, so it relies on the accuracy of their patient care data. Statewide data can be shared, but permission from the agency is needed to share community/local data. Data regarding the rate of dispatcher CPR instructions prior to EMS arrival has been inconsistent.

Specific Use of the Information:

EMS agencies and hospitals have access to the data for their own patients but not for those of other agencies or facilities. The state coordinator has statewide access. At the community level, EMS services and hospitals work together to use CARES data for PI/QI purposes such as to improve response times, raise bystander CPR rates, increase dispatcher CPR instruction rates, are determine AED distribution/location needs. Communities can monitor their performance and compare themselves to state and national benchmarks. CARES is committed to maintaining the confidentiality of EMS agency and hospital data.

System Evaluation:

There are multiple internal checks within the CARES program to prevent errors in data entry. All incorrect/implausible data entries are flagged for correction. Any item left/entered that does not fit the algorithm requires a check by the state coordinator prior to deidentification and submission. There is another check of the data by the CARES team prior to aggregation and year end reporting.

Data Set Availability:

State aggregate data from 2013-2020 are available. Specific county or community data may be available with permission from the EMS service. Contact the MT coordinator to request deidentified, aggregate data for research purposes. Local IRB approval may also be required.

Data Release Policy:

Any research reports or publications shall not separately identify participating EMS agencies or hospitals or their contributed data. The researcher must sign a data use agreement stating they will not share the dataset or expand the analysis beyond the scope of their research proposal. Abstract or presentation proposals must be followed up with a submission within three months of the date that the dataset is provided. Papers must be submitted for review within nine months of the date that the dataset is provided.

Data Publications:

The Montana Cardiac Report is an annual report from the Chronic Disease Bureau of DPHHS.

National data are also available.

Suggested Data Citation:

EMS & Trauma Systems Section, Montana Department of Public Health and Human Services, Cardiac Arrest Registry to Enhance Survival (CARES), [data years].

Central Tumor Registry

Program Webpage for the Central Tumor Registry

Data Contact:

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Montana Department of Public Health and Human Services
(406) 444-2737
hzimmerman@mt.gov

Debbi Lemons, Tumor Registry Coordinator
Montana Department of Public Health and Human Services
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dlemons@mt.gov

Sources of Information:

Montana Statute requires that hospitals, clinical pathologic laboratories, and health care practitioners report data on any reportable tumors that they diagnose or provide treatment for. Data are submitted either electronically using a national standard layout or (much less often) via fax submission of reporting forms. Electronic data are entered directly into the database. Data submitted on paper forms are key entered into the database. The Montana Central Tumor Registry (MCTR) was established in 1979 and data are available from 1980 forward. Each new data year is generally 90% complete by the end of November of the following year, i.e. the 2015 data were 90% complete by November 2016 and 95-100% complete by November 2017.

Description of the Data:

MCTR collects patient characteristics (identifiers, sex, date of birth, age at diagnosis, address at diagnosis, primary payer, race, usual occupation, usual industry, tobacco history, alcohol history, marital status at diagnosis, and co-morbidities and complications), cancer characteristics (place of diagnosis, date of diagnosis, primary site, laterality, pathology, histology, grade/differentiation, and staging), and treatment characteristics (places, dates, and types of treatment). MCTR conducts regular follow-up on cases to determine date of last contact, vital status, or recurrence of the cancer. MCTR also links to death records to record time and cause of death. MCTR collects data on all tumors that are diagnosed or treated in Montana and have data for Montana residents who are diagnosed or treated out of state because of data exchange agreements with most other states.

Strengths of the Data:

MCTR has earned the North American Association of Central Cancer Registries Silver or Gold certification for quality, completeness, and timeliness each year since 1999, meaning that the data are more than 95% complete and adhere to all national standards for data quality. Eighty percent (80%) of MCTR data are geocoded to the street address and 20% are geocoded at the zip code level (or P.O. box when street address does not exist).

Data Limitations:

Eighty percent (80%) of data are collected within 12 months of diagnosis, and 90% are collected within 15 months after diagnosis. Most cases are not reported to the MCTR until cancer treatment is complete. Reporting timeliness can vary among facilities depending on staffing or loss of staff. MCTR collects data on patient characteristics at the time of diagnosis but does not include information about risks or possible exposures that may have occurred prior to diagnosis (except for tobacco and alcohol use history). As such, the MCTR is not a suitable data source for exploring possible relationships between cancer and any behavioral or environmental risk factor. Likewise, MCTR would not be able to link cancer cases back to known environmental or occupational hazards or disasters.

Specific Use of the Information:

MCTR is the primary data source for determining cancer incidence across all types of cancer (including staging) and among population subsets (assuming sufficiently large counts to allow reporting). MCTR data can also be used to examine treatment trends and survivorship. MCTR submits data annually to CDC and the North American Association of Central Cancer Registries. Montana data are of high quality and are included in national datasets and across North America (United States Cancer Statistics [USCS] and Cancer in North America [CiNA]).

System Evaluation:

MCTR data is routinely run against standardized data edits. Data submissions are reviewed for missing or incomplete vital data elements (age, sex, race, county, payer, address, occupation/industry, tobacco history, alcohol history, and stage) and reported back to the facility. Submitted cases are visually reviewed as they are entered into the database for consistency and accuracy of coding. Inconsistent or incomplete data are queried to the provider for clarification on vital data fields (date of diagnosis, primary cancer site, histology, grade, stage, and treatment). Yearly data are considered complete to use when all data edits are clear and the data are estimated to be 90% complete.

Dataset Available:

MCTR data are available from 1980 through two years prior to the present year. Data sets can be requested via the MCTR Data Set Request Form emailed to the Cancer Surveillance & Epidemiology Program manager, Heather Zimmerman. Data sets will be released based on guidelines outlined in the MCTR Data Access Policy. Both the data access policy and the data set request form can be found on the MCTR website. Data sets can be provided in CSV, SPSS, or SAS formats.

Data Release Policy:

Summary statistics are available upon request and will adhere to the DPHHS Public Health and Safety Division data release policy of suppressing cell counts with fewer than 5 observations and will not compute rates for less than 20 events.

Data Publications:

MCTR produces an annual report summarizing the five most recent years of data. The annual report includes summary statistics for all-sites of cancer, the five most common cancer sites, cancer among American Indian populations, and a special feature that is determined based on current trends or cancer control program needs. MCTR also produces an average of two surveillance reports each year that explore specific topics in more depth. Topics are determined based on cancer control program needs. All publications are available on the Montana Cancer Control Program's website.

Suggested Data Citation:

Montana Department of Public Health and Human Services, Montana Central Tumor Registry, [data years and/or title of report], [method and date of accessing the data].

Child Death Review

Program Webpage for the Child Death Review

Data Contact:

Kari Tutwiler, State FICMMR Coordinator
Montana Department of Public Health and Human Services
(406) 444-3394
ktutwiller@mt.gov

Sources of Information:

Death data and information on the circumstances of a death are collected by the county mortality review teams known as the Fetal, Infant, Child, and Maternal Mortality Review & Prevention Program (FICMMR). FICMMR team members gather data from a variety of medical, law enforcement, and social service sources in order to review the death. The team's access to data is strengthened by the provision of the Fetal, Infant, Child and Maternal Mortality Prevention Act, MCA 50-19-401-406. The FICMMR program began entering Montana death data since 2013 via a data use agreement with the National Center for Fatality Review and Prevention. Data from before this agreement is also available as far back as 2006.

Description of the Data:

The FICMMR program reviews every Montana fetal, infant, and child death up through the age of 17. The FICMMR program reviews data collected by numerous agencies that may have been involved with the child's death. These data include death certificates, medical and hospital records, law enforcement death scene investigation reports, emergency medical services, toxicology and autopsy reports, Child & Family Service reports, background information on parents or caregivers, and more.

Strengths of the Data:

State law enables FICMMR teams to access records for a review. Other strengths include data quality reviews conducted on each death report before approval, enhanced database upgrades via the National Center, allowance for custom questions for Montana, and the ability to report data from each county and American Indian reservations to help drive prevention efforts.

Data Limitations:

Data limitations in FICMMR data include a lack of timeliness – information is gathered and deaths are reviewed 12 months after the death. This is due to several factors such as pending criminal investigations, which can potentially pose a conflict of interest, delaying the FICMMR review, finalization of a death certificate, finalization of other medical reports. Another limitation is that review teams may not always be able to obtain all the needed records. While the MCA 50-19-401-406 provides notification of a FICMMR team's right to request and access records for a review, the law does not compel the provision of such; and this can create information gaps.

Specific Use of the Information:

FICMMR data are used to identify death trends and identify prevention efforts at both the state and local levels. For example, these data provided state officials with critical child maltreatment information gathered by the FICMMR teams, which established a partnership between the FICMMR program and the Family Services Division at the Montana Department of Public Health and Human Services. As another example, analysis of FICMMR data revealed the large disparity between white and American Indian infant sleep-related deaths and the risk factors contributing to the deaths, many of which are preventable. These data were then used to develop a new safe sleep initiative between the FICMMR program, the Rocky Mountain Tribal Epidemiology Center, and a tribal nation in Montana. Additionally, local FICMMR teams use the dataset to identify death trends in their counties and prioritize prevention efforts. De-identified and aggregate death data from Montana is included in national datasets after a vigorous application and review process conducted by the National Center for Fatality Review & Prevention.

System Evaluation:

Every death case report receives a quality assurance review. The review is manual and checks for accuracy, consistency of response, missing data fields, and incomplete data fields. Counties are notified of the needed modifications, and a second review is conducted before a case report is approved.

Dataset Available:

Montana's FICMMR case reporting system for 2013 deaths through present. Data are available in aggregate reports only. De-identified, aggregate data is available to state workgroups and partners who assist in child death prevention efforts per the Guidelines for the Release of Public Health Data Derived from Personal Health Information.

Data Release Policy:

Data release follows the Public Health and Safety Division's Guidelines for the Release of Public Health Data Derived from Personal Health Information. Additionally, the National Center for Fatality Review and Prevention (NCFRP), which holds the Child Death Review data for 45 states, provides for the release of aggregated national data as long as no state data is identified individually in a publication without that state's permission. Cells are suppressed if the stratified data represent fewer than 6 cases. Rates are not calculated because the data are not representative of the general population due to selective case review criteria in most states.

Data Publications:

As of 2018, only four years of data are available in the FICMMR case reporting system (2013-2016). At the five-year mark, reports will be identified and produced.

Suggested Data Citation:

The Fetal, Infant, Child, and Maternal Mortality Review & Prevention Program, (FICMMR), Family & Community Health Bureau, DPHHS, [2013 forward]; Data courtesy of county FICMMR teams.

Communicable Disease Surveillance System

Program Webpage for the Communicable Disease Surveillance System

Data Contact:

Helen McCaffrey, HIV Epidemiologist
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(406) 444-0273
hmccaffrey@mt.gov

Rachel Hinnenkamp, NBS Coordinator and Epidemiologist
Montana Department of Public Health and Human Services
(406) 444-0273
rachel.hinnenkamp@mt.gov

Sources of Information:

Montana statutes require the reporting of conditions and communicable diseases of public health significance to local and state public health authorities. MIDIS, the Montana Infectious Disease Information System, and eHARS, the electronic HIV/AIDS Reporting System, are nationally developed applications for the secure receipt and storage of information submitted to local and state public health authorities. The systems contain records for all communicable diseases reportable in the state of Montana. Case reports are entered into each system by state and local health departments and supplemented electronically by laboratory reports. Systems are accessed only by selected local and state public health staff. The purposes of the systems are to collect data for analysis, conduct patient disease investigations, and implement and monitor the effectiveness of disease prevention and treatment efforts. Both systems transmit limited information to the US Centers for Disease Control and Prevention for analysis.

Description of the Data:

MIDIS and eHARS databases include information detailing diagnosis and laboratory testing, geographic and demographic information, and details related to case investigations, including risk factors/behaviors for HIV, STD, and approximately 70 other reportable conditions.

Strengths of the Data:

Inclusion of reportable conditions identified by a provider, laboratory, or other sources in the Communicable Disease Surveillance System is required by statute.

Data Limitations:

Data in the Communicable Disease Surveillance System are limited to what is submitted by providers, laboratories, and state and local health departments. There is potential for underreporting of disease due to undiagnosed conditions or failure to report as required. Data analysis may also be limited due to a low number of disease events.

Specific Use of the Information:

Data in the Communicable Disease Surveillance System can be used to monitor reportable communicable disease case counts, analyze data trends, provide records of care, evaluate effectiveness of disease intervention activities, and ensure that appropriate disease control measures are taken.

System Evaluation:

Data is reconciled quarterly and annually with local health departments and the CDC. Internal database requirements ensure the completeness and quality of data.

Dataset Available:

Summary data are available upon request. Detailed data on general communicable disease are available from 2007 to present; HIV/AIDS data are available from 1985 to present. Earlier data on general communicable diseases are much more limited but available for most years beginning in 1917. Recent data can be generated electronically in a variety of electronic formats; early data are available in PDF or hard copy format.

Data Release Policy:

Data are released in compliance with Montana state law, specifically according to the Government Healthcare Information Act. In addition, DPHHS follows the integrated security and confidentiality guidelines for reportable communicable diseases as mandated by the CDC as well as the policies of the Public Health and Safety Division.

Data Publications:

Aggregate data for all reportable conditions are released in the Communicable Disease Epidemiology (CDEpi) weekly disease report and released to the CDC for publication in the MMWR. Data are also published in the CDEpi Annual Report, and HIV and STD data are published in quarterly and annual disease summaries.

Suggested Data Citation:

Montana Department of Public Health and Human Services, Communicable Disease Surveillance System, [data years].

Emergency Medical Services Data System

Program Webpage for the Emergency Medical Services Data System

Data Contact:

Shari Graham, EMS System Manager
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(406) 444-6098
mkeeffe@mt.gov

Sources of Information:

After 12+ years using HIRMS to manage EMS patient care report (PCR) data, Montana rolled out its new EMS data collection platform through ImageTrend on Jan 1, 2017. The EMS dataset consists of documentation collected by emergency care providers during each patient encounter. In general, EMS data is available in the reporting database within 24 hours of the patient encounter.

Description of the Data:

Patient care documentation includes dispatch and response, patient demographics, circumstances of the incident, condition of the patient, any interventions done, and transport/disposition. One PCR is completed for each patient encountered during an EMS incident. EMS data is required to comply with the National Emergency Medical Services Information System (NEMSIS) standards. Since Jan 1, 2017, Montana has been collecting NEMSIS v3.4 data. A description of the variables in this dataset can be found in the NEMSIS v3.4 data dictionary.

Strengths of the Data:

Montana Statute 37.104.212 requires all ambulance and non-transporting services to submit PCR data to DPHHS for every patient encountered during every EMS incident to which the service responds, meaning that this data source is representative of the Montana population. Thanks to the NEMSIS compliance requirements, EMS data are nationally standardized and must meet certain data quality validation scores, which facilitate aggregation, analysis, and higher data quality. Additionally, many of the data points in EMS data are time-stamped, and EMS data tends to have accurate location information for geo-coding.

Data Limitations:

Prehospital data does not capture longer term mortality or functional outcomes that may arise from acute illness or injury, which are important factors for developing public health agendas. This can be addressed through data linkages.

Specific Use of the Information:

EMS data can be used to evaluate and improve performance, enhance the quality of prehospital patient care, tailor EMS educational curriculums, and identify prevention opportunities. It can also be a useful tool for syndromic surveillance.

A subset of Montana's EMS data is regularly submitted to NEMSIS national data repository.

System Evaluation:

Schematron is used to validate PCR data to an acceptable standard before it can be submitted to the state database.

Dataset Available:

Montana EMS data is available from Jan 1, 2017 forward. Aggregate reports can be requested by emailing the EMSTS epidemiologist, Hannah Yang.

Data Release Policy:

Data will be released in accordance with PHSD guidelines for the release of public health data derived from personal health information.

Data Publications:

The are currently no EMS data publications.

Suggested Data Citation:

EMS & Trauma Systems Section, Montana Department of Public Health and Human Services, Emergency Medical Services Data, [data years].

Fatality Analysis Reporting System

Program Webpage for the Fatality Analysis Reporting System

Data Contact:

Mark Keeffe, Operations Research Analyst
Montana Department of Public Health and Human Services
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Sources of Information:

FARS is a nationwide census providing the National Highway Traffic Safety Administration (NHTSA), Congress, and the American Public yearly data regarding fatal injuries suffered in motor vehicle traffic crashes.

Description of the Data:

Each state provides FARS with details of vehicle traffic crashes that involve fatalities. Data can be complied into state or national reports. FARS data are available from 1975 to present. Queries can be developed using hundreds of variables that are involved in traffic fatalities. Some common queries are alcohol-impaired fatalities and improper restraint.

Strengths of the Data:

FARS data provide an accurate and consistent picture of alcohol-related fatalities in Montana. Montana conducts testing on over 90% of drivers involved in fatalities and reports those results to FARS on an annual basis. Testing levels vary from state to state and may not be as high in other states.

Data Limitations:

Drug-impaired driving is much more complicated than alcohol-impaired driving and more challenging to analyze using FARS.

Specific Use of the Information:

FARS data are primarily used for reports of alcohol-related fatal crashes, but other detailed factors can be queried as well.

System Evaluation:

All data entered into FARS undergoes a thorough certification process.

Dataset Available:

The dataset is publicly available.

Data Release Policy:

FARS is a national database that is publicly available with no limitations.

Data Publications:

Traffic Safety Facts are produced annually by the NHTSA. Various query reports can be generated from hundreds of different datasets within the Fatality Analysis Reporting System (FARS) Encyclopedia.

Suggested Data Citation:

Fatality Analysis Reporting System. National Highway Traffic Safety Administration, [data years].

Forensic Science Division

Program Webpage for the Forensic Science Division

Data Contact:

Scott Larson, Administrator
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Sources of Information:

Data are collected on casework performed from all sections (Medical Examiner System, Toxicology, Biology, Chemistry, Latent Prints, and Firearms) within the Forensic Science Division.

Description of the Data:

These data include death investigation results, drug overdose, driving under the influence of drugs or alcohol, state probation/parole, traffic fatalities, drug prevalence, DNA testing on sexual assault cases, CODIS results, laboratory performance, and other components.

Strengths of the Data:

Strengths include a wide range of data that track laboratory operations in different disciplines. Many stakeholders from around the state are interested in these results.

Data Limitations:

Limitations include a delay while the testing of casework is in progress. In addition, there is a lack of ability to compare the death certification produced by coroners to the toxicology results in non-autopsied cases.

Specific Use of the Information:

Data is used to identify statewide trends in the forensic services provided. This can be used to identify issues within the state. Data is used by many different Montana government agencies (MDT, DPHHS, etc.) as well as federal agencies.

System Evaluation:

Most of the data produced are reviewed manually when possible to correct any information that was entered incorrectly.

Dataset Available:

Depending on the information, data go back anywhere from 2-10 years and are stored in an Excel format. Data requests are usually done by email or phone calls.

Data Release Policy:

All personal identifying information is deleted for all data that is released.

Data Publications:

The Forensic Science Division releases an Annual report in the 2nd quarter of the following year. In addition, the Medical Examiner System also releases a report by the 3rd quarter of the following year. These reports can be found on the DOJ website, or a request can be sent to slarson@mt.gov.

Suggested Data Citation:

Forensic Science Division Annual Report, Montana Department of Justice, [data years].

Hospital Discharge Data System

Program Webpage for the Hospital Discharge Data System

Data Contact:

Isaiah Reed, Epidemiologist
Montana Department of Public Health and Human Services
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isaiah.reed@mt.gov

Sources of Information:

The Montana Department of Public Health and Human Services (DPHHS) has a memorandum of agreement with the Montana Hospital Association (MHA) to receive a subset of inpatient admission (2000 onward) and emergency department visit (2010 onward) data elements based on the Uniform Billing 2004 form (UB-04). The MHDDS currently includes short stay non-Federal hospitals that participate with MHA. Large Montana hospitals all submit data annually to MHA, most critical access hospitals also submit data; this captures an estimated 85-90% of discharges in Montana, though the reporting facilities involved may fluctuate between years.

Description of the Data:

Inpatient and emergency department data include demographic elements, such as age, sex, race/ethnicity (2018 onward), as well as county and state of residence; health related elements, such as primary/principal and secondary/subsequent diagnosis codes (one primary and up to eight secondary), external cause codes (up to three E-codes), procedure codes (inpatient only), and Current Procedural Terminology codes (ED only); and billing elements, such as primary payer, total charges, length of stay, and discharge status.

ICD-9-CM coding was used through Sept 31, 2015, and ICD-10-CM coding replaced it beginning Oct 1, 2015. For most chronic conditions and communicable diseases, ICD-9-CM and ICD-10-CM coded admissions are comparable. Injury, substance use, and mental health admissions and ED encounters are not comparable. However, the Council of State and Territorial Epidemiologists and various partners have collaborated to provide standardized guidance for the use of ICD-10-CM medical administrative discharge data for injury and drug overdose surveillance.

Strengths of the Data:

Montana hospital discharge data are based on billing systems and have information on 85-90% of admissions and encounters within Montana. Hospital discharge data provide a unique surveillance tool

for measuring the burden of health-related conditions that traditionally lack formal registry or reporting mechanisms. In addition, hospital discharge data include charges, which describe the financial impact of certain conditions on Montana's healthcare system.

Data Limitations:

The MHDDS data sets do not contain patient identifiers. As a result, hospital discharges cannot be linked to other data sets, and the data cannot be de-duplicated if individuals are admitted more than once during a time interval of interest. Annual datasets are typically unavailable for six to seven months after the calendar year has finished. No interstate agreements exist for the exchange of data concerning Montana residents hospitalized or visiting the ED out of state. It does not include information from federal facilities, such as the Indian Health Service or Veterans Administration. It is generally recognized that there are significant issues with the collection of, and coding practices for, race and ethnicity within hospital discharge data. Some problems with these variables include fields often containing missing values, certain races often being misclassified as "other", the "declined" classification skewing overall representation, and discharge data values not aligning with the race/ethnicity values contained within census data. Additionally, hospital discharge data systems vary greatly from state to state in terms of mandatory or optional reporting, as well as the number of variable fields included (e.g. the number of diagnosis fields). These variations effect states' abilities to truly standardize surveillance definitions and methods for measuring the burden of health-related conditions while using discharge data.

Specific Use of the Information:

Hospital discharge data on inpatient and emergency department admission describe the burden of several diseases and conditions, including asthma, diabetes, cardiovascular disease, injury, abusive head trauma, and neonatal abstinence syndrome.

Hospital discharge data are used to measure the burden of many chronic diseases, particularly through the use of the Agency for Healthcare Research and Quality's Prevention Quality Indicators, behavioral health and substance abuse through the Council of State and Territorial Epidemiologists' Surveillance Indicators of Substance Abuse and Mental Health, and the CDC's Tools for Categorizing Injuries using ICD Codes.

System Evaluation:

Data is provided by CompDATA, MHA's data vendor, who does data cleaning. In addition, the MHDDS checks data for missing values and range from year to year. Because MHA collects the data, the MHDDS has limited ability to give feedback to hospitals.

Dataset Available:

Direct access to MHDDS data are only available to internal DPHHS employees; summary analysis is available to the general public and basic analysis can be performed using Montana's Indicator Based Information System (MT-IBIS). Inpatient admission data are available from 2000 forward; ED data are available from 2010 forward. Some data elements are available from certain timeframes forward, for example, external cause codes (E-codes) are only available from 2009 onward; race and ethnicity are only available from 2018 onward.

Data Release Policy:

Data access is available for internal DPHHS users only, after a data use agreement application has been completed, reviewed, and approved. However, all parties may request summary analysis from the Hospital Discharge Data System Epidemiologist. Data released to external parties or for publication purposes must comply with the Guidelines for the Release of Public Health Data Derived from Personal Health Information. Hospital confidentiality is protected in all data releases; DPHHS cannot release hospital specific data (or data that pertains to a specific hospital) without permission from that hospital.

Data Publications:

Surveillance and special reports are available on the MHDDS website.

Suggested Data Citation:

Montana Hospital Discharge Data System, [data years]. Office of Epidemiology and Scientific Support, Public Health and Safety Division. Montana Department of Public Health and Human Services. Data provided courtesy of participating MHA members.

NCHS Population Estimates

Program Webpage for the NCHS Population Estimates

Data Contact:

Isaiah Reed, Epidemiologist
Montana Department of Public Health and Human Services
(406) 444-6947
isaiah.reed@mt.gov

Sources of Information:

The National Center for Health Statistics releases bridged-race population estimates of the resident population of the United States for use in calculating vital rates. The bridged-race population estimates are produced under a collaborative arrangement with the U. S. Census Bureau. The bridging methodology is described in the report, United States Census 2000 Population with Bridged Race Categories, which was published in September 2003.

Description of the Data:

Population estimates by bridged race, age, sex, and county of residence from 1990 onward.

Strengths of the Data:

These highly detailed population estimates are used for calculating rates throughout the Public Health and Safety Division.

Data Limitations:

These data do not contain certain important demographic information, such as income and educational attainment.

Specific Use of the Information:

NCHS population estimates are used as standard denominators for nearly all public health datasets in the Public Health and Safety Division.

System Evaluation:

Data are provided by NCHS on public websites.

Dataset Available:

The dataset is available on MT-IBIS, as SAS files with formatting, or as a text file directly from NCHS.

Data Release Policy:

The data are public and can be released without any restrictions.

Data Publications:

NCHS population estimates are available on MT-IBIS.

Suggested Data Citation:

National Center for Health Statistics. Bridged-race intercensal estimates of the July 1, 1990-July 1, 1999; July 1, 2000-July 1, 2009 Postcensal estimates of the resident population of the United States for July 1, 2010-July 1, 2016 United States resident population by year, county, single-year of age, sex, bridged race, and Hispanic origin, prepared by the U.S. Census Bureau with support from the National Cancer Institute. Available on the National Vital Statistics System webpage as of April 24, 2004; Oct 26, 2012; June 27, 2018 (Note: Date varies with series).

Newborn Hearing Screening

Program Webpage for the Newborn Hearing Screening

Data Contact:

Lanny Wilbur, Data Coordinator
Montana Department of Public Health and Human Services
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Sources of Information:

Newborn screening information is collected directly by authorized individuals at Montana hospitals, contracted hearing screeners, midwives, and CSHS staff into a web-based application called HiTrack. Data has been collected since 2002 and the demographic information entered by the users is supplemented with the data available from Vital Statistics.

Description of the Data:

The data includes results of an initial inpatient hearing screen, the results of a later outpatient hearing screening (if necessary), and hearing evaluation results on all infants born in Montana. It also contains Critical Congestive Heart Disease (CCHD) Screening results, notes, and demographic data.

Strengths of the Data:

Hearing and CCHD screening is a legal requirement, and the hospitals must enter their results at least monthly. Since the screening data are matched to vital statistics data, which include all births in Montana, data within the last five years are very complete.

Data Limitations:

Demographic information prior to 2014 is not as complete, which can limit some reporting. For example, running an analysis of hearing loss in infants by location would work for recent years, but not in earlier years, due to a lack of an address in the older data.

Specific Use of the Information:

The counts and rates of babies screened, passed screening, and referred for diagnosis are reported and closely monitored. Each year, a deidentified summary is submitted to the CDC that includes detailed hearing screening results for Montana births.

System Evaluation:

Data entry for key fields is required, and drop-down menus for gender, race, education, dates, and other fields insure standard entries. Duplication of newborn entries can occur, but a de-duplication process is performed regularly. Other quality assurance checks are also done.

Dataset Available:

The deidentified summary submitted to CDC is also available to members of the public upon request. This data can be delivered in a variety of formats, including excel, text, and xml files.

Data Release Policy:

Data are released in compliance with Montana state law, as well as the policies of the Public Health and Safety Division.

Data Publications:

The CDC publishes statistics for all participating states, including Montana.

Suggested Data Citation:

Montana Department of Public Health and Human Services, Newborn Screening, [data years].

Occupational Health & Safety Surveillance Program

Program Webpage for the MOHSS Program

Data Contact:

Emily Healy, Epidemiologist
Montana Department of Labor & Industry
(406) 444-1722
emily.healy@mt.gov

Sources of Information:

The Montana Occupational Health & Safety Surveillance program (MOHSS) is funded by the Centers for Disease Control and Prevention/National Institute for Occupational Safety and Health (CDC/NIOSH). The MOHSS program conducts surveillance of non-fatal and fatal work-related injuries and illnesses in Montana, analyzes occupational health data, develops priorities for intervention based on high-risk work activities, and shares useful information to occupational health and safety stakeholders across Montana.

The MOHSS program is housed in the Employment Relations Division of the Montana Department of Labor & Industry. As a result, MOHSS has direct access to Montana workers' compensation claims data on work-related injuries and illnesses, as well as other labor and industry information. The MOHSS program uses many additional data sources to build the surveillance system, including data from the Montana Department of Labor & Industry, U.S. Bureau of Labor Statistics (BLS), Montana Department of Public Health and Human Services (DPHHS), National Academy of Social Insurance (NASI), National Council on Compensation Insurance (NCCI), and U.S. Department of Labor.

Description of the Data:

MOHSS data are obtained by directly contacting the proprietary program, or by using online public query systems.

The MOHSS program has been granted access to or receives summary statistics from several restricted data sources. These include Workers' Compensation Claims Data from the Montana Department of Labor and Industry; Behavioral Risk Factor Surveillance System data, Hospital Discharge data, Vital Records data, Central Tumor Registry data, and Adult Blood Lead Epidemiology and Surveillance data from the Montana Department of Public Health and Human Services; and Compensation Insurance data from the National Council on Compensation Insurance.

The MOHSS program also uses several public data sources. These include the Survey of Occupational Injuries and Illnesses, the Census of Fatal Occupational Injuries, the Geographic Profiles of Employment

and Unemployment, the Current Population Survey, and the Quarterly Census of Employment and Wages from the U.S. Bureau of Labor Statistics. These also include data from the American Association of Poison Control Centers, the National Academy of Social Insurance, the Occupational Safety and Health Administration, and the Mine Safety and Health Administration.

Strengths of the Data:

The purpose of the MOHSS program is to build a solid surveillance program that can be used to inform intervention and prevention strategies for the Montana workforce. The strengths of the MOHSS program are timely, multi-source surveillance and analysis of work-related injuries (non-fatal and fatal) to identify actionable risk factors. Another strength of the MOHSS program is our collaboration and effective communication with stakeholders across Montana.

Data Limitations:

The MOHSS data sources do not capture all occupational injuries and illnesses in Montana due to systemic underreporting of work-related injuries and exclusions in workers' compensation coverage for certain employment types. While the MOHSS program may not have an exact count of work-related injuries and illnesses, the combination of data sources allows the program to cast a wide net to capture as much information as possible on work-related injuries and illnesses in Montana. Specific data limitations for individual data sources can be obtained through the proprietary data set contact.

Specific Use of the Information:

MOHSS data are used to calculate occupational health indicators, including incidence rates, for timely monitoring of occupational health and safety issues in Montana, to communicate findings to industry and worker organizations (stakeholders), and to inform intervention and prevention activities in Montana. The data are also used to produce publications and educational materials on work-related injuries, illnesses, and fatalities in Montana and to fulfill data requests from internal and external agencies and organizations. The data are also used outside of Montana as part of multi-state data collaboration.

System Evaluation:

The process and results of the MOHSS program are evaluated through quarterly and annual progress reports to the Centers for Disease Control and Prevention (CDC). Data quality issues are routinely discussed and addressed within the MOHSS program and the Workers' Compensation Claims Assistance Bureau in the Montana Department of Labor & Industry.

Dataset Available:

MOHSS uses data from several public and restricted datasets. The MOHSS program can provide data in the form of written reports, Excel files, Text files, CSV files, or SAS datasets. For data requests related to Montana workers' compensation claims data, please contact the MOHSS program.

For data requests related to public data sets, please contact the MOHSS program, or the primary data set custodian. For data requests related to restricted data sets, please contact the primary data set custodian or program.

Data Release Policy:

MOHSS has direct access to Montana workers' compensation claims data and is equipped to perform data queries for specific inquiries. Other MOHSS program data is derived from data sets maintained by other entities, and any data release inquiries should be made directly to the custodians of those data sets. Confidentiality is maintained in all data releases by removing identifying information.

Data Publications:

Beginning in 2017, MOHSS publishes a quarterly newsletter and an annual epidemiology report. A new report on trends in occupational health indicators for Montana from 2004-2014 was released in early 2017. Additional relevant reports will be posted online after being finalized. Past publications are posted on the MOHSS webpage.

Suggested Data Citation:

Montana Occupational Health & Safety Surveillance Program (MOHSS). Montana Department of Labor & Industry, [data years].

Oral Health Program Basic Screening Survey

Program Webpage for the Oral Health Program

Data Contact:

Katie Glueckert, Program Coordinator
Montana Department of Public Health and Human Services
(406) 444-2660
katie.glueckert@mt.gov

Sources of Information:

The Montana Basic Screening Survey is a cross-sectional survey measuring oral health and access to dental services among third grade head start children. Data were collected through open mouth dental screenings based on the Association of State and Territorial Dental Directors Basic Screening Survey (BSS) Manual protocol and collected on paper screening forms. Parents were given the opportunity to opt out of the screening for their children. The head start survey conducted in 2016 included 582 children. The third grade survey conducted in 2014 included 1,862 children.

BSS survey data provide descriptive data for both children and adults in Montana through probability sampling. Data were collected based on standardized BSS protocol and stratified by urban/rural classifications and proportion of school population served by free and reduced lunch populations when available.

Description of the Data:

The data from these surveys measure prevalence of dental decay experience, untreated decay, and dental sealants. These outcomes can be used to estimate oral health and access to dental services among children in third grade and children in the Head Start program.

Strengths of the Data:

The information gathered through the BSS is useful for monitoring Montana's progress in accomplishing the Healthy People 2020 oral health objectives.

Data Limitations:

BSS data collection is not a thorough clinical examination and does not make clinical diagnoses.

Specific Use of the Information:

Montana BSS data was used by the Montana Oral Health Program to monitor the prevalence of dental decay and access to preventive dental sealants. Data are submitted to the Centers for Disease Control and Prevention (CDC) to be included in the National Oral Health Surveillance System.

System Evaluation:

Data analysis was conducted in consultation with the Association of State and Territorial Dental Directors (ASTDD). ASTDD assists states throughout the U.S. in sampling and methodologies in collecting and analyzing open-mouth dental screening data.

Dataset Available:

Data establish an estimate of state-wide prevalence through data briefs. Community-level data are shared only with participant schools when requested.

Data Release Policy:

State estimates are released but not individual or site-level data.

Data Publications:

Data briefs for third grade and Head start datasets can be found on the DPHHS Oral Health Program website.

Suggested Data Citation:

Montana Department of Public Health and Human Services, Basic Screening Survey, [data years].

Outbreak and Syndromic Surveillance

Program Webpage for Outbreak and Syndromic Surveillance

Data Contact:

M'liss Weisner, Epidemiologist
Montana Department of Public Health and Human Services
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Sources of Information:

Montana conducts syndromic surveillance, the process of identifying and tracking population health indicators before confirmed diagnoses are made, based on hospital emergency department visit data. These deidentified data are electronically transferred by hospitals to a database hosted by the CDC and made accessible to state health departments. Syndromic surveillance reporting is voluntary. Year 2015-2020 data for 36 Montana hospitals representing 85% of statewide emergency department visits are currently available.

Description of the Data:

MOSS (Montana Outbreak and Syndromic Surveillance) contains detailed information about emergency department visits at Montana hospitals by in-state patients. Fields include demographics (age, gender, race, ZIP code, county), dates of service, chief complaints, and discharge diagnoses.

Strengths of the Data:

MOSS includes over 85% of emergency department visits in the state of Montana. Access to symptoms of patients in emergency departments, before a diagnosis has even been confirmed, allows for detection and tracking of unusual levels of illness to determine whether a public health response is warranted.

Data Limitations:

Not all hospitals in Montana currently have data in MOSS, and visits by out-of-state patients are not included. Fields have varying levels of completeness, and diagnosis information is not always available. MOSS contains internal identification numbers but not personal identifiers such as SSN, insurance number, or patient name, which could be used to link to other data sets.

Specific Use of the Information:

Chief complaint and discharge code data are used to define and track syndromes, or particular illness types. GI, respiratory, influenza-like illness, and other syndromes are tracked weekly and monitored for any trends requiring a response or further investigation.

System Evaluation:

The CDC National Syndromic Surveillance Program assists with onboarding facilities and generates reports of facilities' data completeness and validity. When concerns are found, CDC staff, state epidemiologists, and the facilities work to correct and improve the accuracy and completeness of the data.

Dataset Available:

Summary reports or Excel data exports for calendar year 2015 or later are available upon request.

Data Release Policy:

Data are released in compliance with Montana state law, specifically according to the Government Healthcare Information Act. In addition, DPHHS follows the integrated security and confidentiality guidelines for reportable communicable diseases as mandated by the CDC as well as policies of the Public Health and Safety Division.

Data Publications:

Trend data for GI and respiratory syndromes are reported in the Montana Communicable Disease Weekly Update. Influenza-like illness data are included in the weekly Montana Influenza Summary.

Suggested Data Citation:

Montana Department of Public Health and Human Services, Syndromic Surveillance System, [data years].

Perinatal Hepatitis B Screening

Program Webpage for Perinatal Hepatitis B Screening

Data Contact:

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Sources of Information:

System data are based upon reports of all hepatitis B virus (HBV) positive lab results and the associated identifying information and demographics via electronic laboratory reporting transferred from laboratories into the Montana Infectious Disease Information System (MIDIS). Other MIDIS data are obtained from hepatitis B surface antigen (HBsAg) positive results from fax reports from out-of-state reference laboratories or local laboratories and hand entered into MIDIS by the perinatal hepatitis B coordinator or local health jurisdictions.

Women of childbearing age with HBsAg positive results are followed up with to determine if they are pregnant, and if so, assigned to local health departments for perinatal hepatitis B prevention case management. Case management data are obtained from the patient, the patient's healthcare provider, the delivery facility, and the infant's healthcare provider.

Montana Code Annotated mandates that women seeking prenatal care submit a blood sample for hepatitis B surface antigen status and requires laboratories to report all HBsAg positive results of pregnant women to local health departments (LHD) or the state perinatal hepatitis B coordinator.

The MIDIS surveillance system is Epidemiology and Laboratory Capacity (ELC) funded.

Description of the Data:

Reports of positive HBsAg tests on all prenatal patients are entered into the MIDIS system. The Immunization Program then obtains the demographic and clinical information from the local health department and enters the patient information into a restricted access registry. When the infant is born, the health department reports DOB, dates of hepatitis B immune globulin (HBIG) and hepatitis B vaccine administration, weight, and insurance status. Local health jurisdictions case-manage the infant to document completion of the hepatitis B vaccine series and the date and result of post-vaccination serology testing, including hepatitis B surface antibody (anti-HBs) and titer and hepatitis B surface antigen (HBsAg). Montana has a five-year average of 8 infants born to HBsAg positive mothers per year.

The Montana Immunization Program perinatal hepatitis B coordinator follows up with case managers from local health jurisdictions monthly for missing data. Montana has not had a case of perinatal hepatitis B. Perinatal hepatitis B prevention data is reported to the Centers for Disease Control and Prevention (CDC) via the Annual Immunization Progress Report.

Strengths of the Data:

The information surveys and monitors children born to hepatitis B positive mothers for possible disease transmission indications.

Data Limitations:

Information is limited to what is provided by laboratories, local health departments, primary care physicians, and birthing hospitals. Some cases may be missed due to no prenatal care.

Specific Use of the Information:

The data are used to monitor the prevalence of hepatitis B in the population of delivering mothers in Montana birthing hospitals to assure that infants at risk of perinatal hepatitis B transmission receive hepatitis B immune globulin and vaccine within 12 hours of birth to help prevent disease and to assure follow-up of appropriate laboratory testing to identify a case of perinatal hepatitis B.

System Evaluation:

The system is evaluated annually by a report submitted to the CDC. The report contains the number of births to HBsAg positive mothers, vaccination completion rates, and post-vaccination testing rates.

Dataset Available:

Summary data are available upon request.

Data Release Policy:

The current registry is a restricted access database housed on a server in Helena. Montana follows the integrated security and confidently guidelines for HIV, STD, viral hepatitis, and TB surveillance programs mandated by the CDC.

Data Publications:

Aggregate data are released to the CDC for publication in the Morbidity and Mortality Weekly Report (MMWR).

Suggested Data Citation:

Montana Department of Public Health and Human Services, Montana Infectious Disease Information System, [data years].

Poison Center Data System

Program Webpage for the Poison Center

Data Contact:

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Montana Department of Public Health and Human Services
(406) 444-4126
maureen.ward@mt.gov

Sources of Information:

DPHHS has contracted with the Rocky Mountain Poison and Drug Safety (RMPDS) in Denver, Colorado since 1983 to provide lifesaving medical advice and poison information to Montanans through a confidential toll-free 24/7 hotline (1-800-222-1222). Calls to the Poison Help line are managed and documented by healthcare professionals who have received specialized toxicology training. Calls are categorized either as "Exposure" or "Information", and are associated with poisons, including illicit drugs, pharmaceuticals, non-drug substances (cosmetics, cleaning products, pesticides, etc.), inhalants/fumes, plants, and more. Calls are most commonly placed by healthcare providers regarding a poisoning patient, or by the general public.

Description of the Data:

For human exposure calls, MPC data structure is 1 : Many (case : receptor), 1 : Many (receptor : substance). It is recommended that data be analyzed at the receptor level (receptor = 1 person exposed to poison(s)). Some of the available data elements are call information (exposure site, reason for exposure), caller information (relationship to patient, caller location), patient demographics, substance (broad category, product name, AAPCC generic code, formulation, active ingredients), exposure info (acuity, duration, amount, route, certainty, effects), information about case management (management site, therapy), medical outcomes, and toxic effects. The dataset also includes animal exposure calls as well as informational calls.

The NPDS data dictionary and AAPCC generic code list contain additional information.

Strengths of the Data:

A unique feature of poison control center case management is the use of follow-up calls to monitor case progress and medical outcome, which results in a robust and comprehensive dataset for exposure-related calls. The dataset includes all calls made to the MPC where the caller has a Montana zip code as

their location, enabling us to map the data by call location and time. The existence of a National data bank (NPDS) ensures that the data are standardized and nationally comparable.

Data Limitations:

MPC data does not represent poisoning incidence. It is limited by the level of awareness about the Poison Help line among the general public, first responders, and healthcare facility-based providers. We recommend also looking at more representative data sources in conjunction with MPC data.

Additionally, it has been difficult for DPHHS analysts to obtain raw datasets from RMPDS although they do send periodic reports of aggregate data.

Specific Use of the Information:

Poison control data can be used for regular reporting, ongoing surveillance, and identification of sentinel poisoning events. MPC submits de-identified case data to the National Poison Data System (NPDS) in near real-time.

System Evaluation:

The dataset is managed by RMPDC.

Dataset Available:

Annual reports for Montana are available from 2010-2018, and quarterly reports also available for 2018-2019. A SAS dataset for years 2004-2014 may be available in certain cases by contacting the DPHHS Injury Prevention Program Coordinator.

Data can also be requested directly from RMPDC or AAPCC.

Data Release Policy:

Data will be released in accordance with the PHSD Guidelines for the Release of Public Health Data Derived from Personal Health Information.

Data Publications:

The RMPDS website for Montana has "At A Glance" quarterly reports, and annual reports.

The AAPCC website also has annual reports.

Suggested Data Citation:

EMS & Trauma Systems Section, Montana Department of Public Health and Human Services, Montana Poison Center Data, [data years].

Pregnancy Risk Assessment Monitoring System

Program Webpage for the Pregnancy Risk Assessment Monitoring System

Data Contact:

Miriam Naiman-Sessions, Section Supervisor
Montana Department of Public Health and Human Services
(406) 444-5275
msessions@mt.gov

Sources of Information:

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a population-based surveillance system that collects information about maternal behaviors and experiences before, during, and just after pregnancy. PRAMS is a mixed mode surveillance system that uses mail and telephone surveys to collect data. A random sample of women who gave birth 3 months prior are selected from the live birth certificate files each month. Participation in the survey is voluntary and identifiable data are never reported. PRAMS is co-sponsored with states by the Centers for Disease Control and Prevention (CDC), and as of 2017, it is currently conducted in 47 states, Washington DC, Puerto Rico, and other US territories. The Montana Department of Public Health and Human Services (MT DPHHS) participated in a one-year point-in-time PRAMS study in 2002 and currently conducts PRAMS beginning in 2017. The mail survey data is collected and entered by MT DPHHS, and the phone data is collected by an outside contractor. The CDC performs the data cleaning and basic analysis and provides the final data set.

Description of the Data:

The PRAMS survey collects data about perinatal maternal behavior and experiences that may be associated with adverse birth outcomes. Data are collected on a variety of topics, including access to prenatal care, quality of prenatal care, insurance status, infant sleeping position, medical problems during pregnancy, delivery of the infant, government assistance, pregnancy intent, smoking, and oral health. Some demographic factors, including age and income level, are asked on the PRAMS survey while others, including race, marital status, and educational attainment, are ascertained from the birth certificate. The survey asks core questions that are asked by all states and each state is given the opportunity to add standard questions specific to their public health needs. In Montana, this allows us to prioritize data collection in a manner that is both insightful and beneficial to our residents and their health. In previous years, Montana has selected modules to examine topics such as preconception care, vaccination, car seat use, drug use, and reasons for induction and low risk Cesarean section. The data gathered from PRAMS are primarily utilized to obtain prevalence estimates that describe mothers' health, behaviors, and attitudes that cannot be obtained from the birth certificate. These results are then used to help guide program planning and implementation, as well as policy development.

Ultimately, this assists MT DPHHS and other partner organizations in their efforts to both improve and protect the health of all Montanans.

Strengths of the Data:

In Montana, PRAMS collects data on diverse public health topics from a large sample size (average 1,700 mothers). Data are weighted so results can be generalized to Montana's entire population of pregnant women. The PRAMS survey and the data that it produces also have the ability to add questions that reflect high priority or high concern areas for Montana, compare Montana's prevalence estimates to other states and the U.S. as a whole, track Montana's state-level progress towards Healthy People 2020 goals and objectives, produce prevalence estimates for a wide range of maternal and infant risk factors (PRAMS is the only source of data in the state of Montana), and obtain meaningful data on Montana's American Indian population through the PRAMS strategies employed to oversample this important population.

Data Limitations:

As with any data source, PRAMS data comes with a few key limitations. The data are self-reported and therefore susceptible to potential biases. PRAMS surveys are mailed based on address information collected from the birth certificate files and surveys are only printed in English and, as such, transient populations and non-English speaking populations are therefore more difficult to reach. The sample size is not large enough to produce county-level estimates. Fetal deaths, stillbirths, abortions, out-of-state births, and birth certificates with missing identification (i.e. mother's last name or mailing address) are excluded from the sample.

Specific Use of the Information:

PRAMS provides data that are not available from other sources about preconception, pregnancy, and the first few months after birth. The Montana DPHHS then uses the data to develop and evaluate programs, provide data for grant applications, identify emerging issues, support new legislative policies, and evaluate health disparities. PRAMS data can be found in the State Health Assessment, PRAMS annual reports, surveillance reports, and grant applications.

System Evaluation:

The MT PRAMS program and phone contractor adhere to quality control standards and protocols set forth by the CDC. Montana State University Institutional Review Board (IRB) and CDC IRB reviewed and approved all MT PRAMS protocol. Data collection and data entry are monitored for accuracy and adherence to protocol.

Dataset Available:

Yearly data are available two years after the survey year. Data are only available in SAS format. The availability of the most recent year of data will be dependent on the time of year and whether the dataset has been finalized and released to MT DPHHS from the CDC. Prevalence estimates will be made publicly available on the Montana Indicator Based Information System (IBIS). Data sets can be requested from MT DPHHS. Additional information regarding our data release policy is below. Analyzed data may also be requested through the PRAMS Coordinator.

Data Release Policy:

The PRAMS Coordinator will release data upon the receipt and review of the required data request form. Requests for data containing protected health information must be previously approved by an IRB committee. Data users are required to provide a copy of all printed and published materials that use Montana PRAMS data to the MT PRAMS program. Data users should not release unreliable data that are characterized by one of the following three attributes: (1) small sample size (n<50), (2) relative standard error > 30%, (3) half-width confidence intervals >10%. It is highly recommended that data users report 95% Confidence Intervals or Standard Errors for all estimates obtained from PRAMS data.

Data Publications:

When available, annual, surveillance, and special reports can be found on the MT PRAMS website.

Suggested Data Citation:

Montana Department of Public Health and Human Services (MT DPHHS) and Centers for Disease Control and Prevention (CDC). Pregnancy Risk Assessment Monitoring System (PRAMS) Data. Helena, MT: Montana Department of Public Health and Human Services, Public Health and Safety Division, [data years].

Prescription Drug Registry

Program Webpage for the Prescription Drug Registry

Data Contact:

Marcie Bough, Executive Officer, Montana Board of Pharmacy
Montana Department of Labor and Industry
(406) 841-2371
dlibsdmpdr@mt.gov

Sources of Information:

The Montana Board of Pharmacy is responsible for the operation and maintenance of the Montana Prescription Drug Registry (MPDR) (§37-7-1502, Montana Code Annotated (MCA)). The Board of Pharmacy is administratively attached to the Department of Labor and Industry. The MPDR was authorized by the Montana Legislature in 2011 (§37-7-15, MCA) and became functional in November 2012 as an online tool to provide a list of controlled substance prescriptions to health care providers to improve patient care and safety. The program may also be used to identify potential misuse, abuse, and/or diversion of controlled substances.

All pharmacies holding an active Montana license, except for Wholesale Drug Distributors, are required to report to the MPDR. They must submit detailed information on all controlled substances, Schedule II, III, IV, and V drugs, dispensed to Montana patients by close of the next business day after the date of dispensing (daily reporting) (Administrative Rules of Montana (ARM) 24.174.1704).

Description of the Data:

Pharmacies are required to submit prescription information for controlled substances, Schedules II, III, IV, and V, dispensed by the pharmacy to patients in Montana. Pharmacies licensed by the Board of Pharmacy as out-of-state mail-service pharmacies are also required to report to the MPDR. The prescription data reported by pharmacies includes information that identifies the patient and the prescriber, the pharmacy, the drug name, strength and dosage, refill information, and how the patient paid for their prescription.

Strengths of the Data:

The MPDR database contains three years of prescription history of controlled substances dispensed to patients in Montana.

Data Limitations:

Pharmacies holding an Institutional Pharmacy license are only required to report dispensed prescriptions that leave their premises in an outpatient capacity; they are not required to report controlled substances administered in the facility.

Direct access and use of MPDR data are limited to the measures outlined in statute (§37-7-1506 MCA). The Board of Pharmacy may release MPDR de-identified information in summary, statistical, or aggregate forms for educational, research, or public information purposes. In addition, MPDR information cannot be used for commercial purposes or civil actions. There are criminal and administrative penalties for inappropriate use of the MPDR (§37-7-1513 MCA).

The following Montana-licensed health care providers are authorized to access the online MPDR service by registering to view the prescription history of patients who are under their care or who have been referred to them for care: Physicians, Dentists, Naturopathic Physicians, Optometrists, Pharmacists, Physician Assistants, Podiatrists, and APRNs with a Prescriptive Authority endorsement; these licensees may also supervise delegates to search the MPDR on their behalf.

MPDR information is also available to any individual requesting a copy of their own prescription history from the MPDR as well as authorized representatives of Medicare, Medicaid, Tribal Health, Indian Health Services, and Veterans Affairs. Law enforcement officers may request data by submitting an investigational subpoena. Licensing board investigators may request information related to a health care professional subject to an active investigation regarding drug misuse or diversion.

Specific Use of the Information:

Along with the uses outlined in statue (§37-7-1506 MCA), public health analyses have been conducted to produce yearly information on prescription opioid rates from 2012-2019 by age and sex, as well as average daily morphine milligram equivalents (MME) by age and sex. Opioid prescriptions by type have also been analyzed by year. Secure data sharing and research is conducted through a Memorandum of Understanding between DPHHS and the Department of Labor and Industry.

System Evaluation:

Data submitted by pharmacies to the MDPR must follow these guidelines.

Dataset Available:

Summary data (opioid prescription rate by year, age, and sex; average daily MME by year, age, and sex; percentages of population on high and very high average daily MME by year, age, and sex) from 2012-2019 can be provided by filling out a data request form.

Other queries regarding the last 3 years of data must be made directly to the Board of Pharmacy. There are forms for law enforcement agencies, licensing board investigators, and individuals requesting personal records.

Data Release Policy:

Release of summary data follows DPHHS guidelines for suppressing cell counts with fewer than 5 observations for stratified data and not computing rates for less than 20 events.

Data Publications:

A recent data publication is Opioid Prescribing Practices in Montana, 2012-2017.

Suggested Data Citation:

Montana Department of Labor and Industry, Montana Prescription Drug Registry, [data years and/or title of report], [method and date of accessing the data].

Prevention Needs Assessment

Program Webpage for the Prevention Needs Assessment

Data Contact:

Will Gardner, Epidemiologist
Montana Department of Public Health and Human Services
(406) 444-4198
william.gardner@mt.gov

Sources of Information:

The Montana Prevention Needs Assessment (MPNA) is conducted bi-annually on even number years in school districts across the state. In addition, 38 other states have or are conducting this survey. The MPNA is developed and administered by Bach Harrison, LLC (a survey research and evaluation services firm) and the Montana Department of Public Health and Human Services – Addictive and Mental Disorders Division and has been administered throughout Montana since 1998. Schools can elect to participate in the survey, and participation is voluntary. Identifiable information is not collected. For schools agreeing to participate in the Montana survey, all students in grades 8, 10, and 12 are asked to complete the survey. Schools also have the option to have all students in grades 7, 9, and 11 participate if they so choose.

Description of the Data:

The MPNA collets data on risky behaviors associated with the use of alcohol, tobacco, and other drugs, such as school dropout, delinquency, and violence, that can result in injury or impede positive development among youth. The survey also collects information on risk and protective factors, which are attitudes and opinions research has shown to be highly correlated with these risky behaviors.

Strengths of the Data:

The MPNA has been administered state-wide in even-numbered years since 1998, and therefore, the State has ample trend data available at the county, region, and state levels (school and district-level data are protected from public use). The survey is offered as a census of grades 8, 10, and 12 (grades 7, 9, and 11 optional also). At a local level, MPNA data is an integral part of the science of prevention, and many districts and schools are encouraged to participate (though participation is not mandatory).

Another strength of the data is its relevance. In each MPNA administration, survey content is carefully considered to ensure that it is gathering relevant and helpful information. For example, when the survey started in 1998, mental health and suicide data were not gathered as they are in recent administrations.

The number of participants varies from year to year with the most recent administrations at 10,810 in 2016, 10,731 in 2014, 14,575 in 2012, and 17,506 in 2010 and an average of 13,000 over the last four cycles.

Data Limitations:

As the survey is voluntary, participation at the county-level can vary from year to year. The data are self-reported and therefore susceptible to potential biases.

Specific Use of the Information:

Bach Harrison (survey contractor) does not share data to be included in larger national datasets; however, Montana's data is included in Bach Harrison's "Bach Harrison Norm" calculations, which are designed to provide states with an average of other states participating in the Prevention Needs Assessment for comparison with state-level risk and protective factor scales.

Data is most commonly used for local, county, regional, and state-level reporting, needs assessment, grant proposals, and evaluation. As the survey gathers data on risk and protective factors (within the school, family, community, and peer/individual domains), substance use, antisocial behaviors, tobacco use, mental health/suicide, and other health behaviors, the data can be used and applied across many fields. School districts and schools use the data for prevention planning, mental health, and other health behavior needs assessment and evaluation, grant writing, and accreditation documentation. Within the prevention field, the data is most often used for needs assessment, evaluation, reporting, etc. Data is often used by researchers for targeted subject-based work and trend analysis.

System Evaluation:

Bach Harrison LLC, which has been the survey contractor since 1998, follows rigorous data cleaning processes to ensure that final data reported and included in the final datasets are clean, accurate, and reflect only honest participation. Surveys are carefully logged and attributed to the schools that returned the data and surveys are scanned using OMR scanners. In terms of data cleaning, Bach Harrison uses a rigorous system of checks and cleaning methods to ensure accurate reporting. Bach Harrison makes use of five validity checks to exclude dishonest participants. Surveys that indicate one or more of the following checks are eliminated from final analyses and reporting: 1) surveys that indicate "not honest at all" on the final survey question regarding honesty, 2) surveys which indicate an impossible grade/age response option combination, 3) surveys that indicate any use of a fictitious drug, 4) surveys that indicate an impossibly high combination/frequency of substance use in the past month, and 5) surveys that indicate higher past-month use than lifetime use.

Dataset Available:

Datasets are available for the following years: 1998, 2000, 2002, 2004, 2006, 2008, 2010, 2012, 2014, 2016, and 2018. SPSS is the format most commonly requested, though the datasets can also be requested in Excel, SAS, or Text format.

Data Release Policy:

Bach Harrison, survey contractor, advises the following for data release: 1) Grade-level findings with fewer than 20 honest participants per grade are strongly cautioned, particularly for risk and protective factor scale items. 2) Cell counts with fewer than 5 observations should not be reported for any demographics or other grouping. 3) All analyses should remove dishonest participants prior to reporting.

Data Publications:

Data for the Montana PNA can be found on the Montana Social Indicators website. Reports released prior to 2018 can also be accessed by contacting the MPNA epidemiologist.

Suggested Data Citation:

Montana Department of Public Health and Human Services, Prevention Needs Assessment, [data years].

School Health Profiles

Program Webpage for the School Health Profiles

Data Contact:

Susan Court, School Health Coordinator
Montana Office of Public Instruction
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scourt@mt.gov

Holly Mook, Coordinated School Health Director
Montana Office of Public Instruction
(406) 444-0773
hmook2@mt.gov

Sources of Information:

The School Health Profiles are a system of school-based surveys that help education and health agencies monitor the current status of school health education, physical education and physical activity, school health policies related to tobacco use prevention and nutrition, school-based health services, family and community involvement in school health, and school health coordination. The Montana Office of Public Instruction, through a cooperative agreement with the U.S. Centers for Disease Control and Prevention, conducts the Profiles survey biennially by administering questionnaires to school principals and health education teachers at the secondary school (grades 6-12) level. The Montana Profiles data collection occurs during the winter of even-numbered years (e.g., 2016, 2018, 2020), generally between February and March.

Description of the Data:

Profiles monitor the current status of school health education requirements and content, physical education and physical activity, practices related to bullying and sexual harassment, school health policies related to tobacco-use prevention and nutrition, school-based health services, family engagement and community involvement, and school health coordination. Profiles also provide data on sexual health education, safe and supportive school environments, sexual health services, health services for students with chronic conditions, supportive school nutrition environments, and comprehensive school physical activity programs. These data show the progress in the implementation of school policies and practices to help improve the health of school-aged youth.

Strengths of the Data:

All Montana secondary schools with an enrollment of at least 25 students are included in the sampling frame of the Montana Profiles every two years. The Profiles are conducted in February of even-numbered years, with some gathering of questionnaires extending into March. Profiles data are meant to be used by leaders and decision makers, especially in schools, school districts, and state education agencies to understand the gaps in policies and practices that can impact student health and academic performance. Identifying gaps in school health policies and practices supports local discussions and decisions about needed changes and monitors those changes over time. Used with CDC's Youth Risk Behavior Surveillance (YRBS) data, Profiles data can provide a powerful approach for decision makers to monitor the impact of their decisions over time. School-based surveillance, provided by Profiles, helps monitor health policies and practices and can guide future decision-making. Policymakers and community leaders can use Profiles data to promote awareness and bring the community together to address gaps in the health and education needs of students; develop policies, practices, and programs that protect and support student health and provide needed services; and inform the efforts of coalitions or task forces in local communities coordinating activities to prevent HIV, STDs, and pregnancy among youth.

Data Limitations:

Low response rate on either the principal's questionnaire or the health education teacher's questionnaire could result in unweighted data results. Profiles coordinator at the Montana OPI contacts all non-responding principals and health education teachers until their questionnaire is returned and/or weighted data are attained.

Specific Use of the Information:

The data results can be used to help assess the status of school health policies and programs in Montana. Profiles covers multiple topics that legislators, school board members, and district/state administrators find useful to their work. The data can be used to support recommendations for changes to policies and practices in secondary schools. Results can also be used to show the need for increased resources and improved professional development for teachers. The Profiles data results can be used to compare the strengths and weaknesses of Montana school health policies, practices, and health education implementation with other states.

System Evaluation:

The Profiles is a two-questionnaire system which asks school principals to report on topics regarding school health policies and practices and asks health education teachers to report on health education topic implementation, resource availability, and professional development.

Dataset Available:

Montana (statewide) datasets are available for further analysis by researchers from the CDC's website.

Data Release Policy:

The School Health Profiles data can be requested from the U.S. Centers for Disease Control (CDC) at the Profiles website by completing a Profiles Data Request Form.

Data Publications:

School Health Profiles trend analysis reports are available on the Montana Office of Public Instruction's Profiles website.

Suggested Data Citation:

Montana Office of Public Instruction, School Health Profiles, [data years].

State Unintentional Drug Overdose Reporting System

Program Webpage for the State Unintentional Drug Overdose Reporting System

Data Contact:

Todd M. Koch, Lead Vital Statistics Epidemiologist
Montana Department of Public Health and Human Services
(406) 444-1756
tkoch@mt.gov

Sources of Information:

Montana's Unintentional Drug Overdose Reporting System is an extension of MT-VDRS with additional data elements specific to drug overdoses. Data is abstracted from two primary sources for each event; the death certificate and medical examiner's or coroner's report.

Description of the Data:

Montana's Unintentional Drug Overdose Reporting System is a comprehensive look at specific types of overdose deaths covering all ages and settings. Items reported include basic demographics like sex, race, age, marital status – similar in content to the death certificate. Data elements which make this system unique include mental health and treatment details, relationship problems, life stressors (problems with finances, job, health, etc.), and toxicology results. Detailed information on the drug(s), drug history, route administered, emergency medical care, and locations where the event occurred complete this robust dataset.

Strengths of the Data:

Deaths are first ascertained using the death certificate and the associated ICD-10 code for the following underlying causes: unintentional drug overdose (X40-X44) and events of undetermined intent (Y10-Y14). Since deaths are required to be reported by law, this ensures capturing nearly 100% of these cases. MT-SUDORS works closely with the State Medical Examiner's office, and details from decedents receiving the benefit of autopsy and/or toxicology are included for all those meeting the case definition.

Data Limitations:

CDC requires MT-SUDORS cases to be completed no later than 12 months after the death. Therefore, annual data files that are complete and ready for analysis will lag by up to a year and a half from the

current calendar year. Since MT-SUDORS began collecting data in 2019, these data will not be available until sometime in 2021.

Like limitations on the completeness of the death certificate, data rely on information provided by the certifying physician, whether the decedent received the benefit of an autopsy or toxicology screening, and information documented in the law enforcement and/or coroner's report.

Specific Use of the Information:

MT-SUDORS provides enhanced statistics for a variety of state, federal, and local programs. It also provides data to assess the burden of drug overdose deaths and evaluate policies and programs that address these deaths.

System Evaluation:

Data are entered into the CDC's secure online web application, which performs validation checks during data entry. MT-SUDORS re-abstracts 5% of a random sample of cases for each complete data year. This ensures consistency in the abstraction process.

Dataset Available:

De-identified tabulated statistics are available to the public according to the department's data release policy. Data for research purposes is not currently available.

Data Release Policy:

All MT-SUDORS data are covered under the DPHHS Public Health and Safety Division data release policy. Data are suppressed when the event is fewer than five and rates are not calculated when the corresponding event is less than 20.

Data Publications:

No publications are currently available, but MT-SUDORS intends to regularly publish reports on selected drug overdose death topics at the earliest practical time.

Suggested Data Citation:

Montana Department of Public Health and Human Services, Montana Unintentional Drug Overdose Reporting System, [data years and/or title of report], [method and date of accessing the data].

Statewide Immunization Information System

Program Webpage for imMTrax

Data Contact:

Michelle Funchess, imMTrax Business Analyst
Montana Department of Public Health and Human Services
(406) 444-2969
mfunchess@mt.gov

Sources of Information:

imMTrax, Montana's Immunization Information System (IIS), is a free program administered by the Montana Department of Public Health and Human Services (DPHHS) containing immunization records for participating Montanans of all ages. imMTrax combines multiple immunization records from Montana healthcare providers (public and private), vital records, and parental "shot cards" to form one complete, electronically preserved record.

imMTrax is only accessed by health professionals, local public health, and school personnel for authorized purposes.

The primary purposes of imMTrax are to assist users in assessing individual immunization needs, determine compliance with school or childcare-entry vaccination requirements, and estimate vaccination coverage among a specific healthcare provider's practice.

Participation in imMTrax is voluntary. Patients or parents/guardians must provide consent for immunization information to be made accessible in imMTrax.

Description of the Data:

imMTrax collects demographic and immunization information from private and public healthcare providers, including hospitals, federally qualified health centers, local health departments, rural health clinics, Tribal and Indian Health Services, medical clinics, doctors' offices, and pharmacies.

The immunization information collected includes vaccination given, date administered, administering or submitting healthcare provider, trade name, lot number, lot expiration date, anatomical site and route of administration, and when applicable, Vaccines for Children (VFC) eligibility status.

The demographic information collected include patient name, date of birth, sex, mother's maiden name, address, phone number, race, and ethnicity.

Strengths of the Data:

imMTrax collects demographic and immunization information that may be updated over the lifespan of each participating Montanan. Participation by Montana healthcare providers continues to grow, resulting in more information being added to imMTrax.

Data Limitations:

imMTrax does not contain immunization information for all Montana residents because healthcare provider and patient participation in imMTrax is voluntary. Healthcare providers are not required to add immunization information to imMTrax. Patients or parents/guardians must provide consent for immunization information to be made accessible in imMTrax.

The accuracy of demographic or immunization information in imMTrax is dependent on correct entry by the healthcare provider submitting the information.

Specific Use of the Information:

imMTrax is only accessed by health professionals, local public health, and school personnel for authorized purposes.

imMTrax information may be used by healthcare providers to assess an individual patient's immunization history and current or future needs. Healthcare providers may also use imMTrax information to estimate vaccine coverage at their own practice. imMTrax can produce reports and other output for healthcare providers to determine which patients need immunization services.

School personnel or health professionals may use imMTrax to determine compliance with Montana school and childcare-entry requirements. The Montana School Certificate of Immunization (HES 101) for childcare and school entry can be obtained and printed from imMTrax.

imMTrax information may be used by DPHHS to estimate state-wide or other geographical immunization coverage rates.

Data Release Policy:

imMTrax is only accessed by and released to health professionals, local public health, and school personnel for authorized purposes. Data may also be released to patients or parents/guardians.

Data Publications:

imMTrax information, healthcare provider enrollment forms, and additional program information are available at the website.

Suggested Data Citation:

Montana Department of Public Health and Human Services, imMTrax, [data years].

Tobacco Quit Line Data System

Program Webpage for the Tobacco Quit Line

Data Contact:

Jennifer Floch, Cessation Specialist
Montana Department of Public Health and Human Services
(406) 444-5687
jennifer.floch@mt.gov

Sources of Information:

These data are collected from the Montana Tobacco Quit Line, which is a free, comprehensive tobacco cessation program. The Quit Line is operated by National Jewish Health and offers coaching services to quit tobacco by phone, through an interactive web portal, and by providing FDA-approved tobacco cessation medications. Data are collected via telephone or online intake surveys. Quit Line services are offered and available to all Montana adults (18+). Tailored programs exist for pregnant women and American Indian participants. A youth quit program launched in 2019 that provides cessation coaching to Montana youth (17 and under). Participation in all Quit Line programs is voluntary.

Description of the Data:

The Montana Tobacco Quit Line intake survey collects data from all participants on tobacco use history and frequency, quit attempts, certain chronic health conditions, health insurance status, and demographic factors, including age, gender, race, disability status, and more. All individual-level intake data are de-identified. Additionally, a follow-up phone survey is conducted six months after enrollment with individuals who consent and who were enrolled in multiple-call counseling. These follow-up data are used to calculate quit rates (at six months) overall and by various respondent characteristics. Montana Tobacco Quit Line data includes Montana residents only.

Strengths of the Data:

The Montana Tobacco Quit Line has been operating since 2004. The core questions on the intake survey for the Montana Tobacco Quit Line are adapted from the North American Quitline Consortium and are consistent with the quit line data reported by 48 other states, the District of Columbia, Guam, and Puerto Rico. Montana is required to report select data elements to the National Quitline Data Warehouse and the Centers for Disease Control and Prevention.

Data Limitations:

Quitline services nationwide are only utilized by 2-4% of all tobacco users. The intake questionnaire is lengthy and can be a deterrent for participants. Only 20-30% of participants who consent to the six-month follow-up survey end up completing the survey. It's possible those who have successfully quit tobacco are more likely to complete the six-month follow-up survey than those who are still using tobacco. All data from both the intake and the six-month follow-up survey rely on self-reported data and are susceptible to potential biases.

Specific Use of the Information:

Montana Tobacco Quit Line data are used to measure the number and type of tobacco users being served by the Montana Tobacco Quit Line and to improve Quit Line operations, service quality, and access. Summary reports from the intake surveys are generated every month, and an outcome report from the six-month follow-up survey is generated every year.

Select data are also reported to the North American Quitline Consortium (NAQC) and the CDC and are included as part of a national quit line dataset. These data are used to track changes in quit line services and utilization over time, allow for comparisons between state data and national data, provide answers to questions about quit lines that a single state cannot answer alone, and assist in promoting the development of best practices.

System Evaluation:

All individual-level data and program activity are collected, stored in, and reported from a custom Case Management System, QuitPro®. QuitPro is designed to require specific information for data entry and will notify the person completing the data entry if anything is missing. Agents are trained on data entry requirements and how to input an answer if the information is missing or incorrect. Agents search for duplicates prior to creating a new participant entry and use the USPS address validation for the participant address information.

Dataset Available:

Annual Intake Demographic Reports are available in PDF form for fiscal years 2012-2017. Complete intake data are available in excel from fiscal year 2018 forward. Annual Outcome Reports are available in PDF form for fiscal years 2013-current. To obtain Montana Tobacco Quit Line data or put in a data request, contact the MTUPP Cessation Specialist.

Data Release Policy:

The MTUPP Cessation Specialist will release data upon the receipt and review of a documented request. The demographic breakdowns, specifically in the Quit Line Outcome Reports often yield small sample sizes. Data users should interpret these counts and rates with discretion and should not use or publish unreliable data. Please follow DPHHS's Guidelines for the Release of Public Health Data.

Data Publications:

There are currently no Tobacco Quit Line publications available.

Suggested Data Citation:

Montana Tobacco Use Prevention Program, Montana Tobacco Quit Line data, [data years].

Trauma Registry

Program Webpage for the Trauma Registry

Data Contact:

Carol Kussman, Trauma Coordinator
Montana Department of Public Health and Human Services
(406) 444-4459
ckussman@mt.gov

Sources of Information:

All Montana health care facilities are required to report trauma patients to the State Trauma Registry, and the information required from them is outlined in Montana Administrative Rule 37.104.3014. The Trauma Registry was established in 1990, and data are available from 2003 forward.

Data are submitted electronically. Smaller volume facilities enter data directly into a web-based application on the centralized server, while larger facilities enter data into locally hosted software applications and upload their files to the centralized registry.

Description of the Data:

Each health care facility is responsible for reporting on trauma patients to whom they provided care if they meet the defined inclusion criteria (including out of state residents who are treated in a reporting facility). Inclusion criteria are reviewed and updated annually by system stakeholders. Trauma registrars at each health care facility collect, code, and enter data describing patient characteristics, injury characteristics (date, time, place, intent/manner, cause/mechanism of injury), prehospital information (response times, vital signs, interventions), details of the trauma team activation, referral information if the patient was an inter-facility transfer, emergency department/resuscitation details (ED arrival date/time and status, vital signs, labs, Post-ED disposition), providers (Type of provider, name, response time), procedures (ICD10 PCS codes, location, start and end date/time, physician), diagnosis (ICD10 CM diagnosis codes, AIS scores), outcome (Discharge date/time, status, and condition, complications, total ICU and Ventilator days, discharged/transferred to, billing data). The data is extracted from the medical record and EMS-run report.

Strengths of the Data:

State Trauma Registry data have high levels of completeness and data quality because health care facilities are legally required to report, and all cases are reviewed by the trauma coordinator at DPHHS.

Trauma registry data capture the whole process, from the injury incident to prehospital care to discharge. Additionally, trauma registry data are unique in that they include detailed physiological information (unlike other sources, such as hospital discharge data, which are based on the billing information).

Data Limitations:

The data in the registry are not population-based; it does not include all injured patients. It only captures the more severe patients that represent the "next level up" in care resources required, according to the inclusion criteria. Inclusion criteria may vary from state to state; therefore, Montana data may not be comparable with other states. The registry does not conduct patient follow-up; therefore, injury-related death or other functional outcomes are not available. In addition, patients who die before reaching the hospital are not included in the State Trauma Registry.

The variation between trauma registrars (such as different methods for estimating missing values), as well as staff turnover, may affect the data quality. Inconsistency of EMS data are also a challenge, since many of the variables depend on the hospital receiving a high-quality EMS report.

Specific Use of the Information:

The Trauma Registry data are used primarily for performance improvement to enhance the quality of patient care by using pre-identified audit filters. The Regional Trauma Advisory Committees (RTACs) and State Trauma Care Committee (STCC) review registry data and use it to guide their activities. Registry data are also used to identify opportunities for injury prevention. Selected data are submitted on a regular basis to the National Trauma Data Standard and the Trauma Quality Improvement Program.

System Evaluation:

There are validation checks built into the software/web version to help with quality control. Inconsistent or incomplete data are queried to the facility's trauma registrar based on review by the State Trauma Coordinator.

Dataset Available:

Data from 2003 forward can be requested via a data request form, and if approved, reports are run by the State office using Excel. Data from 1990 to 2002 are not currently available due to use of an old database system. These will be converted into a dataset so the data can be used in the future.

Data Release Policy:

Summary statistics are covered under the DPHHS Public Health and Safety Division data release policy. Data are suppressed when the event is fewer than five and rates are not calculated when the corresponding event is less than 20.

Data Publications:

Trauma Registry data was used in a 3rd Preventable Mortality Study completed in 2013, which has yet to be published. An annual Trauma Data Report is produced at the end of each year.

Suggested Data Citation:

Montana Department of Public Health and Human Services, Montana Trauma Registry, [data years].

Violent Death Reporting System

Program Webpage for the Violent Death Reporting System

Data Contact:

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Sources of Information:

Montana's Violent Death Reporting Systems consists of data collected on suicides, homicides, events of undetermined intent, unintentional firearm deaths, law enforcement involved deaths, and terrorism. Data is abstracted from three primary sources for each event; the death certificate, law enforcement record, and medical examiner's or coroner's report.

Description of the Data:

Montana's Violent Death Reporting System is a comprehensive look at all types of violent deaths, covering all ages and settings. Items reported include basic demographics like sex, race, age, marital status – similar in content to the death certificate. Data elements which make this system unique include mental health and treatment details, relationship problems, life stressors (problems with finances, job, health, etc.), and toxicology results. Detailed information on weapons, characteristics of the suspects, and locations where the event occurred complete this robust dataset.

Strengths of the Data:

Deaths are first ascertained using the death certificate and the associated ICD-10 code for the following underlying causes: suicide (X60-X84, Y87.0), homicide (X85-X99, Y00-Y09, Y87.1), event of undetermined intent (Y10-Y34, Y87.2 , Y89.9), intentional firearm deaths (W32-W34, Y86-mentioning firearms), legal interventions (Y35.0-Y35.4, Y35.6-Y35.7, Y89.0), and terrorism (U01-U03). Since deaths are required to be reported by law, this ensures capturing nearly 100% of these cases. MT-VDRS works closely with the State Medical Examiner’s office, and details from decedents receiving the benefit of autopsy and/or toxicology are included for all those meeting the case definition.

Data Limitations:

CDC requires MT-VDRS cases to be completed no later than 16 months after the death. Therefore, annual data files that are complete and ready for analysis will have up to a two-year lag from the current calendar year. Since MT-VDRS began collecting data in 2019, these data will not be available until sometime in 2021.

Like limitations on the completeness of the death certificate, the data rely on information provided by the certifying physician, whether the decedent received the benefit of an autopsy or toxicology screening, and information documented in the law enforcement and/or coroner's report.

Specific Use of the Information:

MT-VDRS provides enhanced statistics for a variety of state, federal, and local programs. It also provides data to assess the burden of violent deaths and evaluate policies and programs that address these deaths.

System Evaluation:

Data are entered into the CDC's secure online web application, which performs validation checks during data entry. MT-VDRS re-abstracts 5% of a random sample of cases for each complete data year. This ensures consistency in the abstraction process.

Dataset Available:

De-identified tabulated statistics are available to the public according to the department's data release policy. Data for research purposes is not currently available.

Data Release Policy:

All MT-VDRS data are covered under the DPHHS Public Health and Safety Division data release policy. Data are suppressed when the event is fewer than five and rates are not calculated when the corresponding event is less than 20.

Data Publications:

No publications are currently available, but MT-VDRS intends to regularly publish reports on selected drug overdose death topics at the earliest practical time.

Suggested Data Citation:

Montana Department of Public Health and Human Services, Montana Violent Death Reporting System, [data years and/or title of report], [method and date of accessing the data].

Vital Statistics Surveillance System

Program Webpage for Vital Statistics

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Sources of Information:

Information in the vital statistics system consists of six vital events that are required to be reported and maintained by law; live births, deaths, fetal deaths, induced abortions, marriages, and divorces. The Office of Vital Records (OVR) utilizes an electronic registration system for births, deaths, and fetal deaths.

Description of the Data:

For live births and fetal deaths, the electronic registration system collects identifying information; demographic data, including race, Hispanic origin, and education level of the parents; items related to the mother's previous pregnancy history; circumstances of the birth, such as plurality, birth weight, obstetric procedures, and abnormal conditions of the newborn; and medical risk factors, such as tobacco and alcohol use during pregnancy (and cause of death in the case of fetal deaths). Data are collected on all births and deaths that occur in Montana or that occur to a Montana resident out-of-state. For deaths, the system collects identifying information on the decedent; demographic data, such as address, age, sex, race, and occupation; circumstances of the death, such as date and place; the underlying cause of death; and the contributing causes of death. Deaths to infants less than one year of age are matched to their corresponding death certificates, and the resulting linked infant birth/death files contain all the data mentioned above from both the birth and death certificates. For marriages and divorces, the system collects identifying information on the spouses and the date and county of the event.

Strengths of the Data:

Vital events are required to be reported by law, ensuring nearly 100% registration. Unlike surveys, vital statistics are population-based. OVR has statistical datasets for births and deaths from 1954 to present and indexes of these vital events beginning in 1860. Fetal death data is available from 1989 to present, while linked infant birth/death records are available from 2008 to present.

Data Limitations:

OVR relies on other jurisdictions to transfer records of vital events that occur to Montana residents outside of the state. It is unlikely that Montana receives 100% of these out of state records, so state records may vary slightly from nationally published statistics.

Data is generally available six to nine months after the end of the previous calendar year. The delay is the result of waiting for out-of-state records, last minute edits, and data cleaning.

Much has been written on the completeness of vital records. The information contained on these certificates is limited by the person certifying the event, their access to medical/legal records, autopsy results, and information provided by relatives, friends, or witnesses.

Specific Use of the Information:

The Vital Statistics Analysis Unit (VSAU) provides birth and death statistics for a variety of state, federal, and local programs. It also provides data that can be used to assess the health of the population (i.e. infant mortality, leading causes of death, maternal health characteristics, or infant birth weight).

System Evaluation:

The electronic vital registration system provides edit checks as the user enters the information. Quality assurance checks are conducted on-going to ensure completeness.

Dataset Available:

Identifiable birth, death, and linked infant birth/death data are available to research institutions pending approval from the department. De-identified tabulated statistics are available to the public according to the department's data release policy. Data for research purposes and custom statistical analyses are subject to fees according to statute and administrative rule.

Data Release Policy:

All vital statistics are covered under the DPHHS Public Health and Safety Division data release policy. Data are suppressed when the event is fewer than five, and rates are not calculated when the corresponding event is less than 20.

Data Publications:

VSAU produces an annual report summarizing health outcomes from each of the vital records collected—birth, death, fetal death, induced abortion, marriage, and divorce. VSAU also produces surveillance reports on selected vital events and technical reports each year. All publications are available through the Vital Statistics Analysis Unit's webpage.

Suggested Data Citation:

Montana Department of Public Health and Human Services, Montana Vital Statistics Analysis Unit, [data years and/or title of report], [method and date of accessing the data].

Youth Risk Behavior Survey

Program Webpage for the Youth Behavior Risk Survey

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Sources of Information:

The Youth Risk Behavior Survey (YRBS) is administered by the Montana Office of Public Instruction through a cooperative agreement with the U.S. Centers for Disease Control and Prevention (CDC). The YRBS is a self-reporting student survey conducted biennially the last week of February in odd-numbered years in Montana high schools, middle schools and, non-public accredited and alternative high schools. The Montana YRBS dataset is obtained through a two-stage random sampling of public high schools and selected classes. Survey procedures are designed to protect students' privacy by allowing for anonymous and voluntary participation. Before survey administration, local parental permission procedures are followed. Students complete the self-administered questionnaire during one class period and record their responses directly on a computer-scannable answer sheet. Montana has attained weighted data YRBS results since the inception of the survey in 1991.

Description of the Data:

The Youth Risk Behavior Survey (YRBS) monitors six categories of priority health behaviors among youth and young adults: 1) behaviors that contribute to unintentional injuries and violence; 2) tobacco use; 3) alcohol and other drug use; 4) sexual behaviors that contribute to unintended pregnancy and sexually transmitted infections (STIs); 5) unhealthy dietary behaviors; and 6) physical inactivity. In addition, the YRBS monitors the prevalence of obesity and asthma and other priority health behaviors. Data reports are provided for several student sub-populations: American Indian students on or near a reservation, American Indian students in urban schools, high school students, grades 7-8 students, students attending alternative schools, students with disabilities, and students attending non-public accredited schools. Regional data are available for the nine regions of Montana. County data are available if the county has two or more schools represented by the data.

Strengths of the Data:

The Montana High School YRBS dataset is obtained through a two-stage random sampling of public high schools and selected classes. Survey procedures are designed to protect students' privacy by allowing for anonymous and voluntary participation. Before survey administration, local parental permission procedures are followed. Students complete the self-administered questionnaire during one class period and record their responses directly on a computer-scannable answer sheet. Montana has attained weighted data YRBS results since the survey's inception in 1991; thus, the data are representative of all students in grades 9-12 attending Montana high schools.

Data Limitations:

First, YRBS data are self-reported, and the extent of underreporting or overreporting of behaviors cannot be determined. Second, the school-based survey applies only to youth who attend school, and therefore are not representative of all persons in this age group. Finally, YRBS addresses only those behaviors that contribute to the leading causes of morbidity and mortality among youth and adults. However, school and community interventions should focus not only on behaviors but also on the determinants of those behaviors.

Specific Use of the Information:

Montana YRBS data are used widely to compare the prevalence of health risk behaviors among subpopulations and minority youth (e.g. Native American youth), assess trends in health behaviors over time, monitor progress toward achieving 21 national health objectives for Healthy People 2020 and one of the 26 leading health indicators, provide comparable state data, and help develop and evaluate school and community policies, programs, and practices designed to decrease health-risk behaviors and improve health outcomes among youth. Montana YRBS data are reported in the CDC's MMWR and can be used for comparison purposes among all other states.

System Evaluation:

The CDC's 2019 YRBS standard questionnaire contained 89 questions. This questionnaire was used as the starting point for the Montana questionnaire. States can add and/or delete questions from the standard questionnaire. The modified Montana questionnaire included 94 questions reflective of state health-risk behaviors and concerns. The Montana data has an error rate of +3%; with a higher than normal number of filters being applied for data cleaning. The answer sheets are scanned by Westat, the CDC's contractor for surveillance data processing.

Dataset Available:

The Montana High School raw datasets are available for further analysis through the CDC's website in various epi software programs. The various other reports (e.g., Regional, County, and School-Specific data) are available as reports.

Data Release Policy:

The YRBS Coordinator will release data upon the receipt of a signed data request agreement form. Datasets released will not include school identifiers. Upon completion of data analysis and reporting of findings using further analysis, the data user will furnish a copy of the printed or published material to the YRBS Coordinator.

The YRBS dataset can also be found in two file formats on the U.S. Centers for Disease Control and Prevention's (CDC) website for Data and Documentation.

Data Publications:

YRBS reports, special reports, regional data, and sub-reports of various student populations can be found on the Montana YRBS website.

Suggested Data Citation:

Montana Office of Public Instruction, Youth Risk Behavior Survey, [data years].