

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

Process:

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

The team identified desired outcomes for this assessment:

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

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

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

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

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

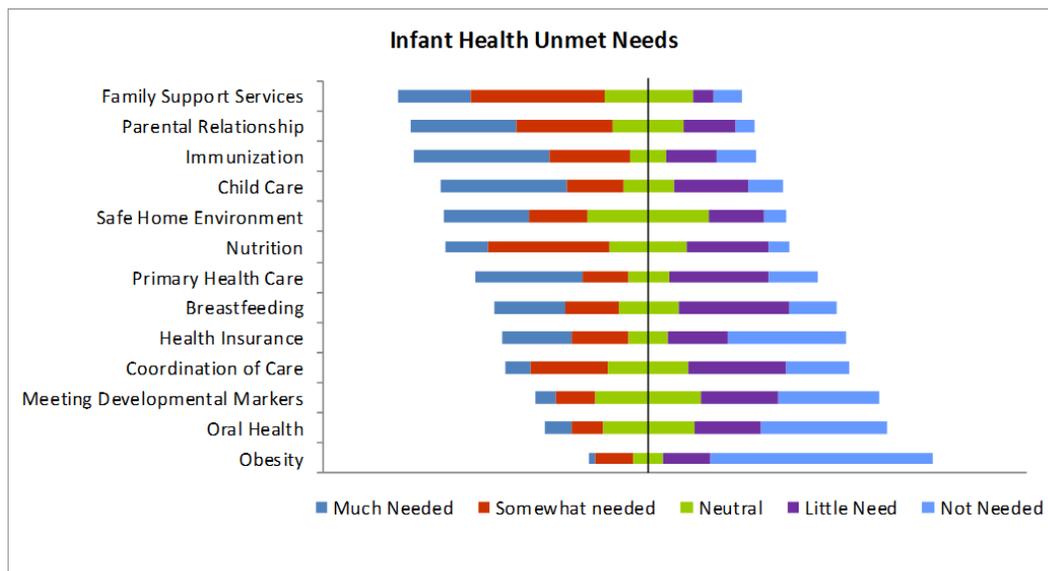
The seven questions were asked of each population category (PC):

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

The survey responses were evaluated by four main criteria:

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

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



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

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

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

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

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

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

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

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

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

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

Findings:

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

MCH Population Needs

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

Domain 1: Women's Maternal Health

- Low-Risk Cesarean Deliveries (NPM 2)

Domain 2: Perinatal/Infant Health

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

Domain 3: Child Health

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

Domain 4: Adolescent Health

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

Domain 5: CYSHCN

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

Domain 6: Cross-Cutting/Life Course

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

Overview of Health Status by MCH Population Group

Pregnant Women, Mothers and Infants:

A snapshot of the health status of Montana's pregnant women, mothers, and infants can be seen from certain common health indicators. The percent of women who smoked during pregnancy was 16.5% in 2013¹ while the 67.2%² of women reported a routine check-up in the past year. Sixty-nine percent of infants were born to women receiving prenatal care beginning in the first trimester.¹ The percent of Caesarian deliveries in low-risk first births was 23.4%.¹ The percent of infants who were ever breastfed in 2013 was 83.5%³. Seven percent of live births were of infants weighing less than 2,500 grams, while 9% of births were infants of less than 37 weeks gestation.¹

Children and Adolescents:

In the 2011/2012 National Survey of Children's Health, 26% of Montanan children were reported to live in a household where someone smokes, 58% of children without special health care needs had a medical home, and 23% of children had a preventive services visit⁴. Seventy-seven percent of children, ages 0-17, had a preventive dental visit in the last year (2011/2012).⁴ In 2013, the 4:3:1:3:3 immunization rate for children 19-35 months of age was 74.2%, and routine vaccination coverage for tetanus, meningococcal, and human papillomavirus vaccines in 13-17 year olds were 87%, 54%, and 51%, respectively⁵. In the same year, the rate of injury-related hospital admissions in children less than 19 years of age was 216.3 per 100,000⁶. The rate of birth to adolescents ages 15 -17 years, was 12.6 per 1,000 in 2013.¹

Children and Youth with Special Health Care Needs:

In the 2011/2012 National Survey of Children with Special Health Care Needs, 57% of Montana's children and youth with special health care needs were reported to have a medical home⁷. Ninety-nine percent of newborns received a blood spot screening before being discharged from the hospital. 100% of infants with a condition identified by newborn screening received timely follow-up, definitive diagnosis, and clinical management⁸. Twenty-eight infants born with a cleft lip and/or palate attended one of the CSHS regional Cleft Craniofacial clinics in calendar year 2014⁹.

State Health Needs Priorities

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

The SHIP action area categories are:

- Public Health Policies
- Prevention and Health Promotion Efforts

- Access to Care, Particularly Clinical Preventive Services
- Public Health and Health Care System

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

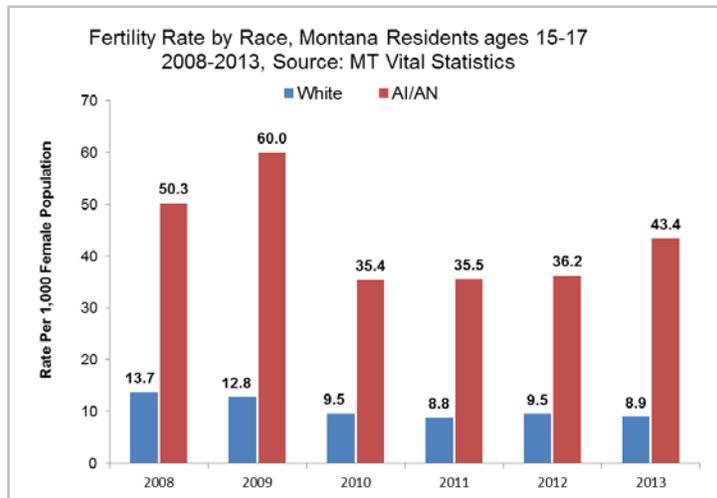
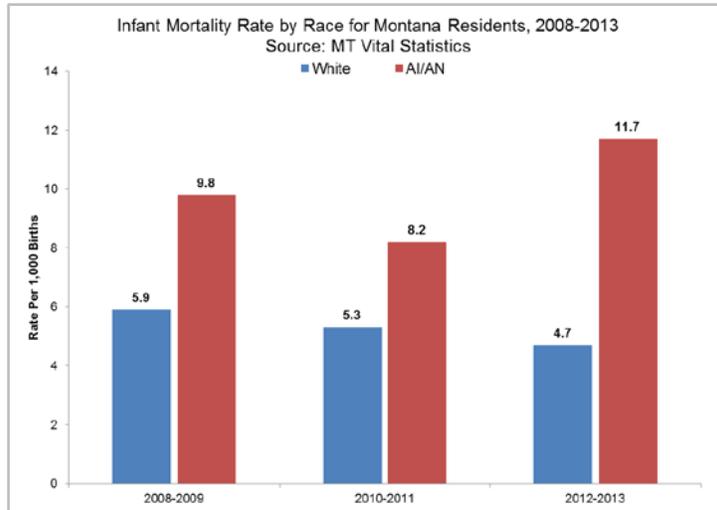
A complimentary source of guidance to the SHIP is the Public Health and Safety Division's Strategic Plan (PHSDSP), published in September 2013. The complete plan is included as an attachment. The 5-year plan includes seven key results areas:

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

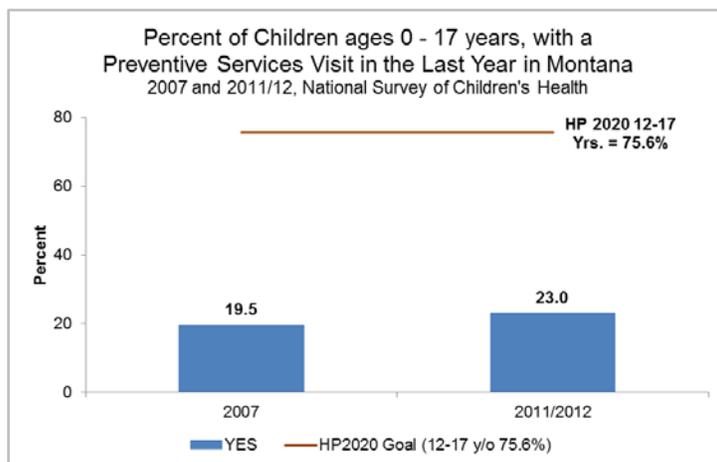
The main goals of the PHSDSP which effect external operations are:

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

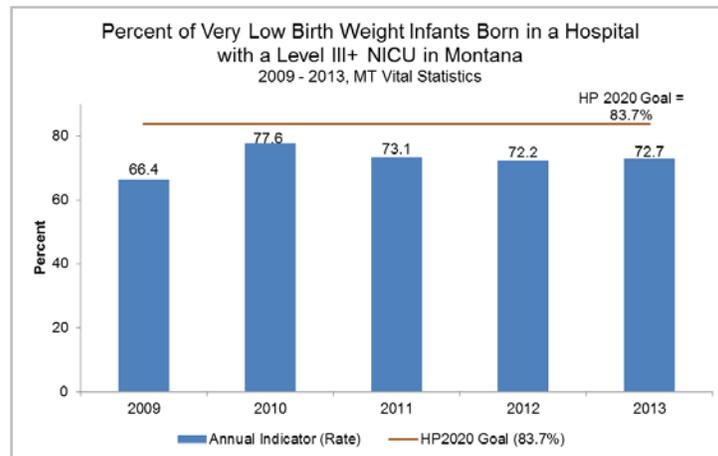
A detailed crosswalk is attached which shows the relationship between the SHIP, PHSDSP and Montana's MCHBG performance measure choices. For some performance measures, the choice was informed by rural geographic or minority American Native population health disparities. In these cases, the statewide data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



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



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



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

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

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

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

Rationale - Access to Care was consistently identified as a continuing health care need on the Needs Assessment Surveys and Key Informant Interviews. Montana faces a large geographic health disparity. Access to Care is a fundamental action area in five

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

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

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

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

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

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

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

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

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

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

Maternal / Women's Health:

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

Perinatal / Infant Health:

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

Children and Adolescents:

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

CYSHCN:

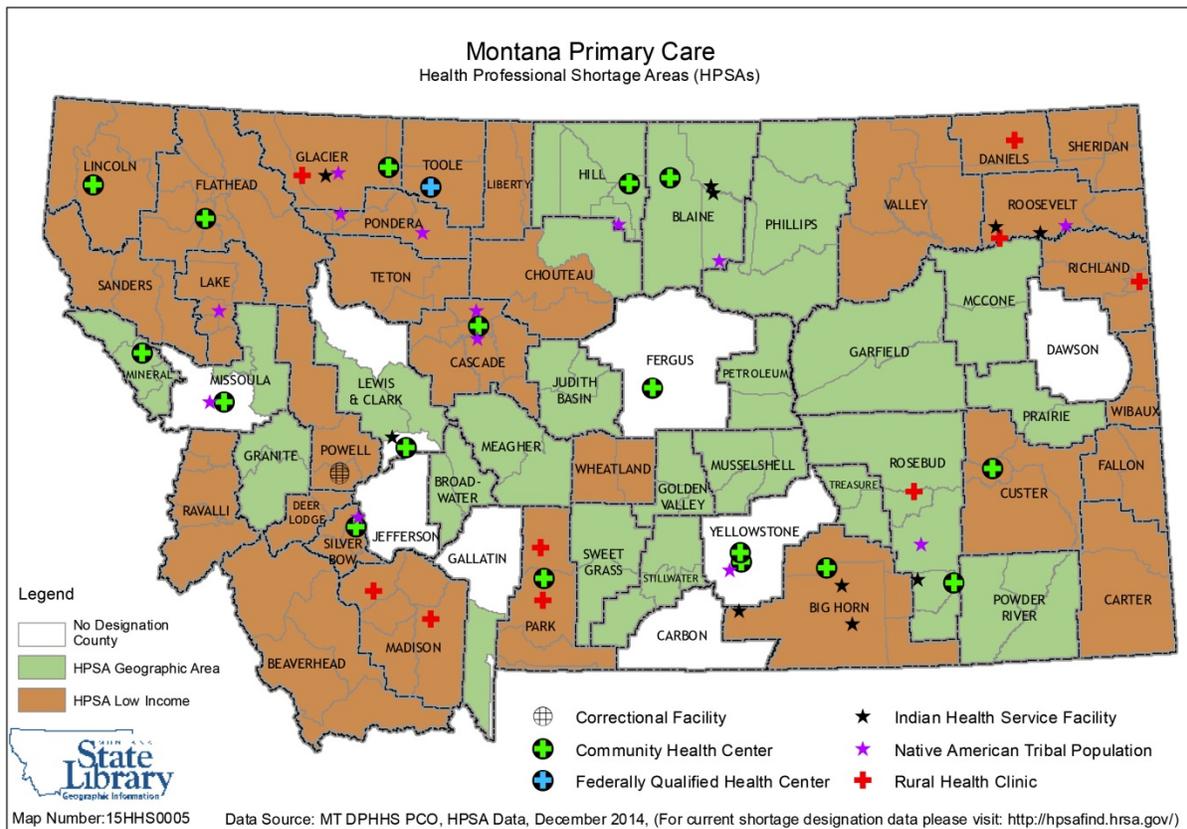
The main success for this domain in Montana is provided by CSHS regional specialty clinics. Nurse Coordinators connect to local resources as needed for providers and families. The challenge of access-to-care remains a large obstacle for many of these children. The CPHD surveys agreed that the top three CYSHCN health needs are also the top three unmet needs: specialty health care services, family support services and coordination of care. Access to

timely data for medical homes and transition services also presents a challenge. Data from the 2010 NS-CSHCN indicate the percent with a medical home is 57%; and for receiving services for transition to adult care it is 51.4%.

Life-Course / Cross-Cutting:

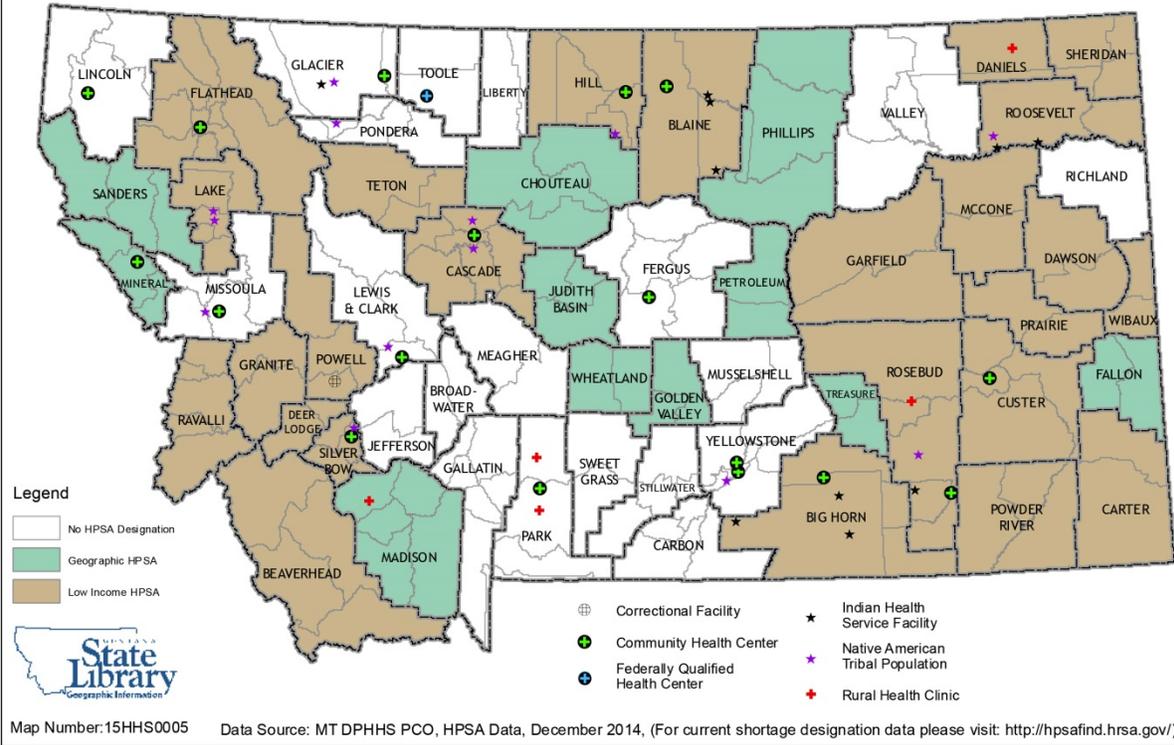
The 2015 Montana Legislature passed a Medicaid expansion bill which will improve adequate insurance coverage for those over the age of 18 years in the state. Affordable Care Act enrollment activities have already helped in this area including a jump in the numbers of children enrolled in Medicaid. Challenges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

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



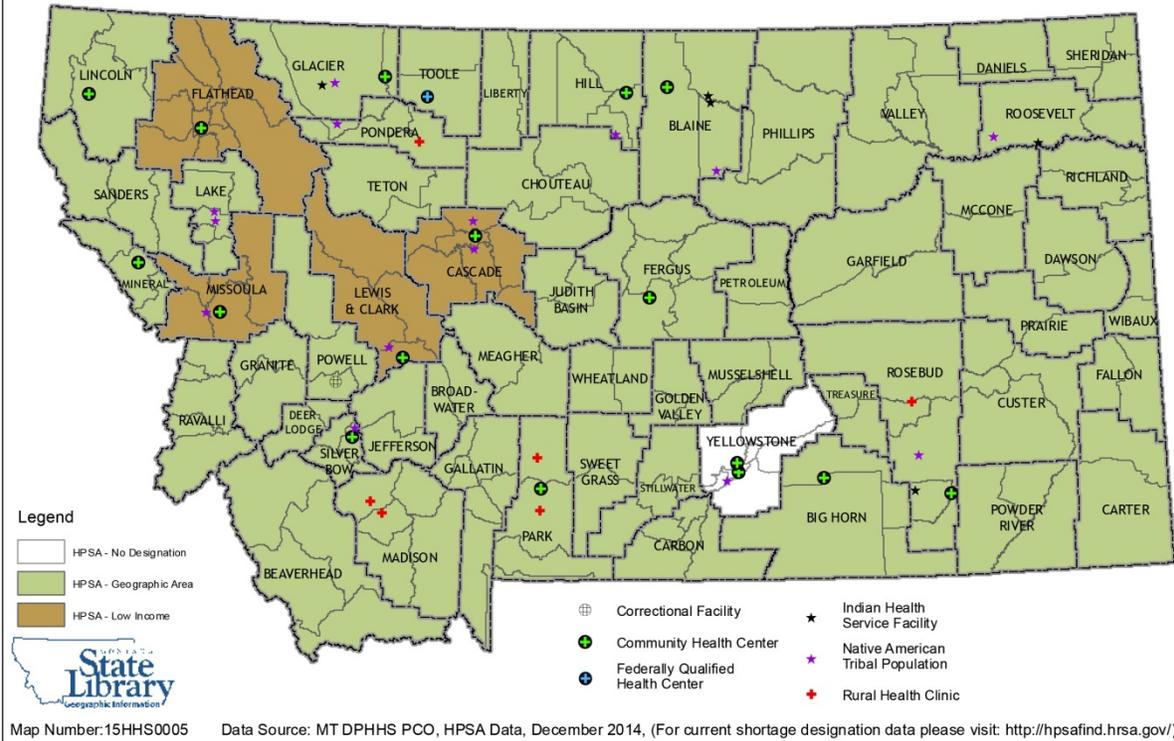
Montana Dental Care

Health Professional Shortage Areas (HPSAs)



Montana Mental Health Care

Health Professional Shortage Areas (HPSAs)



Analysis of Title V Program Approaches

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

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

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

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

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

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

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

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

Title V Program Capacity

Organizational Structure

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

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

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

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

The PHSD contains five bureaus and two offices:

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

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

The FCHB contains five sections:

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

The apportionment of Montana's MCHBG funding is:

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

Other programs within the FCHB are:

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

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

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

Organizational charts are included as attachments.

Agency Capacity

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Preventing tobacco use among young people;
- Eliminating exposure to secondhand smoke;

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

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

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

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

Domain 1: Women's Maternal Health

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

Domain 2: Perinatal/Infant Health

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

Domain 3: Child Health

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

Domain 4: Adolescent Health

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

Domain 5: CYSHCN

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

Domain 6: Cross-Cutting/Life Course

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

MCH Workforce Development and Capacity

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

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

Names and qualifications of senior management and program staff:

- Title V Director and FCHB Chief, Denise Higgins
Denise graduated in 1992 with a B.S. in Medical Technology from Illinois State University, in Normal, Illinois. From 8/1996 to 8/1997, she did MPH coursework at the University of Illinois in Springfield, Illinois. She obtained a certificate in Public Health Management from the University of Washington, School of Public Health in 2014.
Recent work history:
2000: Program Manager, Montana Birth Outcomes Monitoring System, DPHHS PHSD
2004: Laboratory Preparedness Coordinator, DPHHS PHSD Laboratory Services Bureau
2006: Manager, Newborn Screening and Serology Laboratory, DPHHS PHSD
2010: Bureau Chief, Family and Community Health Bureau, DPHHS PHSD
- MCH Supervisor, Ann Buss
Ann graduated in 2008 with a Masters of Public Administration from the University of Montana in Missoula, Montana. She completed 15 hours of coursework in the field of public health and earned a Maternal Child Health Certificate from the University of

Arizona and a Maternal Child Health Leadership Certificate from the University of South Florida. Recent work history:

1991: Employment and Training Counselor, Miles Community College

1997: Executive Director, HANDS Child Care Program

2003: CACFP Program Specialist, DPHHS, HCSD, ECSB

2006: Maternal Child Health Section Supervisor, DPHHS PHSD FCHB

- CSHS Supervisor, Rachel Donahoe
Rachel graduated in 2007 with a B.A. in Sociology from Carroll College in Helena, Montana. Recent work history:
2006: Program Manager, Helena Food Share
2007: Program Manager, God's Love Family Transitional Center
2008: Medicaid Program Officer, DPHHS
2011: Marijuana Program Manager, DPHHS
2014: Children's Special Health Services Supervisor, DPHHS PHSD FCHB
- MECHV Supervisor, Dianna Frick
Dianna Frick graduated in 1996 with a B.A. in International Affairs from Lewis & Clark College in Portland, Oregon. In 2003 she earned an MPH in Maternal and Child Health with a minor in Epidemiology from the University of North Carolina-Chapel Hill, in Chapel Hill, North Carolina. Recent work history:
2001: Consultant and Graduate Student Intern, IntraH/IntraHealth, University of North Carolina at Chapel Hill, Chapel Hill, NC
2003: Public Health Prevention Specialist, Centers for Disease Control and Prevention, Agency Assignment: Division of Sexually Transmitted Disease (STD) Prevention, Program Development and Support Branch, National Center for HIV, STD and TB Prevention (NCHSTP)
2004: Public Health Prevention Specialist, Centers for Disease Control and Prevention, Field Assignment: Family and Community Health Bureau, Montana DPHHS
2006: Maternal and Child Health Epidemiologist, Montana DPHHS
2008: Lead Maternal and Child Health Epidemiologist, Montana DPHHS
2012: Maternal and Early Childhood Home Visiting Section Supervisor, Montana DPHHS
- WIC Supervisor, Kate Girard
Kate graduated in 2009 with a B.S. in Nutrition/Dietetics from California Polytechnic State University in San Luis Obispo, California. In 2011 she earned a MHS from Western Carolina University in Cullowhee, North Carolina. Recent work history:
2009: Nutritionist I, Buncombe County Health Department, North Carolina
2011: Nutritionist II/WIC Director, Madison County Health Department, North Carolina
2013: Public Health Nutritionist/Nutrition Coordinator, DPHHS, FCHB WIC Section
2014: WIC Section Supervisor, DPHHS, FCHB WIC Section
- WMH MCH Program Specialist, Kimberly Koch

Kimberly graduated in 2001 with a B.S. in Health and Human Performance, Health Promotion Emphasis, from the University of Montana in Missoula, Montana. In 2012 she earned a Masters of Public Health from the University of Montana. Recent work history:
2003: Health Educator, Planned Parenthood of the Inland Northwest
2005: Health Education Specialist, DPHHS Montana Tobacco Use Prevention Program
2007: Health Education Specialist, DPHHS Women's and Men's Health Section
2013: MCH Program Specialist, DPHHS Women's and Men's Health Section

- PCO Manager, Julie Fife

Julie graduated in 2006 with a B.S. in Health Sciences from Boise State University, in Boise, Idaho. In 2012 she earned a MPH from the University of Montana, in Missoula, Montana and in 2013 a Certificate in Maternal and Child Health Epidemiology from the University of Arizona, in Tucson, Arizona. Recent work history:
2009: Program Coordinator, Women's Opportunity and Resource Development Center
2012 – Present: MPH Program Adjunct Faculty, University of Montana
2014 – Present: PCO Office Program Manager, DPHHS FCHB

- FICMMR Program Coordinator, Kari Tutwiler

Kari graduated in 1982 with a B.S. in Journalism from Utah State University in Logan, Utah. In 1983, she earned a M.A. in Speech Communications from Eastern Illinois University in Charleston. Recent work history:
2005: Marketing Officer, Children's Mental Health Bureau, MT State Department of Public Health & Human Services, Helena, MT
2010: Marketing Program Coordinator, Gesa Credit Union, Richland, WA
2012: Communications & Event Coordinator, Washington State University- Tri-Cities Campus, Richland, WA
2015: FICMMR Program Coordinator, DPHHS FCHB

- MCHBG Coordinator, Blair Lund

Blair graduated in 1981 with a B.S. in Business Administration, from Rocky Mountain College in Billings, Montana. In 2005 she earned an A.S. in Computer Science from the University of Montana's Helena College of Technology, in Helena, Montana. Recent work history:
1998: Executive Director, Helena Area Habitat for Humanity
2005: Medicaid Data Exchange Business Analyst, Affiliated Computer Services
2007: Internet Marketing Coordinator, Student Assistance Foundation
2010: CHIPRA Grant Coordinator, DPHHS Healthy Montana Kids
2012: ACA Exchange Grant Coordinator, MT Commissioner of Securities and Insurance
2013: MCHBG Coordinator, DPHHS FCHB

- Immunization Program Coordinator, Bekki Wehner

Bekki graduated in 1996 with a BS in Health and Human Development / Family Science from Montana State University, Bozeman, Montana. She went on to receive an

additional BS degree and teaching certification in Health Enhancement / Education from the same University in 2003. Current work history includes:

1997: Case Manager – Big Brothers Big Sisters of Helena

2004: Immunization Information System Coordinator – DPHHS, PHSD

2010: Immunization Information System Manager – DPHHS, PHSD

2012: IT Business Analyst – State of Montana

2014: Montana Immunization Section Supervisor – DPHHS, PHSD

- MCH Epidemiologist, Anya Walker

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

Recent work history:

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

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

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

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

2015: MCH Epidemiologist, DPHHS PHSD OESS

Culturally Competent Approaches to Service Delivery

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

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

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

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

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

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

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

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

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

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

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

Partnerships, Collaboration and Coordination

CSHS has State Implementation Grant specific collaborations with:

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

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

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

Endnotes:

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

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

³ Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity. Breastfeeding Report Card 2013. Retrieved From: <http://www.cdc.gov/breastfeeding/pdf/2013breastfeedingreportcard.pdf>.

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

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

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

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

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

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