2016 Annual Application
and
2014 Report

Maternal and Child Health Services Title V Block Grant

Montana

Submitted
on 9/23/2015

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I. General Requirements

I.A. Letter of Transmittal

Department of Public Health and Human Services

Public Health & Safety Division ♦ Family & Community Health Bureau ♦ 1400 East Broadway Rm A116 ♦

Helena, MT 59602-2953 ♦ Voice:406-444-4572 ♦ Fax: 406-444-2750

Steve Bullock, Governor

Richard H. Opper, Director

June 29, 2015

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

Dear Ms. Lawler:

Enclosed is Montana's application for the 2016 Title V Maternal and Child Health Block Grant (MCHBG) and 2014 Annual Report. MCHBG funding supports state and community-based programs and efforts aimed at improving the health of the maternal child health population.

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

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

Sincerely,

Denise Higgins, Bureau Chief
Family & Community Health Bureau

To contact DPHHS Director: PO Box 4210 ♦ Helena, MT 59604-4210 ♦ (406) 444-5622 ♦ Fax: (406) 444-1970 ♦ www.dphhs.mt.gov

I.B. Face Sheet

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

I.C. Assurances and Certifications

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

I.D. Table of Contents

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

I.E. Application/Annual Report Executive Summary

Montana Maternal and Child Health Block Grant – 2016 Annual Application & 2014 Report
Executive Summary

The annual application and report for Montana's Maternal and Child Health Block Grant (MCHBG) reflects implementation of "MCH Transformation 3.0", and the results of the 2015 5-Year Statewide Needs Assessment.

The Health Resources and Services Administration (HRSA) had three main aims for MCH Transformation 3.0.

- Reduce the reporting burden
- Maintain state flexibility
- Improve accountability and impact

Historically, the narrative reporting on MCHBG activities has been organized by performance measure. The format included *reporting* information on the previous and current fiscal years, and *application* information with plans for the upcoming fiscal year. This document contains the report information on the outgoing performance measures. It also contains action plans for the thirteen new performance measures going forward. The new narrative format requires that all this information is now organized into population domains. These domains are:

- Women's and Maternal Health
- Perinatal and Infant Health
- Child Health
- Children with Special Health Care Needs
- Adolescent Health
- Cross-Cutting / Life Course

The Title V MCHBG legislation also requires the state to prepare and submit a statewide Needs Assessment every five years which identifies the specific needs for:

- Preventive and primary care services for pregnant women, mothers and infants up to age one;
- Preventive and primary care services for children; and
- Services for children with special health care needs (CSHCN).

The findings of the State's Five-year Needs Assessment are expected to serve as the "drivers" in determining state Title V program priorities, and in developing a five-year Action Plan to address them. They should indicate where the

greatest needs are for its MCH and CSHCN populations, and support services which can have a direct positive impact.

Based on its priority needs, as identified in the Five-year Needs Assessment, Montana selected eight of 15 possible National Performance Measures (NPMs) for programmatic emphasis over the five-year reporting period. In addition, the state developed five State Performance Measures to address its unique needs, to the extent that they are not addressed by the NPMs.

The Montana Department of Public Health and Human Services' Maternal and Child Health (MCH) Section began work on the 2015 Needs Assessment in December 2013. The workgroup identified information gathered for the 2012 State Health Improvement Plan and the 2013 Public Health and Safety Division Strategic Plan as the foundation. In order to facilitate additional stakeholder input, an in-depth online survey was created for County Public Health Departments (CPHDs) and other MCH stakeholders to complete.

Performance measure selections were made based on highest need, the ability of CPHDs to impact health outcomes, and availability of data. In addition, the methodology included considering if the need was an area of responsibility for DPHHS' Public Health and Safety Division. For some priority needs the choice was also informed by rural geographic or minority population health disparities.

Analysis of all available 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

Montana's eight National Performance Measure choices are as follows:

- NPM 2 - Low-Risk Cesarean Deliveries
- NPM 4 - Breastfeeding
- NPM 5 - Infant Safe Sleep
- NPM 7 - Child Injuries
- NPM 10 - Adolescent Preventive Care
- NPM 12 - Transition Services
- NPM 13 - Oral Health
- NPM 14 - Pregnancy and Household Smoking

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

- SPM 1 - Access to Public Health Services
- SPM 2 – Family Support and Health Education
- SPM 3 – Immunization
- SPM 4 – CSHCN Medical Home

- SPM 5 - Teen Pregnancy Prevention

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

Accomplishments and Challenges by Domain -

Maternal / Women's Health:
When it comes to health care for women of childbearing age, Montana is currently experiencing a mixture of results based on specific type of care. Primary and preventive care percentages are moving in a positive direction, and it is hoped that the recent passage of Medicaid expansion will continue the trend. The more challenging areas are: mental health care, substance abuse care and prevention, STD/STI education and prevention, and reproductive / sexual health care. These were all identified in the top five unmet needs according to the online needs assessment surveys. Geographic disparities exist in connection to 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 was 91.2%. This compares well with the Healthy People 2020 (HP2020) goal of 81%. The FCHB will continue working to support this rate, and to improve the rate of babies which are exclusively breastfed at six months. 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 up to 250% of the FPL. One health indicator which the FCHB is working to improve is cesarean deliveries among low-risk first births. From 2009 – 2013 Montana's rate hovered right around the HP2020 goal of 23.9%, but that is still a fairly high percentage. The Infant Mortality CoIIN identified OB/GYN champions who are helping to make this a less acceptable practice.

Children and Adolescents:
There is a lot of crossover between the Children and Adolescent domains when addressing successes and challenges. While still high, the rate of non-fatal 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 has stayed constant at about 76.6 percent since 2007. The CPHDs identified oral health as the top children's unmet health need, which also pertains to the Life-Course domain. The highest ranked unmet health needs for adolescents on the surveys are mental health and substance abuse.

CYSHCN:
The main success for this domain in Montana is provided by the CSHS regional specialty clinic staff. Nurse Coordinators make the best use of resources for providers, families and CSHS staff. The challenge of access-to-care remains a large obstacle for many of these children. The 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 do a great deal to improve adequate insurance coverage for those over the age of 18 in the state. Affordable Care Act enrollment activities have already helped with success in this area, including a jump in the numbers of children enrolled in Medicaid. Challenges are found in 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 created SPMs 1 and 2 to address emerging needs which effect life-course health. SPM 2 also addresses the social determinants of health.

Over the next year, the FCHB will be working to identify evidence-based strategies for making progress on each of the eight National and five State Performance Measures. Realistic outcome goals will also be set, in order to gauge headway in achieving the desired health status and performance outcomes. Representatives from CPHDs and other stakeholders will be part a workgroup to advise on additional details for the state's MCHBG 5-Year action plan.

The rest of Montana's MCHBG 2016 Application and 2014 Report sections cover additional information and details on the key points introduced in this Executive Summary.

II. Components of the Application/Annual Report

II.A. Overview of the State

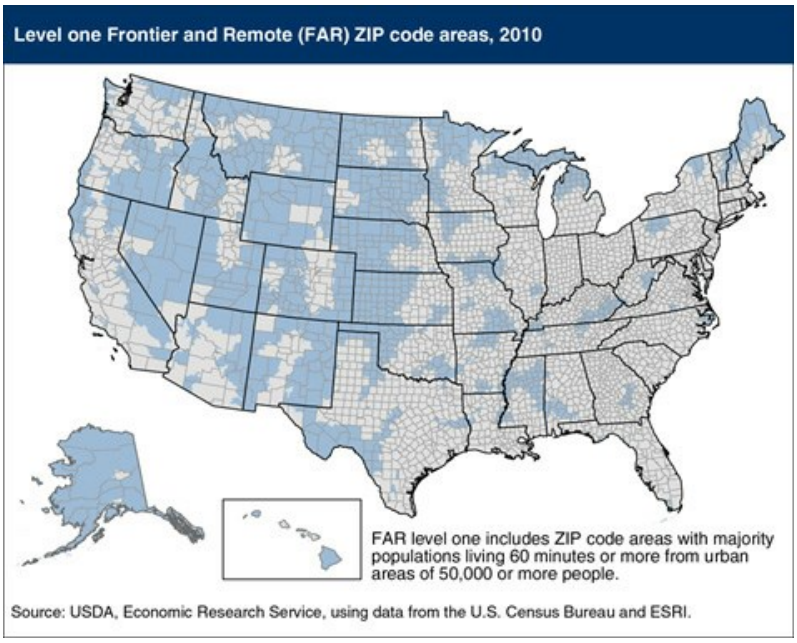
Montana Maternal and Child Health Block Grant – 2016 Application and 2014 Report
Overview of the State

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

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

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

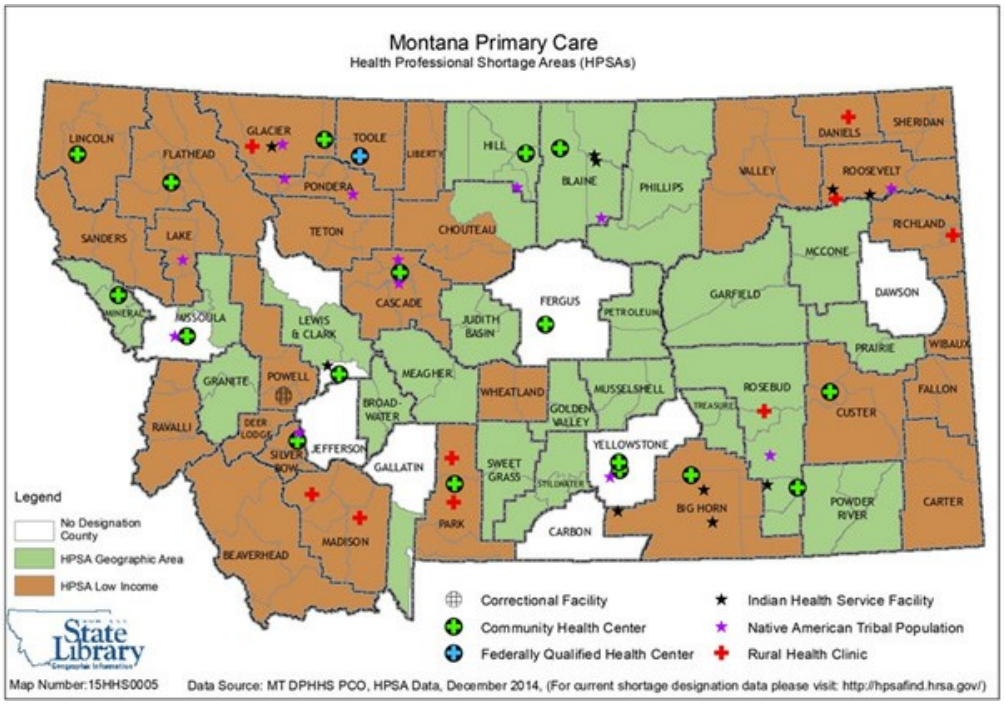
The definition of a Level 1 Frontier and Remote Area is that residents must have to travel at least 60 minutes to reach an urban area of 50,000 or more people. *Although 52 percent of the land area of the United States is in these areas, only 4 percent of Americans live there*. The map below shows the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



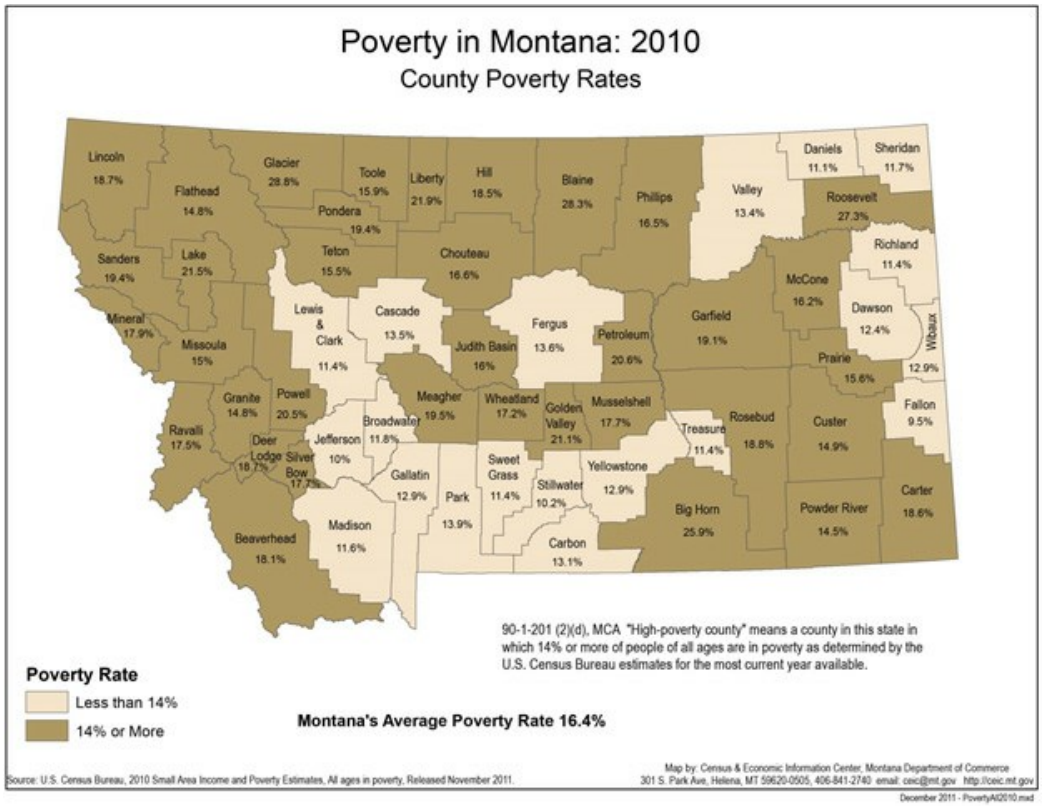
Montana's racial make-up is predominately white, with a 2013 census estimate at 89.5% of the population. American Indians make up the largest minority, at approximately 6.5%. The ethnic Hispanic or Latino population is only 3.3%, compared to 17.1% nationwide.

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

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



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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II.B. Five Year Needs Assessment Summary

II.B.1. Process

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

Process:

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

The team identified desired outcomes for this assessment:

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

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

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

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

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

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

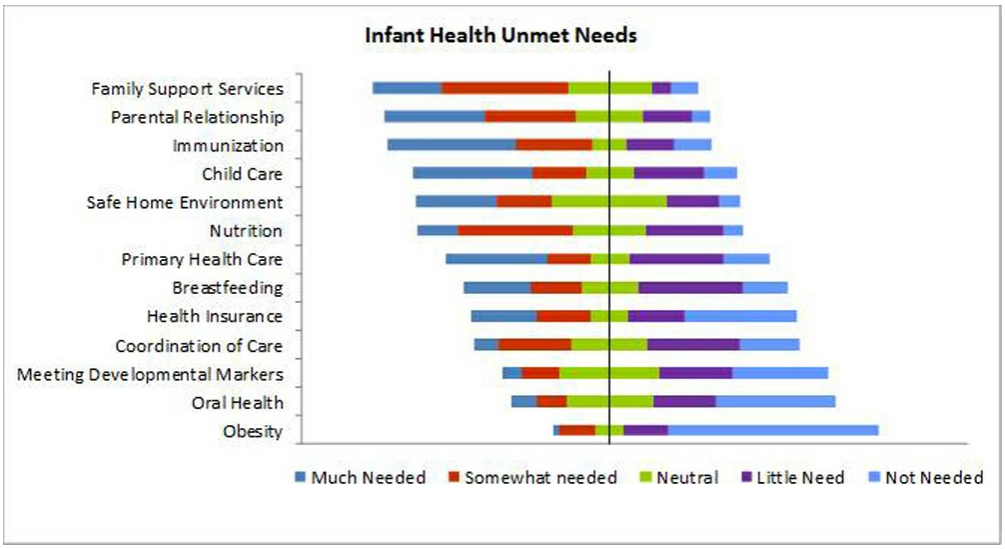
1. Please rank the following health needs, beginning with 1 as the most important (PC) health need in your service area.
2. Are there other common (PC) health needs in your service area, which were not listed in the previous question?

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

The survey responses were evaluated by four main criteria:

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

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



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

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

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

would it be and why?

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

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

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

Table 1: Montana Public Health and Safety Division Strategic Plan Assessment Customer Needs, Wants and Expectations

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

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

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

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

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

II.B.2. Findings

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

MCH Population Needs

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

- Low-Risk Cesarean Deliveries (NPM 2)

Perinatal/Infant Health:

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

Child Health:

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

Adolescent Health:

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

CYSHCN:

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

Cross-Cutting/Life Course:

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

II.B.2.a. MCH Population Needs

Overview of Health Status by MCH Population Group

Pregnant Women, Mothers and Infants:

A snapshot of the health status of Montana's pregnant women, mothers, and infants can be seen from certain common health indicators. The percent of women who smoked during pregnancy was 16.5% in 2013[1] 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 were someone smokes, 58% of children without special health care needs had a medical home, and 23% of children had a preventive services visit[4]. 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%, respectively[5]. In the same year, the rate of injury-related hospital admissions in children less than 19 years of age was 216.3 per 100,000[6]. 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 home[7]. Ninety-nine percent of newborns received a blood spot screening before being discharged from the hospital. 100% of infants with a condition identified by newborn screening received timely follow-up, definitive diagnosis, and clinical management[8]. Twenty-eight infants

born with a cleft lip and/or palate attended one of the CSHS regional Cleft Craniofacial clinics in calendar year 2014[9].

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.

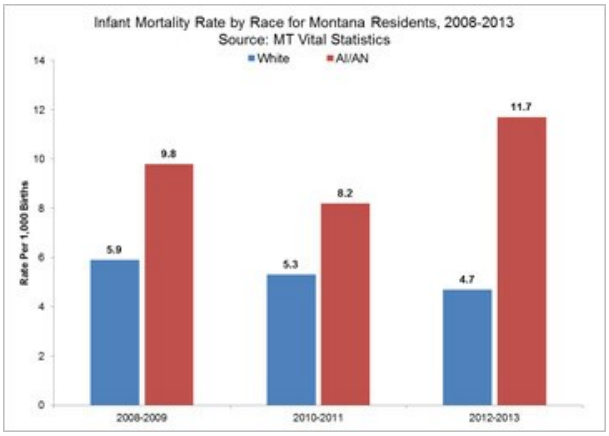
A complimentary source of guidance to the SHIP is the Public Health and Safety Division's Strategic Plan (PHSDSP), published in September 2013. The complete plan is included as an attachment. The 5-year plan includes seven key results areas:

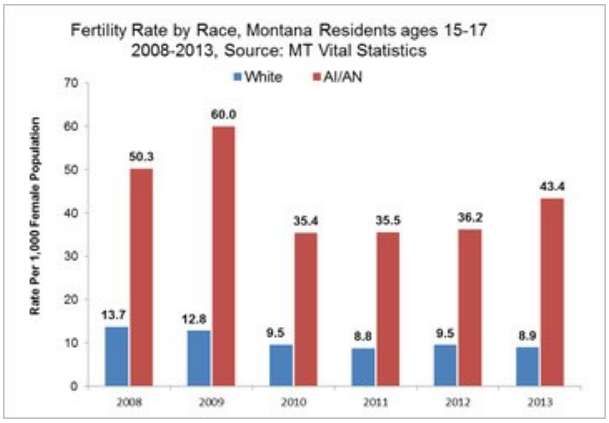
- Policy development and enforcement
- Disease and injury prevention and control, and health promotion
- Health services, particularly clinical preventive services
- Assessment and surveillance
- Public health and health care system
- Internal operations and workforce development
- Financial systems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

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

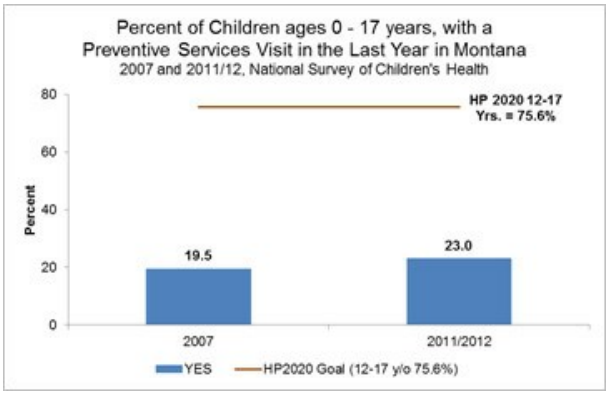
- Develop and support policies to promote and protect health
- Enforce public health laws and regulations to promote and protect health
- Implement evidence-based health promotion and prevention programs
- Promote health by providing information and education to help people make healthy choices
- Improve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

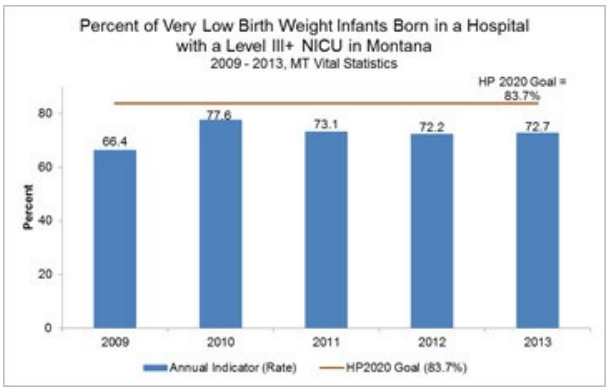




One indicator of geographic health disparity can be seen in the percent of children with a preventive services visit, as shown by the next graph:



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

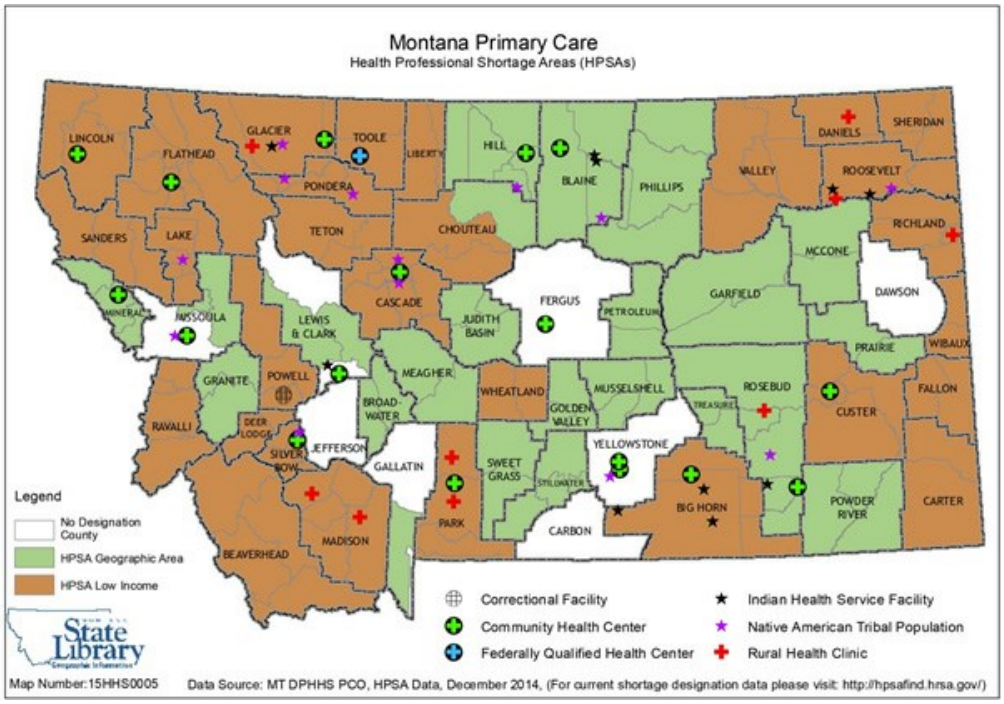
a less acceptable practice. Montana still falls below the HP2020 goal of 83.7% of Very Low Birth Weight infants born in a Level III+ NICU, presumably due to geographic disparities.

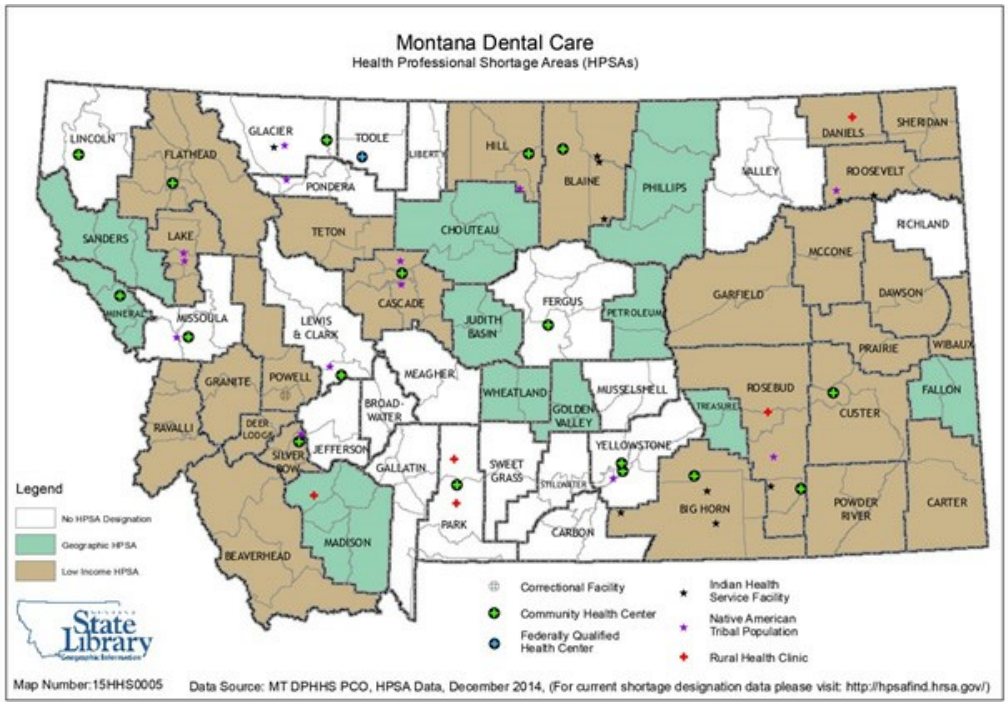
Children and Adolescents:
There is considerable crossover between the Children and Adolescent domains when addressing successes, challenges and health disparities. While still high, the rate of non-fatal childhood injuries has been declining. In 2008 the rate per 100,000 among children aged 0-19 was 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.

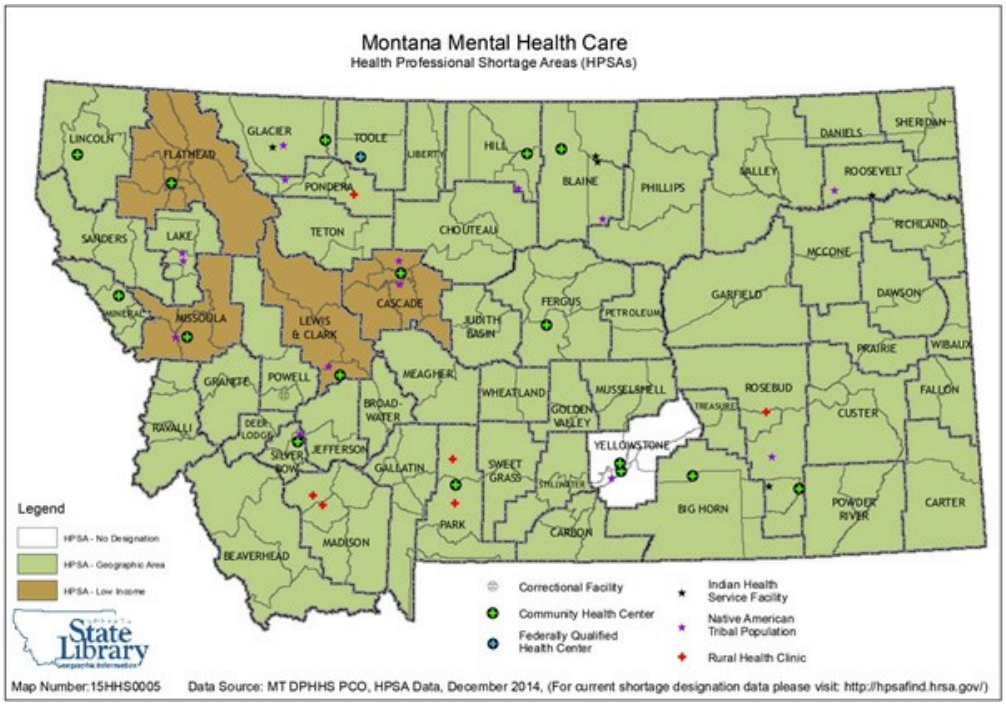
CYSHCN:
The main success for this domain in Montana is provided by CSHS regional specialty clinics.
Nurse Coordinators connect to local resources as needed for providers and families. The challenge of access-to-care remains a large obstacle for many of these children. The CPHD surveys agreed that the 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 Primary Care
Health Professional Shortage Areas (HPSAs)
LINCOLN
FLATHEAD
GLACIER
TOOLE
LIBERTY
HILL
BLAINE
PHILLIPS
VALLEY
DANIELS
SHERIDAN
ROOSEVELT
PONDERA
TETON
CHOUTEAU
SANDERS
LAKE
RICHLAND
MCCONE
MINERAL
MISSOULA
LEWIS & CLARK
CASCADE
JUDITH BASIN
FERGUS
PETROLEUM
GARFIELD
DAWSON
PRAIRIE
WIBAUX
GRANITE
POWELL
MEAGHER
WHEATLAND
MUSSELSHELL
ROSEBUD
FALLON
BROAD-WATER
GOLDEN VALLEY
TREASURE
CUSTER
RAVALLI
DEER LODGE
SILVER BOW
JEFFERSON
GALLATIN
YELLOWSTONE
SWEET GRASS
STILLWATER
BIG HORN
POWDER RIVER
CARTER
PARK
CARBON
MADISON
BEAVERHEAD
Legend
No Designation County
HPSA Geographic Area
HPSA Low Income
Correctional Facility
Community Health Center
Federally Qualified Health Center
Indian Health Service Facility
Native American Tribal Population
Rural Health Clinic
State Library
Map Number:15HHS0005
Data Source: MT DPHHS PCO, HPSA Data, December 2014, (For current shortage designation data please visit: http://hpsafind.hrsa.gov/)


Montana Dental Care
Health Professional Shortage Areas (HPSAs)
LINCOLN
FLATHEAD
GLACIER
TOOLE
LIBERTY
HILL
BLAINE
PHILLIPS
VALLEY
DANIELS
SHERIDAN
ROOSEVELT
PONDERA
TETON
CHOUTEAU
SANDERS
LAKE
RICHLAND
MCCONE
MINERAL
MISSOULA
LEWIS & CLARK
CASCADE
JUDITH BASIN
FERGUS
PETROLEUM
GARFIELD
DAWSON
PRAIRIE
WIBAUX
GRANITE
POWELL
MEAGHER
WHEATLAND
MUSSELSHELL
ROSEBUD
FALLON
BROAD-WATER
GOLDEN VALLEY
TREASURE
CUSTER
RAVALLI
DEER LODGE
SILVER BOW
JEFFERSON
GALLATIN
YELLOWSTONE
SWEET GRASS
STILLWATER
BIG HORN
POWDER RIVER
CARTER
PARK
CARBON
MADISON
BEAVERHEAD
Legend
No HPSA Designation
Geographic HPSA
Low Income HPSA
Correctional Facility
Community Health Center
Federally Qualified Health Center
Indian Health Service Facility
Native American Tribal Population
Rural Health Clinic
State Library
Map Number:15HHS0005
Data Source: MT DPHHS PCO, HPSA Data, December 2014, (For current shortage designation data please visit: http://hpsafind.hrsa.gov/)



II.B.2.b Title V Program Capacity

Analysis of Title V Program Approaches

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

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

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

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

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

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

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

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

The workflow to issue contracts for the MCHBG in Montana begins in January. Upcoming program changes are incorporated into new contract and reporting documents in anticipation of regional trainings for the counties in March. The counties fill out an extensive pre-contract survey in April, selecting their performance measures and letting the state program know about their planned activities. They do their work and reporting based on the state fiscal year, which starts on July 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.

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

Title V Program Capacity

Organizational Structure

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

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

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

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

The PHSD contains five bureaus and two offices:

- Financial Services and Operations

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

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

The FCHB contains five sections:

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

The apportionment of Montana's MCHBG funding is:

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

Other programs within the FCHB are:

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

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

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

Organizational charts are included as attachments.

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

Agency Capacity

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

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

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

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

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

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

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

The *Maternal and Early Childhood Home Visiting (MECHV)* Section supports a majority of MCH services. Staffing includes an epidemiologist and nurse consultant. Contracts cover a network of 84 home visitors. There are 19 Best Beginning Coalitions across the state which act as home visiting advisory groups. The past four years have seen an

increase in program capacity to over 900 clients. Funding is from three main sources: state general fund and tobacco trust settlement of $652,892; Maternal, Infant, and Early Childhood Home Visiting federal funding of $1 million annually for service delivery, and one-time federal expansion grants of $5.7 million and $5.2 million.

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

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

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

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

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

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

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

All 56 Montana counties have federally designated Health Professional Shortage Areas (HPSA) or Medically

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

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

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

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

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

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

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

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

and sustaining effective immunization strategies.

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

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

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

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

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

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

Women's Maternal Health:

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

Perinatal/Infant Health:

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

Child Health:

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

Adolescent Health:

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

CYSHCN :

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

Cross-Cutting/Life Course:

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

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

MCH Workforce Development and Capacity

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

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

Names and qualifications of senior management and program staff:

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

- MCH Supervisor, Ann Buss -
  Ann graduated in 2008 with a Masters of Public Administration from the University of Montana in Missoula, Montana. She completed 15 hours of coursework in the field of public health and earned a Maternal Child Health Certificate from the University of Arizona and a Maternal Child Health Leadership Certificate from the University of South Florida. Recent work history:
  1991: Employment and Training Counselor, Miles Community College
  1997: Executive Director, HANDS Child Care Program
  2003: CACFP Program Specialist, DPHHS, HCSD, ECSB
  2006: Maternal Child Health Section Supervisor, DPHHS PHSD FCHB

- CSHS Supervisor, Rachel Donahoe -
  Rachel graduated in 2007 with a B.A. in Sociology from Carroll College in Helena, Montana. Recent work history:
  2006: Program Manager, Helena Food Share
  2007: Program Manager, God's Love Family Transitional Center
  2008: Medicaid Program Officer, DPHHS
  2011: Marijuana Program Manager, DPHHS
  2014: Children's Special Health Services Supervisor, DPHHS PHSD FCHB

- MECHV Supervisor, Dianna Frick -
  Dianna Frick graduated in 1996 with a B.A. in International Affairs from Lewis & Clark College in Portland, Oregon. In 2003 she earned an MPH in Maternal and Child Health with a minor in Epidemiology from the University of North Carolina-Chapel Hill, in Chapel Hill, North Carolina. Recent work history:
  2001: Consultant and Graduate Student Intern, Intrah/IntraHealth, University of North Carolina at Chapel Hill, Chapel Hill, NC
  2003: Public Health Prevention Specialist, Centers for Disease Control and Prevention, Agency Assignment: Division of Sexually Transmitted Disease (STD) Prevention, Program Development and Support Branch, National Center for HIV, STD and TB Prevention (NCHSTP)
  2004: Public Health Prevention Specialist, Centers for Disease Control and Prevention, Field Assignment: Family and Community Health Bureau, Montana DPHHS
  2006: Maternal and Child Health Epidemiologist, Montana DPHHS
  2008: Lead Maternal and Child Health Epidemiologist, Montana DPHHS
  2012: Maternal and Early Childhood Home Visiting Section Supervisor, Montana DPHHS

- WIC Supervisor, Kate Girard -
  Kate graduated in 2009 with a B.S. in Nutrition/Dietetics from California Polytechnic State University in San Luis Obispo, California. In 2011 she earned a MHS from Western Carolina University in Cullowhee, North Carolina. Recent work history:
  2009: Nutritionist I, Buncombe County Health Department, North Carolina
  2011: Nutritionist II/WIC Director, Madison County Health Department, North Carolina
  2013: Public Health Nutritionist/Nutrition Coordinator, DPHHS, FCHB WIC Section
  2014: WIC Section Supervisor, DPHHS, FCHB WIC Section

- WMH MCH Program Specialist, Kimberly Koch -
  Kimberly graduated in 2001 with a B.S. in Health and Human Performance, Health Promotion Emphasis, from the University of Montana in Missoula, Montana. In 2012 she earned a Masters of Public Health from the University of Montana. Recent work history:
  2003: Health Educator, Planned Parenthood of the Inland Northwest

2005: Health Education Specialist, DPHHS Montana Tobacco Use Prevention Program
2007: Health Education Specialist, DPHHS Women's and Men's Health Section
2013: MCH Program Specialist, DPHHS Women's and Men's Health Section

- PCO Manager, Brandy Kincheloe *(Hired August 2015, information updated for final application submission.)* Brandy graduated in 2004 with an A.A. in Communication from Casper Community College. In 2009, she earned a B.S. in Sociology from the University of Montana. She became a LEAN instructor in 2014, and is a certified Wellcoach. Recent work history:
  2009-2011: Director of Social Services, Hillside Health Care Center, Missoula, MT
  2011-2013: Community Living Program Specialist and Nutrition Case Manager, Missoula Aging Services, Missoula, MT
  2013-2015: Community Health Improvement Specialist, Clark Fork Valley Hospital, Plains, MT

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

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

- Immunization Program Coordinator, Bekki Wehner -
  Bekki graduated in 1996 with a BS in Health and Human Development / Family Science from Montana State University, Bozeman, Montana. She went on to receive an additional BS degree and teaching certification in Health Enhancement / Education from the same University in 2003. Current work history includes:
  1997: Case Manager – Big Brothers Big Sisters of Helena
  2004: Immunization Information System Coordinator – DPHHS, PHSD
  2010: Immunization Information System Manager – DPHHS, PHSD
  2012: IT Business Analyst – State of Montana
  2014: Montana Immunization Section Supervisor – DPHHS, PHSD

- MCH Epidemiologist, Anya Walker -

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

2007: Bond Program Assistant, Dept. of Commerce, Board of Investments, Helena, MT
2008: Admin. Asst., Dept. of Labor and Industry, Data Management Unit, Helena, MT
2009: Program Specialist/Contract Manager, Dept. of Comm., Housing Div., Helena, MT
2013: Senior Research Analyst/Statistician, DPHHS PHSD OESS Vital Statistics
2015: MCH Epidemiologist, DPHHS PHSD OESS

Culturally Competent Approaches to Service Delivery

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

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

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

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

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

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

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

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

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

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

Montana County Public Health Departments*
Serving Local American Indian Reservations - SFY13 MCH Data
(**PLEASE NOTE**: Clients voluntarily self-report race on CPHD intake forms)

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

Acronyms:
MCH = Maternal and Child Health
CPHD = County Public Health Department
AI = American Indian
SFY = State Fiscal Year (July 1 - June 30)
MOU = Memorandum of Understanding

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

Partnerships, Collaboration and Coordination

CSHS has State Implementation Grant specific collaborations with:

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

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

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

Endnotes:

[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

II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1	Family Support and Health Education	New	
2	Access to Care	Continued	
3	Immunization Rates	Continued	
4	Child Injuries	Continued	
5	Smoking During Pregnancy and Household Smoking	Continued	
6	Breastfeeding Rates	New	
7	Oral Health	Continued	
8	Teen Pregnancy Prevention	New	
9	Low-Risk Cesarean Deliveries	New	
10	Infant Safe Sleep	New	

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

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

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

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

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

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

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

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

Montana's State Selected Priorities - Final Selection
with Related Domains & Performance Measures

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

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

More detailed discussion and rationale for National and State performance measure selections can be found in

sections “II.D.” and “II.E.”, which are dedicated to explaining the linkage of each with the state selected priorities.

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

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

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

Infant Safe Sleep*	Part of targeted approach to infant mortality, and one of the focus areas for Montana's Infant Mortality CoIIN. The new 2015 Health Survey of Montana's Mothers and Babies will provide baseline data. New priority for 2016-2020.
Injury Prevention*	Encompasses all causes of injury and death for ages 0-19 years. In FY 2015, almost 20% of CPHDs chose to address unintentional injury as their performance measure, and 51 reported on injury prevention activities. Continued priority for 2016-2020.
Low Birth Weight	Targeted through focused areas which are related, such as those covered by NPM 2, and SPMs 1,2,and 5.
Low-Risk Cesarean Deliveries*	The DPHHS Director created the Montana Prenatal Quality Collaborative for Reducing Early Elective Deliveries in 2014. Birth certificate data for 2008-2012 show approximately 17% of pre-term births annually were the result of induction or cesarean section. New priority for 2016-2020.
Maternal Mortality	Not an area of high need, and is being addressed by local FICMMR Teams.
Medical Home	Ongoing need for CYSHCN, it is being addressed through SPM 4. It was not chosen for the final priority list due to the limit of 10.
Meeting Developmental Markers	Ranked high as an unmet need for children with and without special health care needs. It is being addressed by the more focused priority areas covered by NPM 2 and SPM 2.
Mental Health	Received high unmet need ranking for all domains except infants. However, it is better addressed by other divisions within DPHHS. SPMs 1 and 2 will also provide support.
Motor Vehicle Deaths	Covered under the injury prevention area.
Newborn Screening	Very important ongoing function. Process is well handled by CSHS and the PHSD Laboratory.
Nutrition#	Ranked as a high unmet need for infants, children and adolescents. Addressed by SPM 2 through health education, and by the WIC program. Not chosen for the final list due to the limit of 10.
Obesity#	Ranked as a high unmet need for children, adolescents and women of childbearing age.. Addressed by SPM 2 through health education. Not chosen for the final list due to the limit of 10.
Oral Health*	Ranked high as an unmet need for children. FCHB priority area with long-term effects over the life course. Also supported by SPM 1. Continued priority for 2016-2020, with NPM 13.
Parental Relationship#	Ranked high as an unmet need for infants and adolescents. Addressed as a part of Family Support Services & Health Education
Parenting Education#	Ranked high as an unmet need for adolescents and women of childbearing age. Addressed as a part of Family Support Services & Health Education, and also by NPMs 5, 7 and 14.
Preconception Health	The only priority need from the 2011-2015 Needs Assessment which is being replaced. It is a component of several other topic areas.
	Ranked as a high need for women of childbearing age. Addressed by NPM 2 and SPM 1. Not chosen for the final list due to the limit of

Prenatal Care	10.
Reproductive Health Services	Ranked as a high need for adolescents. Addressed through SPMs 1 and 8. Not chosen for the final list due to the limit of 10.
Safe Home Environment#	Ranked as a high unmet need for infants and children. Addressed as a part of Family Support Services & Health Education, along with NPMs 5,7 and 14.
Smoking: Pregnancy and Household*	High priority area for the PHSD, with long-term effects over the life course. In 2014, approximately 30% of primary caregivers enrolling in home visiting reported smoking. Continued priority for 2016-2020, with NPM 14.
Specialty Health Care Services	Ranked as a high unmet need for CYSHCN, it is being addressed through the CSHS regional clinics, and CPHD referral requirements. It was not chosen for the final priority list due to the limit of 10.
STD/STI Education and Prevention#	Ranked as a high unmet need for adolescents and women of childbearing age. Addressed through SPM 2 and the Title X contractors. Not chosen for the final list due to the limit of 10.
Suicide	See Mental Health - Montana has a special state-level Suicide review team.
Teen Pregnancy Prevention*	High priority for the PHSD, and of concern as a minority health disparity area. Addressed through SPMs 1 and 2, and through the Title X contractors. New priority for 2016-2020.
Transition Services	A high priority for CSHS, which has a State Implementation Grant to help with support of transition services. Not chosen for the final list of state priorities due to the limit of 10. However, NPM 12 was chosen to fulfill the requirement of a national performance measure for the CYSHCN domain.
Violence / Bullying	Addressed through more targeted topic areas, i.e. NPM 7 and SPM 2.
Women's Health Services	Ranked as a high unmet need for women of childbearing age. Addressed through SPMs 1 and 5. Not chosen for the final list due to the limit of 10.

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

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	24.0	24.0	24.0	24.0	24.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	92.0	92.0	92.0	92.0	92.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	24.0	24.0	24.0	24.0	24.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50.0	50.0	50.0	50.0	50.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	225.0	225.0	225.0	225.0	225.0

Annual Objectives					
	2016	2017	2018	2019	2020

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	80.0	80.0	80.0	80.0	80.0

NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50.0	50.0	50.0	50.0	50.0

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	22.0	22.0	22.0	22.0	22.0

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	78.0	78.0	78.0	78.0	78.0

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	16.0	16.0	16.0	16.0	16.0

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	25.0	25.0	25.0	25.0	25.0

The Annual Objective measures currently entered are "placeholders." An MCH Advisory Group will be working with an epidemiologist during FFY16 to finalize obtainable goals.

Linkage of Montana's MCHBG 2016-2020 State Selected Priorities with
National Performance and Outcome Measures

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

Montana's State Selected Priorities
with Related National Performance Measures

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

The following is the rationale for each NPM choice:

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

Rationale - The Montana Prenatal Quality Collaborative (MPQC) was created in 2014, to address the DPHHS

Director's priority for reducing Early Elective Deliveries. Birth certificate data for 2008-2012 show approximately 17% of pre-term births annually were the result of induction or cesarean section.

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

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

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

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

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

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

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

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

All mothers who deliver during calendar year 2015 will be asked to complete the Health Survey of Montana's Mothers and Babies, which is modeled on the CDC Pregnancy Risk Assessment Monitoring System (PRAMS). The survey, a collaborative effort with the FCHB, OESS, and the Montana HealthCare Foundation, will provide additional data on safe sleep practices. Along with data collected by local FICMMR teams, which is entered into the Child Death Review (CDR) Reporting System, it will be used for developing and distributing targeted messages.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- NPM 2 = NOMs 4.1-4.3, 5.1-5.3, 6 and 7
- NPM 4 = NOM 9.5
- NPM 5 = NOMs 9.1-9.3, and 9.5

- NPM 7 = NOMs 15, and 16.1-16.2
- NPM 10 = NOMs 19, and 22.2-22.5
- NPM 12 = NOM 17.2
- NPM 13 = NOMs 14 and19
- NPM 14 = NOMs 2, 4.1-4.3, 5.1-5.3, 6, 8, 9.1-9.5, and 19

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

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

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

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

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

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

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

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

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

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

adolescent immunizations against Diphtheria, Tetanus, Pertussis, meningococcal, and Human Papillomavirus. (imMTrax)

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

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

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

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

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

II.F. Five Year State Action Plan

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

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Low-Risk Cesarean Deliveries			Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births	Percent of cesarean deliveries among low-risk first births		

Women/Maternal Health

Women/Maternal Health - Plan for the Application Year

(This section contains information for the report and application, as we did not make separate documents for the domains.)

Montana MCHBG 2016 Application and 2014 Report
Women's and Maternal Health Domain

Performance Measures Included: (**P** designates performance measures for fiscal years 2011-2015, and **N** designates new performance measures for fiscal years 2016-2020)
Last Year's Accomplishments and Current Activities =

- PSPM 3 – **Gestational Diabetes**

  Plan for the Coming Year and for 5-Year Action Plan =
- NNPM 2 – **Low-Risk Cesarean Deliveries**

  In regards to the population domain of women's and maternal health, the FCHB has been specifically addressing a state performance measure related to gestational diabetes for the last five years. This has been done in partnership with the Diabetes Program in the Public Health and Safety Division (PHSD) Chronic Disease and Health Promotion Bureau. In looking forward, the 5-Year Needs Assessment identified low-risk cesarean deliveries as being unacceptably high – and so selected NPM 2 as the priority for this domain for the next five years. According to the Montana Office of Vital Statistics, the rate for 2013 was 23.4% of all low-risk births.

Gestational Diabetes

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

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

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

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

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

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

Low-Risk Cesarean Deliveries

In February 2014, the Director of the Montana Department of Public Health and Human Services (DPHHS) requested that a DPHHS committee be created: the Montana Prenatal Quality Collaborative (MPQC) for Reducing Early Elective Deliveries. The MPQC is composed of four Family and Community Health Bureau (FCHB) staff, and receives input from the Medicaid Health Reform Specialist and FCHB Bureau Chief. The pre-term birth rate was determined from 2008 to 2012 birth certificate data. This data indicated that of the 12,000 average yearly births, 27% were between 36 and 38 weeks completed gestation and of these births, 47% or approximately 2000 births annually were the result of induction or cesarean section.

Effective October 1, 2014 Montana Medicaid enacted the payment reduction policy regarding early elective deliveries and non-medically necessary cesarean sections. Facilities who perform non-medically necessary cesarean sections at any point in gestation will receive a 33% payment reduction. Physicians who perform these deliveries do not receive their maternity policy adjustor of 12%, which is currently the maximum amount allowed by Montana law. Medical necessity is based on American Congress of Obstetricians and Gynecologists, and Joint Commission standards. All Montana birthing hospitals have had their early elective deliveries and non-medically necessary cesarean sections policies approved by Medicaid.

Prior to and during the implementation of this policy, Medicaid worked with the Montana Perinatal Quality Collaborative to educate providers about the risks associated with non-medically necessary early inductions and cesarean sections. As of June 2015, 11 facility claims and 31 physician claims have been reduced due to non-medically necessary cesarean sections.

The MPQC reviewed the Medicaid Payments Policy for Elective Deliveries, and then began educating healthcare professionals and hospitals on this new policy. The MPQC continues to assist hospitals in reviewing their elective deliveries policies and procedures, and in providing feedback based on national policy standards from professional organizations as requested. With assistance from the MCH Epidemiologist, the MPQC provides hospital specific data regarding inductions and caesarean section deliveries.

The MPQC created educational messages on the importance of pregnancies through 39 weeks and distributed them to health care professionals, hospital staff, and patients. The educational messages will be shared more widely with additional PHSD programs and community based organizations, such as the Montana Nurses Association and the Montana Chapter of the American Congress of Obstetricians and Gynecologists. These communications will also include the Medicaid Elective Delivery Policy.

The State Health Improvement Plan (SHIP) was developed by the PHSD in 2013, with input from over 300 interested parties. It outlines health improvement priorities in five areas, one of which is to promote the health of mothers, infants, and children. It includes the goal to decrease the proportion of pre-term births from 9% to 7% by 2018 through PHSD and DPHHS programs' strategies.

Montana's Infant Mortality (IM) Collaborative Improvement & Innovation Network (CoIIN) team will play a pivotal role in developing and maintaining public and private organization partnerships, which aim to promote a 39 week gestational period. IM CoIIN members include: representation from the MPQC and Indian Health Services; the Montana Tobacco Use Prevention Program Coordinator; and is led by the Fetal, Infant, Child and Maternal Mortality Review (FICMMR) Coordinator.

The Maternal Mortality Review (MMR) Work Group will continue meeting in SFY 2016 to review the local FICMMR team's maternal mortality review case reports, which are submitted to the State FICMMR Coordinator. Montana's maternal death rate averages about 12 deaths per year. In the coming years, the MMR Work Group will have the opportunity to develop maternal prevention recommendations using the information from the maternal mortality review case reports.

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

Women/Maternal Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	24	24	24	24	24

Please see the "Plan for the Application Year" for the information for the report, as we did not create two separate documents.

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Infant Safe Sleep			Infant mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	Percent of infants placed to sleep on their backs		
Breastfeeding Rates			Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months		

Perinatal/Infant Health

Perinatal/Infant Health - Plan for the Application Year

(This section contains information for the report and application, as we did not make separate documents for the domains.)

Montana MCHBG 2016 Application and 2014 Report
Perinatal and Infant Health Domain

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

Last Year's Accomplishments and Current Activities =

- PNPM 10 – **Motor Vehicle Deaths**
- PNPM 11 – **Breastfeeding**
- PNPM 12 – **Newborn Hearing Screening**
- PNPM 17 – **Very Low Birthweight Infants Born in Level III NICU**
- PNPM 18 – **Prenatal Care**
- PSPM 4 – **Unintentional Injury Deaths**

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

- NNPM 4 – **Breastfeeding**
- NNPM 5 – **Infant Safe Sleep**
- NNPM 7 – **Injury-Related Hospital Deaths**

The main MCHBG categories of activity that fit into the Perinatal and Infant Health domain for Montana are: Perinatal and Newborn Health Care, Breastfeeding, and Infant Safety. This narrative will report on past accomplishments and challenges, current effectiveness, and initiation of new efforts based needs assessment analysis.

Two specific performance measure categories which span the timeframes of two 5-Year Statewide Needs Assessments are injury prevention and breastfeeding. Infant Safe Sleep (also known as "Back to Sleep") is a new national performance measure. The performance measures which make up the Perinatal and Newborn Health Care category are part of the reporting on last year's accomplishments and current activities only, and while not part of the priorities in the upcoming state action plan, will continue to be of importance to the Family and Community Health Bureau (FCHB).

Perinatal and Newborn Health Care

Newborn Hearing Screening

The Universal Newborn Hearing Screening and Intervention (UNHSI) Program continues to provide feedback to all 28 Montana birth hospitals, ensuring that all hearing screening data is reported and accurate. The consistent screening rate is 96%. On-site quality assurance visits will continue as planned in the UNHSI quality assurance plan. Medical records from the facility are compared with the reported data, and any discrepancies are noted and addressed with the facility staff. Screening and reporting protocols are reviewed with hospital staff. After completion of the review, a detailed report of findings, including suggestions for improvement, is sent to the screening staff and the facility CEO.

These visits are used to ensure that the UNHSI program has access to accurate data and that hospitals are providing appropriate educational materials and hearing screening services. The goal is to reduce the number of babies lost to follow-up, after initial newborn hearing screenings are performed in the hospital. Access to hearing screening records from the hospitals in a timely manner will remain a priority, so data is available for all quality improvement activities.

All Montana birthing hospitals converted to the web-based version of the reporting system by the end of FFY 2014. This reduced the time it takes the UNHSI program to access screening data from hospitals, leading to more timely follow-up for babies who missed hospital screenings or who received a refer result from the screening. The conversion also simplified the process of sending hospital data to the UNHSI program by eliminating the need for secure file transfer through email. Now all hospitals use the web-based version of the database, and all data entered at the hospital level is immediately accessible by the UNHSI staff. Hospital staff also began documenting critical congenital heart defect screening in the reporting system during FY 2015.

Hospitals have also been encouraged to follow a more frequent reporting timeline - from reporting once a month to reporting every two weeks. The larger facilities found that reporting more often actually lessened the reporting burden. More frequent reporting allows the UNHSI program to identify infants that need follow up sooner. This decreases the lost to follow up rate and meets the CDC's guidelines for screening and diagnosis. This process also provides UNHSI staff with the contact information needed to provide follow-up on babies who do not pass their inpatient screening.

The Children's Health Referral and Information System (CHRIS) database also continues to be updated. This improves the UNHSI program's ability to import hearing screening records from the reporting system and match them with birth records, to identify babies who did not receive screenings. Updates also improved UNHSI reporting capabilities and program capacity to provide improved feedback to hospitals and other partners. Multiple enhancements to the CHRIS database streamlined the matching and reporting processes.

During FY 2015, UNHSI staff is working with stakeholders to update the state administrative rules of the program. The Stakeholders Group is comprised of the UNHSI program and data coordinators, the Montana Medicaid Part C Coordinator, the Montana Chapter of the American Academy of Pediatrics' Champion for Early Hearing Detection and Intervention, two pediatric audiologists, the Montana School for the Deaf and Blind consulting audiologist, two parents, and one hospital hearing screening staff person. Planned updates will ensure more timely access to hearing screening results and therefore improved timeliness of follow-up.

Educational materials continue to be distributed to all hospitals so families have access to updated, culturally sensitive, and relevant information regarding hearing screening and the need for follow-up if their babies do not pass their hospital hearing screenings. The "Family Roadmap" is an example. It's a family-friendly, step-by-step guide that outlines the screening and diagnosis path for a family after their infant does not pass the hearing screening in the hospital. Along with the Family Roadmap, updated language for delivering the screening process and results to parents was developed and disseminated.

Parents of all infants who did not receive adequate follow-up in 2013 are being asked to complete a survey to identify the reasons why follow-up was not completed. A contractor will be hired to use the data collected to develop a targeted public relations campaign, with the goal of reducing loss to follow-up. Stakeholder input will be a relevant part of the development process.

Very Low Birth Weight Babies Born in a Level III NICU

The main program the FCHB has for ensuring that Very Low Birth Weight (VLBW) babies are born in a Level III Neonatal Intensive Care Unit (NICU) is Home Visiting. It addresses the main avoidable causes of premature and low birth weight babies, with the most at-risk maternal population. These causes include: smoking, substance abuse, lack of prenatal care, poor nutrition, and stress.

The Maternal and Early Child Home Visiting (MECHV) sites with state funding, and/or federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding, continue to implement their selected home visiting model, Nurse-Family Partnership or Parents as Teachers. The home visiting sites provide relevant training and information regarding healthy pregnancies and delivery with clients enrolled prenatally. If caregivers become pregnant while enrolled, home visitors ask whether they want to focus home visits on the pregnancy. Home visiting clients with no insurance coverage are referred to Medicaid or other resources, and those without a healthcare provider are referred to an appropriate source.

Local programs follow up with pregnant women about their prenatal care visits and provide information about healthy pregnancies. The programs also assist pregnant clients in accessing and maintaining health insurance. Two-hundred and sixty-eight pregnant women were enrolled in home visiting at MT MECHV-funded sites in Federal Fiscal Year 2014. Information on prenatal care is updated at each home visit. All client data is entered into the MTmechv data system or, in the case of NFP sites, downloaded to Montana's program from the NFP ETO data system. The MTmechv system is web-based, so all information is available to home visitors as needed to manage client care and all home visitors, supervisors, and data entry staff members receive training on how to complete the forms and use the data system.

Access is a major issue for health care in Montana, where much of the population lives in rural areas. The four hospitals with Level III Neonatal Intensive Care Units (NICUs) in the state all have air and ground transportation services for maternal and neonatal patients in need of specialized critical care. Their air ambulances include both helicopters and fixed-wing aircraft, and feature highly qualified medical crews – including those needed for neonatal intensive care and high-risk obstetric care. They provide rapid response, and work collaboratively with medical professionals in outlying communities.

Here is a brief description of each:

- St. Vincent Healthcare, Billings – St. Vincent's NICU is the closest one for most of the eastern half of the state. A good example of a small hospital in their service area is Sheridan Memorial in Plentywood, which is 278 aeronautical miles away.
- Benefis Health System, Great Falls - Benefis' NICU serves the central portion of the state.
- Community Medical Center, Missoula – one of two NICUs in the relatively more populated western part of Montana, the service area is still very large – covering the whole southwest corner of the state.
- Kalispell Regional Medical Center, Kalispell – 116 miles north of Missoula, Kalispell Regional's NICU serves a more remote portion of northeastern Montana.

Prenatal Care

The main FCHB program with the ability to address prenatal care is the Maternal and Early Childhood Home Visiting section.

The Montana home visiting sites funded with state funding and/or federal Maternal, Infant, and Early Childhood Home

Visiting (MIECHV) funding continue to implement their selected home visiting model. The home visitors discuss prenatal care with clients enrolled prenatally and provide referrals and assistance as needed. The program outcome measure is: Percent of pregnant women enrolled prenatally who receive 80% or more of the recommended number of prenatal care visits after program enrollment.

Ten new sites (and 15 new contractors) started implementing evidence-based home visiting with federal MIECHV Expansion funds in the summer of 2014 and are expected to continue through 2015. This brings the total number of sites to 19. The total caseload capacity for the existing and new contractors is approximately 1000 clients. Programs implementing Nurse-Family Partnership (NFP) enroll women during pregnancy. Parents as Teachers, SafeCare Augmented and Family Spirit enroll families with young children in addition to pregnant women. Even if they are pregnant when they enroll, the majority of clients enroll after the first trimester of pregnancy.

If caregivers are already enrolled as a client and become pregnant while enrolled, the home visitor asks whether they want to enroll as a pregnant client and focus home visits on the pregnancy. Prior to providing home visiting services, home visiting sites are trained in the home visiting model, as well as in the Montana program component, such as: screening requirements, assessment tools, continuous quality improvement, and the program forms and data system. All client data are entered into the MTmechv data system or, in the case of NFP sites, downloaded to Montana's program from the NFP ETO data system.
Home visits are scheduled on a weekly or every other week basis, providing an opportunity for the home visitor to check in with the client in between prenatal care visits with their provider. Home visiting clients with no insurance coverage are referred to Medicaid or other resources, and those without a healthcare provider are referred to an appropriate source. Home visitors also follow up with pregnant women about their prenatal care visits and provided information about healthy pregnancies. Two hundred and sixty-eight pregnant women were enrolled in home visiting at MT MECHV sites in Federal Fiscal Year 2014.

Prior to the summer of 2014 the home visiting contractors were health departments. The MIECHV Expansion funding was made available to non-profits, community health centers, and other types of organizations in addition to health departments. This allowed communities to determine which organization was best suited to manage the program. Contractors now include a community health center and non-profit organizations.

One county in FY 2014, and three counties in FY 2015, choose NPM 18 as the focus of their efforts and activities for the MCHBG.

Breastfeeding

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Infant Safety

Injury

This section on injury prevention activities contains combined information for PNPM 10, PSMP 4 and NNPM 7.

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

Twenty-seven local *Fetal, Infant, Child and Maternal Mortality Review* (FICMMR) Teams review motor vehicle and all other unintentional injury deaths, and implement community prevention activities related to prevention. The state FICMMR Program Coordinator assists with: evidence-based practices and prevention activities, information to standardize reporting, collaboration through conference calls, and information through newsletters, webinars, trainings, and journal articles. In November 2013, a packet of educational materials was mailed out to all 56 counties and 7 tribes which included: car seat safety, the importance of buckling up, farm equipment safety, teen drinking and driving, safe sleep, poison control and choking hazards.

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

Through the Maternal and Child Health Block Grant (MCHBG) Task Orders, County Public Health Departments

(CPHDs) are required to complete one injury prevention activity each year. In the first three quarters of SFY 2015, 62 injury prevention activities were completed.

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

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

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

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

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

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

Safe Sleep

MT is participating in the AMCHP/NICHQ/HRSA sponsored Infant Mortality Collaborative Improvement and

Innovation Network (IM CoIIN). IM CoIIN members include several from the FCHB, the MT Tobacco Use Prevention Program Coordinator, Indian Health Services, the Medicaid Health Reform Specialist, the Medicaid EPSDT Nurse Consultant, and is led by the FICMMR Coordinator.

The team opted to participate in the Smoking Cessation, Safe Sleep, and Preconception/Interconception Health Learning Networks which allows the members access to a multitude of resources located on the IM CoIIN NICHQ website and participation on topic specific webinars. Montana's Infant Mortality CoIIN team will play a pivotal role in developing and maintaining public and private organization partnerships aiming to promote the action plans developed for the three learning networks.

The SHIP developed by the PHSD and with input from over 300 interested parties, includes two related goals to the IM CoIIN activities: by 2018 decrease the proportion of women who report they smoke during pregnancy from 16% to 12%; and increase the proportion of women who report they entered prenatal care in the first trimester from 76% to 83%. The SHIP and PHSD Strategic Plan also include strategies to increase awareness of maternal, child, and infant health through public education.

These strategies include: baby on back to sleep; implement quality improvement activities that improve the delivery of clinical preventive services; the use of clinical practice guidelines, i.e. reduced induction and early elective cesarean sections; and implement evidence-based health promotion and prevention activities by providing training and resources to health professionals and others. The training will help to implement programs that improve modifiable risk factors for adverse outcomes of pregnancy, such as smoking cessation and access to prenatal care.

Data provided for the July 2014 IM CoIIN Conference indicated that Montana's overall infant mortality rate was 6.45 per 1,000 live births, somewhat higher than the goal of 6.0 per 1,000 live births. Of this rate, the rate was 10.19 per 1,000 American Indian/Alaska Native live births compared to 6.07 per 1,000 Non-Hispanic white live births.

The IM CoIIN team decided to focus their attention on addressing the American Indian population's IM rate by collaborating with the March of Dimes (MoD), Montana Chapter. MoD applied for and received a mini-grant from the MoD Foundation for offering "Train the Trainer" training on a program called "The Coming of the Blessing: A Pathway to a Healthy Pregnancy." This program is designed for use with American Indian and Alaska Native families. The training, scheduled for August 4, 2015, will be open to approximately 30 individuals who work closely with the AI population.

All mothers who delivered during calendar year 2015 will be asked to complete the Health Survey of Montana's Mothers and Babies, which is modeled on the CDC Pregnancy Risk Assessment Monitoring System (PRAMS). The survey, a collaborative effort with the FCHB, Office of Epidemiology and Scientific Support, and the Montana HealthCare Foundation, will provide additional data on safe sleep practices, smoking habits, and preconception and interconception health practices. This data will be analyzed together the data collected by the local FICMMR teams, which is entered into the Child Death Review (CDR) Reporting System. The FICMMR teams collect data on smoking during pregnancy and safe sleep habits. The combined information will be used for developing and distributing targeted messages.

The FICMMR Coordinator will be leading a CDR quality improvement initiative which focuses on 21 CDR Sections that are of critical importance for local teams to accurately complete. The CDR Sections include prenatal care access, smoking during pregnancy, and sleeping or sleep environment. The Coordinator will also be implementing a back to sleep program.

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	92.0	92.0	92.0	92.0	92.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	24.0	24.0	24.0	24.0	24.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50	50	50	50	50

Please see the "Plan for the Application Year" for the information for the report, as we did not create two separate documents.

State Action Plan Table						
Child Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Child Injuries			Child Mortality rate, ages 1 through 9 per 100,000 Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate,	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19		

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000			
Immunization Rates	Objectives will be developed for SPM 3a: 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. Data will be collected by the DPHHS imMTrax system.					

Child Health

Child Health - Plan for the Application Year

(This section contains information for the report and application, as we did not make separate documents for the domains.)

Montana MCHBG 2016 Application and 2014 Report
Child Health Domain

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

Last Year's Accomplishments and Current Activities =

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

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

- **N**NPM 7 – **Injury Related Hospital Admissions** (Ages 1 – 10)
- **N**SPM 3a – **Immunizations** (Ages 19 – 35 months)

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

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

Immunizations

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

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

1. Contractors routinely maintained immunization records in the statewide immunization information system (imMTrax). This maintenance consisted of not only adding newly acquired records but also performing data quality assurance activities including patient de-duplication.

2. Provided outreach and referrals for children identified by immunization information systems as missing or coming due for immunizations, by implementing new clinic reminder/recall processes.

3. Developed new protocols for reducing missed opportunities for vaccination (e.g. reviewing immunization records at every visit, and eliminating missed opportunities for simultaneous vaccination). Many contractors also worked with IZ staff to build a targeted quality improvement plan for increasing vaccination rates.

4. Met quarterly with local Vaccine for Children (VFC) providers to review the data reports provided by the IZ

program, and share best practices for increasing immunization rates.

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

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

A new Immunization Program Manager began in December 2013. Meetings between the IZ program and the MCHC section were held, to facilitate collaboration with the 20 counties who chose NPM 7 for their performance measure. The MCHC section will continue to share immunization information with all the CPHDs and attend the quarterly IZ VFC provider calls and offer assistance as appropriate.
The Montana Maternal and Early Childhood Home Visiting program sites, located in 19 communities, will continue to assess and refer children as needed for well-child visits and immunizations. Children attending WIC Clinics and one of the three CSHS regional clinics will also be assessed for their immunization status and referred as needed.
For FY 2016, the activities carried out by IZ contractors in previous years will be continued. These activities, which have also been under way in past years, include:

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

Obesity

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

All 47 Montana WIC clinics have a registered dietitian (RD) either on staff or available by contract to provide nutrition assessment, intervention and follow up to participants considered high-risk, including overweight/obese children. Dietitians are uniquely qualified to address complex topics such as excess weight gain and less than ideal feeding practices. For clinics that do not have an RD on staff, the contact was completed by phone, or using web-based technology (WebEx). This use of distance education improved access to quality nutrition services in areas where

they would otherwise not have been available.

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

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

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

Local agency staff members are provided training and information in a variety of ways. In April, 2014 the Montana WIC program held its spring conference, which included a presentation called, "Bridges Out of Poverty." This training was highly successful at educating local clinic staff about the complexities of working with low-income families, and how to improve communication with our participants.
In addition, nutrition-related trainings, articles, and webinars were posted in a newsletter to promote and support continuing education among staff. WIC also collaborated with the Nutrition and Physical Activity program to host the Breastfeeding Collaborative in September, 2014. It is well established that breastfeeding promotes healthy growth and reduces the risk for overweight and obesity during childhood.

Injury

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

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

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

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

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

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

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

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

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

The state action plan will include the development of DPHHS approved injury prevention messages, developed from

evidence-based approaches. These will be distributed among the FCHB's established partner network, as indicated in the Needs Assessment.

Child Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	225	225	225	225	225

Please see the "Plan for the Application Year" for the information for the report, as we did not create two separate documents.

State Action Plan Table						
Adolescent Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Teen Pregnancy Prevention	Ojectives will be developed for SPM 5: Teen Pregnancy Prevention: Rate of birth for girls ages 15 to 17 years. Data will be accessed from the DPHHS MT Office of Vital Statistics.		Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000 Percent of children with a mental/behavioral condition who receive treatment or counseling Percent of children in	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			excellent or very good health			
			Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)			
			Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza			
			Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine			
			Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine			
			Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal			

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			conjugate vaccine			
Immunization Rates	The objectives will be based on the SPM 3 b.: Percent of 13-17 year olds who have received age appropriate adolescent immunizations against Diphtheria, Tetanus, Pertussis, meningococcal, and Human Papillomavirus. Data will be collected from the DPHHS imMTrax system.		Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000 Percent of children with a mental/behavioral condition who receive treatment or counseling Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile) Percent of children 6 months through 17 years who are	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

State Action Plan Table						
Adolescent Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
			vaccinated annually against seasonal influenza			
			Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine			
			Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine			
			Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			

Adolescent Health

Adolescent Health - Plan for the Application Year

(This section contains information for the report and application, as we did not make separate documents for the domains.)

Montana MCHBG 2016 Application and 2014 Report
Adolescent Health Domain

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

designates new performance measures for fiscal years 2016-2020)

Last Year's Accomplishments and Current Activities =

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

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

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

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

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

Teen Pregnancy Prevention

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

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

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

In FFY 2013, the DAs served an estimated 2,137 female adolescents (15-17) and also provided specific outreach

projects designed for adolescents at high risk for teen pregnancy and birth. The number of women of childbearing age receiving services was 18,979. They will continue to provide adolescents with quality family planning services and include counseling on abstinence, the importance of family involvement, avoiding coercion, and confidentiality.

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

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

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

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

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

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

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

WMHS applied for an additional Teen Pregnancy Prevention grant that would have targeted communities with the greatest need. These communities (Hill County, Roosevelt County, Big Horn County, and Lake County) were identified as having a high teen birth rate and include all or part of a reservation. Unfortunately, this grant was not

approved. Butte Silver Bow Family Services was able to partner with the Pregnant and Parenting Teen Grant and WMHS has supported them in this effort by providing data and teen pregnancy toolkits.

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

Preventive Services

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

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

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

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

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

Immunizations

Montana created a state performance measure for immunization to address the ongoing need, and the fact that

many CPHDs face challenges from vaccine hesitancy. The adolescent population has been included to make the measure more comprehensive, as follows: *Percent of 13-17 year olds who have received age appropriate adolescent immunizations against Diphtheria, Tetanus, Pertussis, meningococcal, and Human Papillomavirus.*

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

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

Injury

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

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

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

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

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

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

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

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

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

Suicide

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

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

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

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

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

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

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

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

Adolescent Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	80	80	80	80	80

Annual Objectives					
	2016	2017	2018	2019	2020

Please see the "Plan for the Application Year" for the information for the report, as we did not create two separate documents.

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Access to Care	Objectives will be developed for SPM 4: Medical Home: percent of CYSHCN ages 0 – 18 years who have a medical home. Data will be from the NSCH and Montana specific data collected from DPHHS regional specialty clinics and from partners.					
Access to Care			Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health	Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care		

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs

Children with Special Health Care Needs

Children with Special Health Care Needs - Plan for the Application Year

(This section contains information for the report and application, as we did not make separate documents for the domains.)

Montana MCHBG 2016 Application and 2014 Report
CYSHCN Domain

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

Last Year's Accomplishments and Current Activities =

- **P**NPM 1 – **Screen Positive Newborns**
- **P**NPM 2 – **Families partner in Decisions and Service Satisfied**
- **P**NPM 3 – **Medical Home**
- **P**NPM 4 – **Adequate Insurance for CYSHCN**
- **P**NPM 5 – **Community-Based Systems, Ease of Use**
- **P**NPM 6 – **Transition to Adult Health Care**
- **P**SPM 1 – **Cleft Lip and/or Palate Interdisciplinary Clinics**

Plan for coming year and Five-Year Action Plan =

- **N**SPM 4 – **Medical Home**
- **N**NPM 12 – **Transition to Adult Health Care**

The main MCHBG categories of activity that fit into the CYSHCN domain for Montana are: Diagnosis and Treatment, Adequate Insurance, Family Inclusion in Decision and Community Care Systems, Medical Home, and Transition to Adult Care.

Two of these categories contain performance measures which span the timeframes of two 5-Year Statewide Needs Assessments: Medical Home and Transition to Adult Health Care. Categories which are only part of reporting on last year's accomplishments and current activities are: Diagnosis and Treatment, Adequate Insurance for CYSHCN, and Family Inclusion in Decision and Community Care Systems. While these are not specific priorities in the upcoming state action plan, they will continue to be of importance to the FCHB.

Diagnosis and Treatment

The performance measures covered in this section are: PNPM 1 and PSPM 1.

Newborn Screening and Follow-Up

The Montana Newborn Screening (NBS) program is a partnership between Children's Special Health Services (CSHS), the Montana Public Health Laboratory (MT-PHL), and the infant's primary care provider. The Montana Public Health Laboratory receives all Montana bloodspot specimens and screens for all the conditions in the Recommended Uniform Screening Panel. Specimens are shipped to the Wisconsin State Laboratory of Hygiene (WSLH) for Tandem Mass Spectrometry and Severe Combined Immunodeficiency (SCID) screening.

The Department of Public Health and Human Services (DPHHS) proposed a rule change for NBS to add point of care pulse oximetry screening for CCHD to the mandated panel, effective July 1, 2014. These rules required use of the department's CCHD screening protocol and reporting system. Parent and provider CCHD educational materials and resources were made available on the CSHS website. On July 1, 2015, Montana began screening for SCID.

These rule changes also updated bloodspot screening to require: collection by 48 hours of age (instead of 72), more than one bloodspot screen for infants hospitalized for neonatal intensive care, detail of the process of reporting and follow-up of out of range results, to require documentation of parental refusal of newborn screening, and to stipulate the use and storage of residual bloodspot specimens by the department. These rules incorporated national recommendations for newborn screening system improvement.

Timeliness in newborn screening received a lot of attention during this period as a result of a national survey and newspaper article that outlined the deadly consequences of delays in newborn screening. In January 2014, Montana completed a survey from the Association of Public Health Laboratories (APHL) on the timeliness of "Specimen Collection and Transport within Newborn Screening Programs." WSLH began sending timeliness reports to Wisconsin submitters in January 2014 which incorporated quality indicators from the HRSA-supported Newborn Screening Technical Assistance and Evaluation Program (NewSTEPs) at APHL. Montana received a Wisconsin report on the specimens we submitted. Development of similar reports from MT-PHL to Montana submitters was initiated, and a data specialist began building the reports in June 2014.

Neometrics iCMS, a web and role-based case management software system for NBS, was purchased and installed in the summer of 2013. Implementing its functionality was met with challenges, which were addressed in meetings held every two weeks with: the NBS coordinator, laboratory managers, IT systems support staff, and vendor staff. The HL-7 export of results from the laboratory system to Neometrics is in operation, but follow-up actions are not functional.

CSHS is working to provide resources and technical assistance to hospitals and providers in implementing and reporting CCHD screening. Over 85% of babies born in hospital settings in May 2015 were reported to have had CCHD screening. Three workshops ("Safe, Sound, and Screened") were held in the spring of 2015 (and more planned around Montana), offering direct entry and certified nurse midwives, as well as apprentices, coordinated information and training from bloodspot, hearing, and CCHD screening staff. Twenty-nine individuals attended the trainings. Evaluations were overwhelmingly positive and CSHS received valuable feedback about barriers midwives face when implementing and reporting screening. This feedback is helping direct CSHS strategies to offer effective and consistent support and training to midwives.

The Newborn Hearing Screening Program is working with a marketing group to rebrand the program and provide educational materials and media spots through several platforms including social media and radio. New brochures have been approved and are going to print. Digital ads are online and a NBS new parent magazine is being developed which will be available by October 1, 2015.

Cleft Lip and/or Palate Interdisciplinary Clinics

CSHS continued to contract with 40 specialty providers and 3 sites to provide specialty clinics throughout the state. CSHS funds clinic teams to provide Metabolic, Cystic Fibrosis and Cleft/Craniofacial Clinics. CSHS bills for the clinics, but does not balance bill the patient if they are uninsured or under-insured. Clinics were offered in accessible areas around the state, including two on American Indian reservations. Team staffing remained stable, with experienced staff providing evaluations and recommendations to children, families and their health care providers. CSHS maintained existing contracts and assisted in securing additional providers where necessary. From 10/01/2013-09/30/2014 twenty clinic days were held at 8 different locations and there were 319 visits to cleft/craniofacial clinics by 297 individual clients. CSHS maintained and upgraded the Child Health Referral and Information System (CHRIS); a statewide database that supports documentation of clinic recommendations, care coordination activities, and referrals to local follow up.

Optimal outcomes for children with cleft/craniofacial conditions require sequential treatment provided by multiple professionals and programs. CSHS provided technical assistance to cleft team providers and clinic staff for local care coordination and follow up resources.
CSHS neared completion of a self-rating speech satisfaction survey of parents and children. The survey concluded in spring, 2015.The study compared how parents and older children rate their speech, compared with a speech assessment by team speech language pathologists. The results were used to assess parent\child satisfaction with speech development.

CSHS will continue to bill for Cleft/craniofacial team clinics and provide technical support for provider teams.

CSHS works closely with the Medicaid Maternal and Child Health Nurse to facilitate care coordination for Montana children admitted to out-of-state tertiary care centers. Many medically complex newborns and children are eligible for Medicaid. However, Montana's rural nature makes follow-up care difficult in many regions of the state. This collaboration helps to identify gaps in coverage, identify local community resources, and provide consultation about local resources available in the community. In the past year, CSHS helped approximately 100 families to establish strong community supports prior to discharge from a tertiary center. Out-of-state tertiary care centers have become more familiar with CSHS as the information source for hospitals, which helps the program to provide better transitions back to the community for children receiving out-of-state care.

The Medicaid Child and Maternal Health Nurse also works with the CSHS Nurse Consultants on reviewing medical necessity for various therapies, medical tests, medications and durable medical equipment under Medicaid's Early & Periodic Screening, Diagnosis and Treatment (EPSDT).

Adequate Insurance for CYSHCN
CSHS continued to assist families to obtain health care coverage by providing outreach materials and consultation, and by supporting care provided at the specialty clinic sites.

CSHS continued monitoring coverage issues for CYSHCN, and has worked to raise awareness regarding helmet therapy to treat severe plagiocephaly. The Healthy Montana Kid's Program (HMK) is now covering helmet therapy.

During FFY 2014 there were 23 families determined to be at or below 250% of the FPL who qualified for CSHS financial assistance which paid up to $2,000 for services/items not covered by insurance, i.e. plagiocephaly helmets. There were 77 individuals that were approved to receive financial assistance for genetic testing not covered by private insurance companies.

Children's Special Health Services (CSHS) continues to provide minimal financial assistance to families who are primarily underinsured or uninsured and at, or below, 250% of poverty. CSHS will continue to provide financial assistance for genetic testing which is not covered by health insurance, or which is not available to clients with Medicaid.

CSHS plans to continue team billing for Cleft\craniofacial, Cystic Fibrosis and Metabolic Clinics. Families are not balance billed for team clinics billed by CSHS; if a child does not have adequate insurance, or is uninsured, CSHS absorbs the additional cost.

CSHS will continue to work with Medicaid to facilitate Early Periodic Screening, Diagnosis and Treatment (EPSDT) activities. CSHS nurse consultants meet with the Medicaid Family and Maternal Health Nurse weekly to discuss care issues and to promote understanding of Medicaid programs and the needs of CYSHCN.

CSHS nurse consultants and the Medicaid Maternal and Child Health Nurse Consultant reviewed and revised the CYSHCN Targeted Case Management (TCM) rules, which included a 2% rate increase for providers. A public hearing on the revised CYSHCN TCM rules was held on May 28, 2014, and they became effective July 1, 2014. CSHS will continue to explore sustainability of targeted case management services for CYSCHN by encouraging local health departments to bill Medicaid for CYSHCN TCM.

Family Inclusion in Decision and Community Care Systems

The performance measures covered together in combination in this section are: PNPM 2 and PNPM 5.

CSHS is developing a Cleft/Craniofacial Clinic Stakeholders Group which will have parent representation. This group will be responsible for providing recommendations to the Montana Cleft Team members for achieving American Cleft Palate Association (ACPA) Standards for team care, and for providing consultation to the department.

Three families participated in the rules hearing for the implementation of screening for Critical Congenital Heart Defects (CCHD), providing testimony in support of CCHD screening for all newborns. Sharing personal family stories, they emphasized that early identification and treatment of their child's critical congenital heart disease would have made a difference in their child's outcome.

The Rural Institute of the University of Montana continued work with the Consumer Advisory Council (CAC), which directed the efforts of the Institute in planning strategies to educate families about CYSHCN transition to adult services. The CAC is made up of 19 members who are primarily youth and young adults with special healthcare needs and their parents.

A parents-as-mentors program called *The HALI Project* has been implemented in three pediatric practices and one FQHC in Montana. There are seven parent mentors currently working in the practices. The goal of the HALI Project parent partners is to support and empower families of CYSHCN when making decisions about their child's care and accessing services.

The HALI Project was developed and has been implemented in parts of Texas, Wyoming and now Montana, by the program developer, Brad Thompson. Mr. Thompson provides annual in-person training, monthly group calls, and individual support calls to the parent mentors. Mr. Thompson is a licensed counselor and the parent of a child with special health care needs. A CSHS staff-person attended in-person training in June, 2014 with Mr. Thompson and the Parent Partners.

Parent Partners told personal stories about their interactions with other CYSCHN parents and brainstormed ideas to better serve CYSHCN families. In addition to one-on-one work with families, the parent partners do outreach and education to the community and the providers they work with. Providers consistently report parent partners are a great asset to their practices, and they continually refer families at a higher frequency.

A cooperative effort between the Wyoming Department of Health, Mountain States Genetic Regional Collaborative, the HALI Project and CSHS is currently under way to evaluate the HALI Project. The evaluation is meant to gauge the effectiveness of the parent partners in their efforts to assist CYSHCN families to navigate the healthcare system, access community and government resources and provide ongoing mentoring and generally support and empower CYSHCN families. A survey was given to CYSHCN parents before and after a period of time when the CYSHCN family received services from a parent partner. A compilation of results are expected in late summer, 2015.

Medical Home

The Newborn Hearing Screening program supported coordinated, comprehensive care by requiring pediatric audiologists to use the Child Health Referral and Information System (CHRIS) to document screening and diagnostic assessment results. The matching process in CHRIS allowed for hearing screening data to be matched directly to birth record information. Development in CHRIS was started to allow for the import and matching of bloodspot data using the same principles of the hearing screening match process. An important goal of CSHS is for primary care physicians to be able to access the database to see a unified record within CHRIS that contains all newborn screening results along with patient demographics.

St. Vincent's Healthcare continued development of the Montana Medical Home Web Portal to provide current, reliable information and resources to providers and families of CYSHCN in a convenient and user-friendly format. Clinical resources posted on the portal, such as specialty providers and multi-disciplinary clinic information, were vetted by a team which included CSHS staff, a developmental pediatrician, and St. Vincent Healthcare staff.

The CHRIS software application was enhanced to include the generation of faxback forms. These forms included the patient's name and date of birth, mother's name, and the dates of referred (not pass) hearing screenings. The hearing program can now fax forms to the primary care physician to either prompt the physician to make a referral to an audiologist or report back to the program with any follow up results. The goal was to generate more medical home involvement with hearing screening follow-up.

Transition to Adult Care

CSHS addressed transition issues for CYSHCN by providing educational materials to families and communicating with healthcare payers, including Healthy Montana Kids (Children's Health Insurance Program and Children's Medicaid). The CSHS transition website continued to be maintained and updated to provide accurate information and resources on transition issues faced by CYSHCN.

Specialty clinic staff and contractors continued to provide education to families who attend clinics on issues that arise for CYSHCN when they transition from one treatment phase to another and when they transition to the adult healthcare system. These efforts were targeted to specific needs of families based on the diagnosis of the child, and the resources available in their communities.

The Rural Institute of the University of Montana continued to provide opportunities for CYSHCN to offer input on the Consumer Advisory Council. The RI continued to maintain a transition listserv which provided education and

resources, and it published 300 copies of a healthcare coverage and transition resource guide of healthcare options in Montana, in adaptive formats. The guide is available online and has been distributed throughout Montana. The Rural Institute (RI) provided six webinars focused on healthcare transition topics. RI is currently working on an evaluation of the transitions guide and the webinars they have presented. This evaluation should be complete by August, 2015.

CSHS continued to collaborate with Parents Let's Unite for Kids, Montana's Family-to-Family Information Center, and other Montana programs serving CYSHCN, to ensure that all families have access to transition information and available resources.

Future Activities: Medical Home and Transition Services

CSHS has identified two priorities to focus on in the coming year and over the next five-year period: NPM 12 - Percent of children with and without special health care needs who received services necessary to make transitions to adult healthcare; and SPM 5 - Percent of CYSHCN ages 0-18 who have a medical home.

Programs implemented through the Integrated Community Systems for CSHCN Grant in Montana have worked to promote medical homes and care transition for CYSHCN. Montana will continue the parent partner project, the medical home portal, and the transition to adult care projects through SFY 2016. CSHS also intends to facilitate sustainability planning, so these projects are able expand and continue.

CSHS will continue to support Cystic Fibrosis, Cleft/Craniofacial, and Metabolic Clinics in Montana. Contracts will include language requiring clinics to promote medical homes and transition assistance to CYSHCN who attend clinics. CSHS will collaborate with providers to define, implement and evaluate strategies in clinics.

CSHS is currently working with the Rural Institute of the University of Montana to perform a comprehensive program assessment. The assessment is using a Concerns Report Method which includes open-ended interviews with families, consumers, and providers; a review of current literature; and development of a concerns matrix to guide future strategic planning. A preliminary concerns matrix and recommendations are expected in late summer, 2015. CSHS will use this information to guide future planning for the section. An assessment design team met in June 2015 to guide this process. The team consists of CYSHCN health care providers, families, service providers and consumers.

Children with Special Health Care Needs - Annual Report

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50	50	50	50	50

Please see the "Plan for the Application Year" for the information for the report, as we did not create two separate documents.

State Action Plan Table

Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Access to Care	Objectives will be developed for 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. Data will be reported by the county public health departments on the state provided data reporting form.					
Family Support and Health Education	Objectives will be developed for 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					

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	referral and follow-up system, or provided with health education as needed. Data will be collected from the county public health departments report on the state provided data reporting form.					
Oral Health			Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months Percent of children in excellent or very good health	A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year		
Smoking During Pregnancy and Household Smoking			Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes		

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
			deliveries (<2,500 grams)			
			Percent of very low birth weight deliveries (<1,500 grams)			
			Percent of moderately low birth weight deliveries (1,500-2,499 grams)			
			Percent of preterm births (<37 weeks)			
			Percent of early preterm births (<34 weeks)			
			Percent of late preterm births (34-36 weeks)			
			Percent of early term births (37, 38 weeks)			
			Perinatal mortality rate per 1,000 live births plus fetal deaths			
			Infant mortality rate per 1,000 live births			
			Neonatal mortality rate per 1,000 live births			
			Post neonatal			

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births Percent of children in excellent or very good health			

Cross-Cutting/Life Course

Cross-Cutting/Life Course - Plan for the Application Year

(This section contains information for the report and application, as we did not make separate documents for the domains.)

Montana MCHBG 2016 Application and 2014 Report
Cross-Cutting / Life Course Domain

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

Last Year's Accomplishments and Current Activities =

- **P**NPM 9 – **3rd Graders Oral Health Screening**
- **P**NPM 13 – **Health Insurance**
- **P**NPM 15 – **Smoking Last 3 Months Pregnancy**
- **P**SPM 2 – **Medicaid Clients Oral Health Screening (Ages 0 – 6)**
- **P**SPM 5 – **Smoking Entire Pregnancy**

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

- **N**NPM 13 – **Oral Health Preventive Visits, Pregnancy and Ages 1-17**

- **N**NPM 14 – **Pregnancy and Household Smoking**
- **N**SPM 1 – **Access to Care**
- **N**SPM 2 – **Family Support & Health Education**

The main MCHBG categories of activity that fit into the Cross-Cutting / Life Course domain for Montana are: access to care, adequate insurance, family support and health education, smoking, and oral health. This narrative will report on past accomplishments and challenges, current effectiveness, and initiation of new efforts based on the needs assessment analysis.

Two of these categories contain performance measures which span the timeframes of two 5-Year Statewide Needs Assessments: oral health and smoking. Access to Care and Family Support & Health Education, are new state performance measures created to address top emerging needs identified in the 2015 Statewide 5-Year Needs Assessment. Adequate health insurance is a part of the reporting on last year's accomplishments and current activities, and while not one of the priorities in the upcoming state action plan, will continue to be of importance to the FCHB.

Access to Care

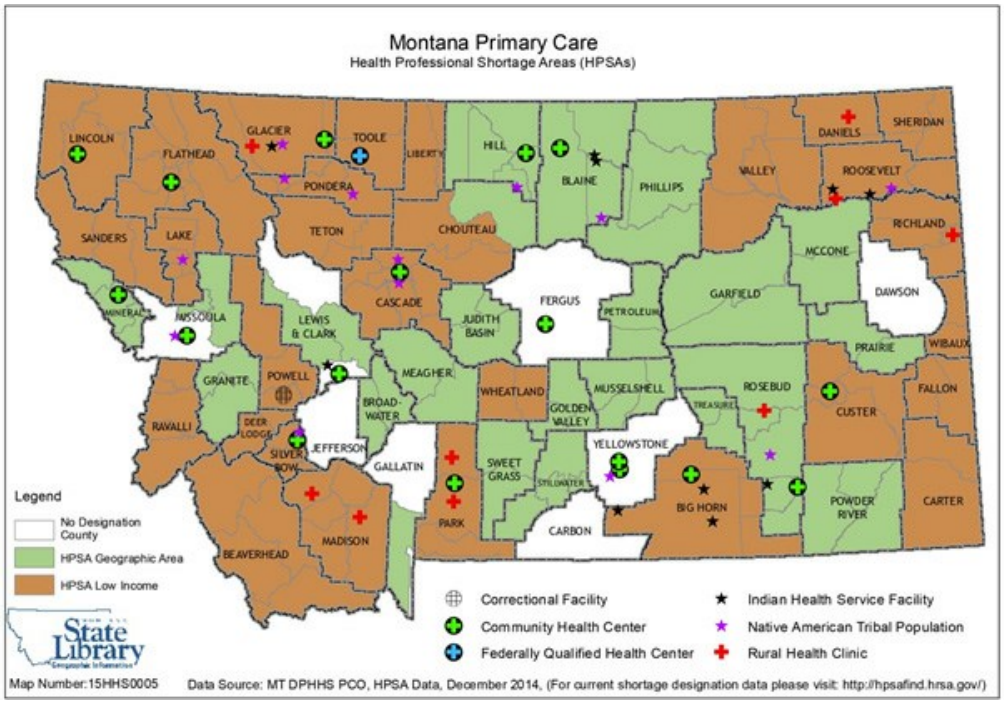
Access to Care is one of the main action-area categories in Montana's State Health Improvement Plan. In addition, the Public Health and Safety Division's Strategic Plan includes these goals:

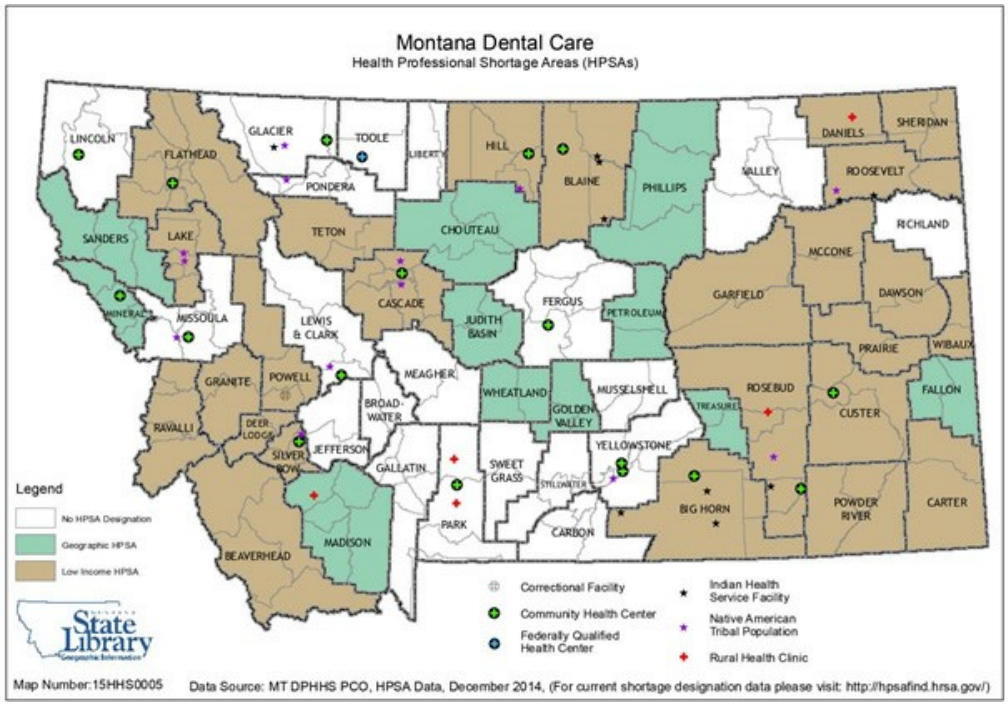
- Improve the delivery of clinical preventive services, and
- Increase use of appropriate health services, particularly by underserved and at-risk populations.

Montana's public health services are delivered primarily through contracts with County Public Health Departments (CPHDs) and tribal public health departments in every county and reservation in Montana, as well as outpatient clinics, community health centers, hospitals and other community-based organizations statewide. Geographic disparities exist, however, in connection to enabling services. The very low population base in Montana's frontier counties creates a double challenge of decreased availability of health services, and lack of health care providers.

There is huge variation in the potential size of the maternal and child population served by Montana's counties. In 2015 the MCH population ranged from 197 individuals in Petroleum County, to 73,779 individuals in Yellowstone County. Of Montana's 56 counties, in state fiscal year 2015 the 10 counties eligible for minimum baseline funding accounted for less than 1% of the state's maternal and child population; 41 counties held only 20%; and the 6 largest counties accounted for 60% of the MCH population. The majority of the counties with low population are where the greatest geographic health disparities occur due to access-to-care issues.

All 56 Montana counties have federally designated Health Professional Shortage Areas (HPSA) or Medically Underserved Areas or Populations (MUA/P). Many federal and state programs use these designations for eligibility and prioritization purposes. The following maps show the Health Professional Shortage Areas for primary care, dental health providers, which relates directly to access-to-care challenges:



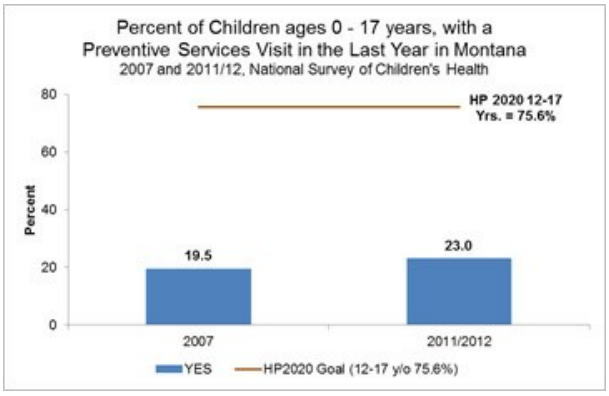


Another area which can be classified as both an access- to-care health disparity and challenge is oral health. The rate of preventive visits for children ages 0-17 years has stayed constant at about 76.6 percent since 2007. The CPHDs identified oral health as the top children's unmet health need, which pertains to the Life-Course domain.

The challenge of access to specialty care also remains a large obstacle for many children with special health care needs in Montana. For some specialty services, (i.e. some pediatric surgeries) families must travel out-of-state for care. In order to reduce the burden on families, the Children's Special Health Section works with staff at tertiary care

centers to ensure families have access to care when returning home.

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



In the past two years, the CPHD contracts have included increasing requirements for planning, reporting and evaluating their MCHBG activities. This transition has been accompanied by additional support at regional trainings and webinars. The large CPHDs take these requirements in stride; but many of the smaller ones have outdated record-keeping systems and problems aggregating enough county specific data to measure the results of their activities in the short term. As a result the number of counties accepting MCHBG funding has decreased from 54 counties participating in fiscal year 2013, to 50 in fiscal year 2016.

During this coming year a study group will be created with representatives of different sized CPHDs, to address the funding formula and provide input on the NPM and SPM State Action Plans. Two new State Performance Measures (SPMs) have also been developed to address priorities not covered by any of the National Performance Measures. SPM 1 was created as a result of the increasing access-to-care challenges identified in the 2015 Statewide 5-Year Needs Assessment:

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

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

Six frontier-level population CPHDs are collaborating with the FCHB on a pilot project of this performance measure for FY 2016. The main focus is to help provide support for *all* of the MCH services they provide. Although activities do not have to fit into any one performance measure, these partners have submitted plans and methods of evaluation.

Adequate Health Insurance

At the end of September 2014, Montana had 103,538 children enrolled in the Healthy Montana Kids Plan (HMK), a combination of children's Medicaid and CHIP coverage. This was an increase of 1,147 children over the previous

September. The Affordable Care Act had an effect on the comparative rates of enrollment however, and the ratio of change between children's Medicaid and CHIP. Children's Medicaid enrollment increased by 5,341, while CHIP decreased by 4,232.

The Census Bureau's March 2014 Current Population Survey, Annual Social and Economic Supplement, stated that the uninsured rate for children ages 0-18 in Montana was at 6%. Coverage equaled 44% for those with employer provided insurance, and children's Medicaid and CHIP covered 37%. All American Indian children in the state are also covered by the Indian Health Service, for medical and public health services.

Work continued on "family friendly" approaches for those seeking health care or who have questions about the Affordable Care Act (ACA). Montana:

- Launched an updated online application to coordinate with the federal streamlined application;
- Sent ACA related information to 75,000 current Medicaid and HMK households explaining that their current coverage met ACA compliance and there was no need to take further action;
- Established a toll-free number for callers with ACA, Medicaid, or HMK Plan related questions;
- Continued to target outreach to the state's seven tribal reservations; and,
- Updated the online self-service portal so applicants may check their benefits or application status.

The "Service First" initiative was established by DPHHS in December 2013 "to provide the right services at the right time in the best way possible for Montanans." The initiative's objectives include: a main street presence in most communities; friendly offices focused on customer service; efficient work processes and case handling; simplified notices, forms, and policies; utilizing technology to better support clients' needs; and workforce training.
Montana elected to facilitate Medicaid enrollment by extending the Medicaid renewal period. This allowed renewals that would otherwise have occurred during January 1 to March 31, 2014 to occur later, and avoided having to operate two sets of eligibility rules because of new household composition rules that went into effect after March 31st.

Children in families with income up to 250% of the Federal Poverty Level (FPL) continue to be eligible for the Healthy Montana Kids program. It is also expected that more uninsured children will be enrolled due to a ripple effect from recent Medicaid expansion, passed by the Montana legislature in April 2015.

Family Support and Health Education

State Performance Measure 2 was created as a result of the increasing need for enabling services and health education, which were identified in the 2015 Statewide 5-Year Needs Assessment. It also helps to address social determinants of health.

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

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

High-level guidance for this performance measure is also provided in the SHIP "Prevention and Health Promotion

Efforts" section, and in the PHSDSP goals to "Promote health by providing information and education to help people make healthy choices."

The main goal of SPM 2 is to provide referrals to enabling services, some case management as needed, and requested health education *in the physical setting of the CPHD facility*. This model does not require as many resources in funding and personnel, and will help track and support work that is already provided by the CPHDs in a more comprehensive manner.

Six CPHDs are collaborating on a pilot of SPM 2 for FY16, and this will provide baseline data for the measure. Three of these counties represent larger population counties in the state: Gallatin, Lewis & Clark and Missoula. Richland County represents a mid-size population county, and sits in the epicenter of the Bakken oil boom area. The two smaller population counties, Madison and Powell, will also pilot the measure.

New forms to support the implementation of SPM 2 were created by the MCH section staff. First, the counties will use a "Family Needs Survey." When clients come into the health department they will be given the opportunity to complete a short survey. From this survey, clients can select from 15 topics commonly mentioned by families, as areas where they would like help in identifying resources or learning more information. At the end is a place to write down additional requests for services not mentioned on the list.

If a CPHD client indicates an interest to meet with a staff member to discuss the topics selected, then an appointment is made either immediately or as soon as possible. At that time a consent form is signed. The staff member then uses an assessment tool which was created to gather the information needed to provide the most effective assistance.

The counties will collect de-identified data on a standardized form to submit to the FCHB. The information covers: the main survey topics selected by the client, their MCH population category, the types of referrals made, and any health education topics - covered along with dates.

Smoking During Pregnancy & Household Smoking

At the beginning of FY 2014, nine sites provided home visiting services as part of the Montana Maternal and Early Childhood Home Visiting Program (MT MECHV), which includes state funding and federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding. They implemented the Parents as Teachers (PAT) or Nurse-Family Partnership (NFP) home visiting models. Tobacco use assessment, and referral to cessation resources, was provided under both models. Clients who used tobacco were referred to cessation services if appropriate. The Montana Tobacco Use Prevention Program (MTUPP) was a partner in providing cessation support for pregnant and port-partum women, and provided training as needed. In FY 2014, 137 of 452 (30.3%) primary caregivers reported smoking when they enrolled in the MT MECHV program

In the summer of 2014, ten new sites (and 15 new contractors) began implementing evidence-based home visiting using PAT, NFP, SafeCare Augmented or Family Spirit with federal MIECHV Expansion funds. The new models were added because SafeCare Augmented addressed child abuse and neglect and is a shorter curriculum, and Family Spirit is specifically developed for tribal communities. This increased the total program caseload to approximately 1,000 clients. Some sites provide more than one model. The total number sites implementing each model is: PAT = 18, SafeCare = 7, NFP = 5, and Family Spirit = 1. Approximately 20% of the clients are women who enroll while pregnant. Under several of the home visiting models they are served for multiple years: Parents as Teachers, Nurse-Family Partnership, and Family Spirit.

During FY 2015, sites funded with state funding and/or federal Maternal, Infant, and Early Childhood Home Visiting

(MIECHV) funding continued to implement their selected home visiting model. Tobacco cessation is an ongoing component. Clients receive support and follow-up from the home visitors about their cessation efforts. Women are referred to MTUPP as needed and the program provides training to the home visitors. For clients served between October 2011 and December 2014, 36% of primary caregivers who reported using tobacco at enrollment quit while enrolled.

MTUPP is requiring local tobacco prevention specialists to provide outreach and education about their quit-line pregnancy program to the health clinics in their communities which serve pregnant women. QUIT Line information is available at: http://dphhs.mt.gov/publichealth/mtupp/quitline.aspx

In FY 2016, home visitors will continue to assess primary caregivers and pregnant enrollees for tobacco use. Clients who use tobacco will be referred to appropriate cessation services and will receive support and follow-up from the home visitors about their cessation efforts. The program collects and reports on the percent of families with tobacco use in the home at the time of enrollment, and the percent of primary caregivers and pregnant participants who are current tobacco users (measured at enrollment and annually).

Over the next 5 years, home visitors at implementing sites will continue to assess the primary caregivers and pregnant enrollees for tobacco use, and refer to appropriate assessment programs if appropriate. The program will continue to collaborate with the Montana Tobacco Use Prevention Program (MTUPP) on tobacco cessation efforts.

In FY 2015, Toole CPHD selected SPM 5 (smoking during anytime during pregnancy) and developed these three activities and evaluation methods:
Activity 1: All pregnant WIC participants will be screened for tobacco use and referred to the Quitline if they use tobacco.
Evaluation: Staff will maintain a log sheet of all pregnant WIC participants who report tobacco use and indicate whether they were referred to the Quitline.
Activity 2: All pregnant WIC participants who report tobacco use will receive a tobacco cessation pamphlet.

Evaluation: Staff will maintain a log sheet of all pregnant WIC participants who report tobacco use and indicate whether they were given a tobacco cessation pamphlet.

Activity 3: Tobacco cessation resources will be provided to local health care providers with information on the reasons to encourage women of child bearing age to not use tobacco and to quit if they already use.

- Evaluation: The tobacco use prevention coordinator's catalyst reporting will indicate the tobacco cessation resources shared with local health care providers.

In FY 2016, Park CPHD has chosen to focus on NPM 14 as its performance measure. Park's activities and evaluation methods are:

- Activity 1: Identification of women smoking in the first trimester through provider referrals
  - Evaluation: Continual monitoring of number of referrals from providers

- Activity 2: Referral of women to the Quitline
  - Evaluation: Number of women receiving services will be tracked

- Activity 3: Education outreach for reproductive aged women currently smoking to increase cessation prior to conception
  - Evaluation: Number of women served by education services and number of Quitline referrals

Oral Health

The Maternal and Child Health (MCH) Section Supervisor provided direct oversight of the Oral Health Program (OHP) until February 2014. Then, through funding provided by HRSA's Grants to States to Support Oral Health Workforce Activities, a full-time coordinator was hired to provide day-to-day oversight and administration of OHP activities, and to promote oral health assessments for children ages 0 to 6. The OH Coordinator, a dental hygienist with a Master's Degree in Community and Rural OH, serves as a resource for county public health departments (CPHD), public and private entities, and directly oversees the Grants to States to Support Oral Health Workforce Activities which include:

- Partnering with the University of Washington School of Dentistry for 27 dental student rotations in underserved areas;
- Collecting dental sealant surveillance data by partnering with the Montana Dental Association, Montana Dental Hygienists' Association and Sealants for Smiles, who conduct Basic Screening Survey (BSS) of 3rd grade children;
- Training 20 dental health providers on how to complete a BSS;
- Expanding the reach and scope of two Medicaid Programs: the Access to Baby Child Dentistry (ABCD) and fluoride varnish applications in primary care settings by physicians to include more dental and primary care practices;
- Promoting the Office of Rural Health/Area Health Education Center's (ORH/AHEC) efforts providing outreach for dental provider recruitment/retention in rural and underserved communities;
- Providing technical assistance to the ORH/AHEC Career Outreach Pipeline Program" aimed at fostering interest in dental careers among Montana's adolescents by providing dental career learning opportunities to 6,000 students;
- Collaborating with the Primary Care Office on a dental provider survey which is collecting data about the dental provider's future number of working years; and,
- Conducting outreach to foster inter-professional oral health activities among public health and primary medical providers for care collaboration and sharing the results with the ORH/AHEC, UW School of Dentistry, and MT Dental Association. The goal is to increase the number of health professionals which will help to increase the number of MT children receiving preventive care, including dental sealants.

The OH Coordinator offered technical assistance to a CPHD with a high percentage of Native American children, which had chosen NPM 9, through facilitation of open mouth screenings. Fifty-nine children were screened in grades kindergarten through 5 and among children with permanent molars, less than 15% had preventive sealants. The OH Coordinator provided the public health nurse with an OH Resource Guide outlining provisions for services, including travel reimbursement for Medicaid enrollees and the Sealants for Smiles (SFS) program contact information. Sealants for Smiles is a state-wide collaborative of dental professionals that provide school-based dental sealants in schools with over 50% free and reduced lunch populations.

The OHP will continue to build capacity, by increasing the awareness of the impact of oral health on overall health. Outreach during FY 2015 offered an opportunity to begin collaboration with other Montana DPHHS programs and public health stakeholders, to integrate oral health promotion. A communication plan was implemented and evaluation data is continuously being collected related to outreach. During previous outreach, a primary focus was on preventing the transmission and infection of decay-causing bacteria during infancy and early childhood - while emphasizing the importance of dental care during pregnancy.

The OH Coordinator continued work to develop an oral health surveillance system, and a draft burden of oral disease document called "Oral Health Surveillance, 2004-2013." The results indicated that during 2006 and 2014, 30 and 40

schools participated in the surveillance program, respectively. Approximately two-thirds of surveyed Montana 3rd graders in 2006 and 2014 had a history of dental decay. For both 2006 and 2014 the rate of untreated decay remained higher than the Healthy People 2010 target of 21%. Among children identified with dental needs, less than 3% had urgent needs in 2014 compared with over 7% in 2006. The percentage of children with the presence of preventive dental sealants increased nearly 10% since 2006 and is above the Healthy People 2010 objective for the percentage of children with dental sealants of 50%. In 2014, over 92% of children classified as AI/AN had a history of dental decay and over 56% had untreated decay, compared with 58% and 18% of children classified as white, respectively. The data collection will be utilized to foster program evaluation and future planning related to the oral health of MT children. The data is also being included in the Montana OH surveillance system, where analysis can help to address disparities in the 0 to 6 year old population. The full report is accessible at: http://dphhs.mt.gov/publichealth/Montana-Public-Health

The OH Coordinator is collaborating with Sealants for Smiles, and the Ronald McDonald Care Mobile, to establish a sustainable foundation for future school-based sealant activities. Additional outreach includes collaboration with the Montana Dental Hygienists' Association Public Health Committee, to conduct an assessment of 27 WIC Agencies to determine the knowledge level of WIC staff about oral health. The results will be utilized for assistance in training WIC staff, which was requested by the WIC Program.

The OH Coordinator conducted targeted trainings for MCHBG public health staff in 5 locations throughout MT during March 2015. Participants were provided an overview of the etiology of disease, and a laminated copy of the American Academy of Pediatrics oral health risk assessment tool. They were also given a demonstration of "knee-to-knee" dental screening practices including fluoride varnish applications for children identified as high-risk. Evaluation methods, which included a pre- and post-test during the trainings and a follow-up evaluation afterwards, were used to determine the utilization of materials presented.

During FY 2015, the OHP completed controlled dental surveillance on the third grade population which will continue to be disseminated during outreach. During FY 2016 the OHP will complete dental surveillance in the Head Start (HS) population to foster early preventive dental care in high-risk populations. Preliminary outreach and preparation for HS surveillance began during FY 2015 to engage HS staff and stakeholders, and data collection will begin early in FY 2016.

The recently developed Montana Oral Health Surveillance System includes data on the proportion of Medicaid-enrolled pregnant women that receive dental services. The OHP communication plan includes outreach to obstetric providers with Centers for Medicare and Medicaid Services (CMS) print materials to increase the proportion from the FY 2014 baseline of 20%. The surveillance system also includes CMS Form-416 data, related to utilization of dental care among Montana children. Outreach will continue to foster early initiation of dental care to determine risk and reduce the prevalence of disease.

Surveillance assessment of primary care settings was made to ascertain how many were providing preventive dental care. A Medicaid query during SFY 2013 determined that only 2 physicians in Montana were reimbursed for fluoride varnish applications. Those providers indicated that there were no significant barriers to the delivery of oral health services in this setting, so outreach activities on this subject were included in conjunction with other work activities.

Cross-Cutting/Life Course - Annual Report

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					

	2016	2017	2018	2019	2020
Annual Objective	22.0	22.0	22.0	22.0	22.0

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	78.0	78.0	78.0	78.0	78.0

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	16.0	16.0	16.0	16.0	16.0

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	25.0	25.0	25.0	25.0	25.0

Please see the "Plan for the Application Year" for the information for the report, as we did not create two separate documents.

Other Programmatic Activities

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

II.F.2 MCH Workforce Development and Capacity

MCH Workforce Development and Capacity

Montana's Maternal and Child Health workforce consists of state and county level public health professionals working to improve the lives of the maternal and child health population as outlined by Title V of the Social Security Act, Maternal Child Health Block Grant (MCHBG). Responsibility for the main administration of the MCHBG resides with the Maternal and Child Health Section (MCH) within the Family and Community Health Bureau (FCHB). The Children's Special Health Section (CSHS) is also located in the FCHB and covers implementation of services for children and youth with special health care needs.

In 2012, the Public Health and Safety Division (PHSD) began the state health improvement planning process, which culminated in the June 2013 release of the "Big Sky. New Horizons. A Healthier Montana: A Plan to Improve the

Health of Montanans," a roadmap through which Montana can improve the health of its citizens. The roadmap, also referred to as the State Health Improvement Plan (SHIP) outlined five health improvement priorities and four key action areas, including "Strengthening Montana's public health and health care system."

The SHIP formed the basis for the PHSD Strategic Plan; 2013-2018 published in 2013. The PHSD Strategic Plan is organized into 7 Key Result Areas with corresponding goals and strategies. Under Key Result Area 6, Internal Operations and Workforce Development, Goal 6.4 states, "Recruit, retain and develop a highly effective workforce." The strategies under this goal include:

- 6.4.1 Integrate nationally-recognized public health workforce competencies into hiring, performance standard setting, evaluation, individual development planning, orientation, training and succession planning processes.
- 6.4.2 Develop career ladders to allow for employee advancement and retention.
- 6.4.3 Train employees to use evidence-based public health practices and to contribute to public health literature.
- 6.4.4 Collaborate with schools of public health and other academic programs to develop the public health workforce.
- 6.4.5 Recruit, support and train public health interns and fellows to increase public health capacity, enhance public health education and training, and increase the likelihood of recruiting highly trained public health workers

The SHIP and PHSD Strategic Plan were integral components of the PHSD's application to the Public Health Accreditation Board (PHAB) submitted in May, 2015. An outgrowth of these two documents is the PHSD Workforce Development Plan released in November 2014, which specifically addresses the PHAB Domain 8: Maintain a competent public health workforce and the aforementioned strategies. In the spring of 2013, the PHSD assessed the competency of its staff using adapted versions of two nationally recognized sets of public health competencies: the *Core Competencies for Public Health Professionals* and *the Competencies for Applied Epidemiologists in Governmental Public Health Agencies.*

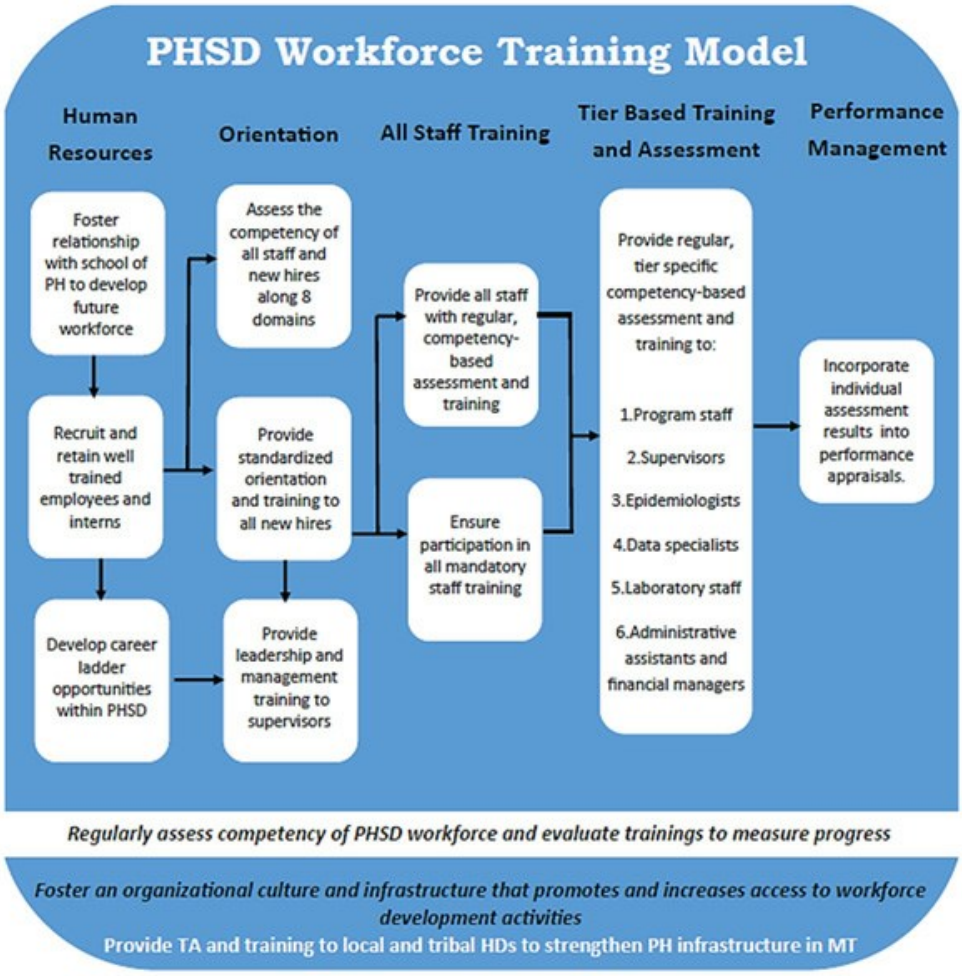
The PHSD developed a workforce training model by combining the key elements of the PHSD Strategic Plan, Workforce Assessment and the PHAB standards related to workforce development. The PHSD Workforce Development Plan was released in November 2014. These plans are accessible at: http://dphhs.mt.gov/publichealth.aspx

The Montana Department of Public Health and Human Services (DPHHS) is committed to becoming an Adverse Childhood Experiences (ACES) and Trauma-Informed Agency and is systematically providing education for employees and contractors. In March 2015, all DPHHS staff were required to complete a 20-minute online course as an introduction. DPHHS Master Trainers are currently working with division-level ACES facilitators to provide specific training and technical support to programs wanting more tools to move this work forward. Children's Special Health Services Supervisor, Rachel Donahoe, has received certification as an ACES Trainer.

In May 2015, DPHHS executives, managers and invited partners from across Montana State government gathered for education on the implications for state service system improvements - from the ACES Study and related neuroscience, epigenetics, and resilience research. This two-day workshop served to increase knowledge about

ways that toxic stress during development can affect cognition, relationships, health, behavior, patterns of crisis and coping, and ability to comply with rules and instructions.

The FCHB is one of five Bureaus housed in the PHSD, with a total of 192 employees, of which 39 work in the FCHB, all of whom are located in Helena. The MCHBG directly funds 11 FCHB employees: supervisors, program specialists, MCH epidemiologist, financial specialist, nurse consultants, and administrative support, and the indirect rate covers a portion of the Title V Director's position. The PHSD Workforce Plan (illustrated below) acknowledges the unique training needs of all the staff and provides the framework for how the PHSD will systematically train its workforce.



The Workforce Plan is in alignment with PHAB standards. For example: PHAB Standard 8.2 requires that health departments *"Assess staff competencies and address gaps by enabling organizational and individual training and development opportunities."* The PHAB guidance for this standard recommends using the Core Competencies for Public Health Professionals developed by the Council on Linkages Between Academia and Public Health Practice for the competency assessment.

Based on this advice and after researching other national sets of core competencies, the PHSD developed a comprehensive workforce assessment that consisted of 6 different assessment tools administered to 7 different groups of employees which drew from three sets of national competency standards. The results are illustrated as follows:

Employee Group	National Set of Competencies Used	# of Competencies Assessed	Organization that Developed Competency Set	Completion rate
Program Staff	Core Competencies for Public Health Professionals– Tier 1	66	Council on Linkages	79%
Supervisors	Core Competencies for Public Health Professionals– Tier 2	68	Council on Linkages	69%
Upper Management	Core Competencies for Public Health Professionals– Tier 3	79	Council on Linkages	82%
Admin Assistants & Financial Specialists	Core Competencies for Public Health Professionals– Tier 1, Financial Planning and Management Domain	12	Council on Linkages	79%
Epidemiologists	Competencies for Applied Epidemiologists in Governmental Public Health Agencies– Tier 2	244	Council for State and Territorial Epidemiologists	81%
Data Specialists	Competencies for Applied Epidemiologists in Governmental Public Health Agencies– Select competencies from Tier 1	38	Council for State and Territorial Epidemiologists	72%
Laboratory Staff	2011 National Laboratory Capacity Assessment competency areas	38	Association of Public Health Laboratories	84%

This workforce assessment tool forms an integral component for ongoing assessment of PHSD staff. The PHSD plans to re-administer its workforce assessment every three years, to evaluate the impact of the workforce development plan as it is implemented. In addition, in the first week of employment at the PHSD, all new hires will be sent the assessment that matches their job description to evaluate their baseline level of competence.

The PHSD is cognizant of the fact that results from the 2013 Workforce Assessment indicated that 30% of the staff plan to retire or find employment outside of the PHSD within the next five years. Of the 11 directly funded FCHB staff, 2 staff members will retire within the next 18 months. Orienting and training new employees is a component of the PHSD Workforce Development Plan and is another example of how the Plan will support the MCH workforce development and capacity. The Curricula and Training Schedule for all PHSD employees is illustrated next.

CURRICULA AND TRAINING SCHEDULES

Training Name	Audience	Schedule	Core Competencies or Domains Covered in Curricula	Administration Format
PHSD Division overview and Strategic Plan	All PHSD new hires	Offered quarterly	Council on Linkages 1A2, 5A8	Live format
Tier-specific PH Competency Assessment	All PHSD new hires	Week 1 of employment	All competencies and domains assessed for specific position	Survey Monkey
PHSD Support Services	All PHSD new hires	Week 1 of employment	Council and Linkages 7A2	Moodle
PHSD Integrated Performance Management System	All PHSD new hires	4 trainings completed by end of Month 1 of employment	Council on Linkages 7A7, 7B8, 7C9, 7A8, 7B9, 7C10, 8A7, 8B7, 8C7, 2A10	2 online trainings (Moodle), two in- person trainings with supervisor & IPMS staff
Montana State Health Improvement Plan	All PHSD new hires	Month 1 of employment	Council on Linkages 1A1, 1A2, 5A8	Moodle
PHSD Policies and Procedures	All PHSD new hires	Week 1 of employment	Council on Linkages 7A1 and 7A2	Moodle
On-Boarding Evaluation	All PHSD new hires	End of Month 1 of employment	Evaluation of all competencies and domains covered in on-boarding training	Survey Monkey
Document that training has been completed	All PHSD new hires	End of Year 1 of employment		Supervisor documents and submits to HR

The PHSD established a partnership with the University of Washington (UW) whereby UW offered a Public Health Management Certificate course to interested state and county public health professionals who completed an application process. The application process required each individual to identify what skills they wanted to gain

through participating in the program and how they would utilize those skills after program completion. There was a monetary investment for the participants, which was covered by the participant's employer.

The first cohort of 29 students, 14 state and 15 county level professionals, began their masters' level coursework at the 2013 PHSD Summer Institute and participated in monthly webinars using distance education technology. Included in the 2013 student cohort were the Title V Director and the WIC Retail Program Manager. These 29 public health professionals will be joined by the 2015 cohort of 30 students, who will begin their coursework at the week-long 2015 PHSD Summer Institute Conference. The 2015 cohort includes the CSHS Supervisor, Health Education Specialists working in the Women's and Men's Health and Maternal & Early Childhood Home Visiting Sections, and a WIC Retailer Services staff member.

The Summer Institute includes a Leadership Plenary designed to help all public health employees understand the challenges of employee succession and transition. The theme of the session is leadership succession, which is a hot topic right now across the nation in public health academic circles and in practice. The session will cover how to plan for and conduct a change of leadership of Public Health (PH) programs and management of PH systems, sections, or offices (departments) to prevent a shortfall in PH services delivery, or to maintain a band of excellence during the transition. The Title V Director and MCH Supervisor will be attending the Leadership Plenary.

The PHSD has initiated in house staff trainings. Ongoing trainings include Writing Policies and Procedures and Performance Management. All staff will be afforded the opportunity to participate in the Fall 2015 Plan, Do Study, Act training.

In addition to the PHSD Workforce Development Plan capturing the State Title V staff's specific training needs, each staff person is afforded the opportunity to specify their training needs to their direct supervisor at their annual performance evaluation, which lead to the CSHS Supervisor as an AMCHP CYSHCN mentor in FY 2014. Title V staff often enroll in courses offered by the State of Montana's Department of Administration includes the Professional Development Center (PDC). The PDC offers classes in person and on line classes in topics such as Effective Communication Skills, Supervision for the 21st Century, and Strategic Planning. For more information go to: http://pdc.mt.gov/

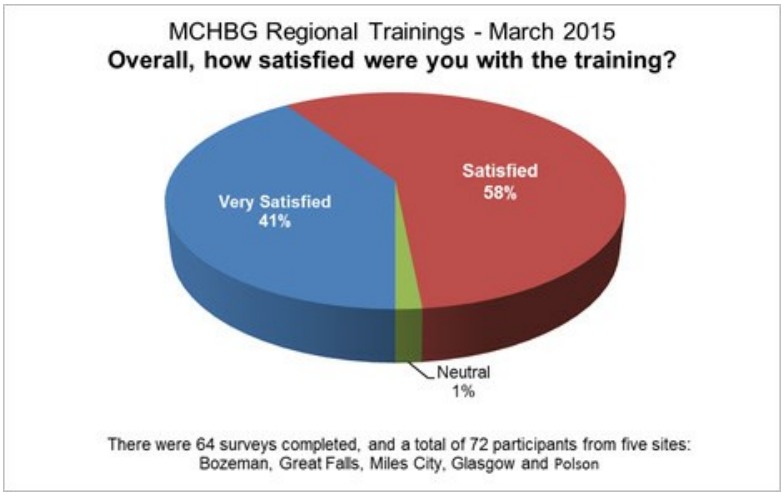
County public health departments (CPHDs) and Tribal Health Departments serve as very important partners in serving the maternal and child population in Montana. Recognizing this fact generated work by the PHSD Systems' Improvement Office to further explore how the PHSD could develop a strategy for supporting and strengthening CPHDs and Tribal health departments. Working from the PHAB national standards and the state health improvement plan, the PHSD developed a survey to understand board of health function and the capacity of CPHDs and Tribal health departments.

The survey was developed to assess board of health function, capacity, funding sources, accreditation, knowledge, attitudes, and beliefs about health department function, and areas where PHSD can support CPHDs and Tribal health departments. The survey was reviewed by PHSD Bureau Chiefs and lead local public health officials from different sized jurisdictions prior to being administered. The results of the survey will be used by PHSD to improve the support provided to CPHDS and Tribal health departments to strengthen the public health infrastructure and ultimately the health of Montanans. The survey result report, Lead Local Public Health Official Survey, is being vetted for publication anticipated to be in the Fall of 2015.

Preliminary information from the survey paints a picture of the CPHD and Tribal health department workforce and capacity future needs. Lead local public health officials were full time (40 hours/week) in 70% (39/56) of the jurisdictions and part time in 30% (17/56) working an average of 22.9 hours/week (range: 5–32 hours/week; median: 22 hours/week). The average tenure of lead local public health officials was 9.9 years (range: 8 months–38 years; median: 6 years).

The survey also indicated that workforce capacity is a challenge. Almost a third of lead local public health officials were part time and 22 estimated retiring in the next five years. The results of the survey demonstrated many potential areas were the public health system in Montana can be strengthened. Twelve recommendations were developed, which included:
12. PHSD needs to develop trainings and resources to address the areas of needed support for local and Tribal health departments

As noted in the PHSD Workforce Training Model graphic, the PHSD will provide technical assistance and training to CPHDs and tribal health departments to strengthen the public health infrastructure in Montana. To the extent that resources allow, the PHSD program staff will work with the CPHDs and Tribal public health departments providing training, resources, and technical assistance. For example, the Maternal and Child Health Section provides yearly training to the MCHBG contractors. The following graph details attendee's feedback on the value of the trainings in March 2015:



II.F.3. Family Consumer Partnership

Montana 2016 Annual Application and 2014 Report
Family and Consumer Partnership

Montana's racial make-up is predominately white, with a 2013 census estimate at 89.5% of the population. American Indians make up the largest minority, at approximately 6.5%. The ethnic Hispanic or Latino population is only 3.3%, compared to 17.1% nationwide. Montana's Title V-- Maternal Child Health Block Grant (MCHBG) program provides needed public health services to all Montanans living in one of the 50 counties which have selected to receive FY 2016 MCHBG funding. For those opt-out counties, the state level MCH staff is available to provide technical assistance and referral services as needed.

The public health services provided by MCHBG funding compliment the Department of Public Health and Human Services (DPHHS) goals:

- All Montana children are healthy, safe and in permanent, loving homes.
- All Montanans have the tools and support to be as self-sufficient as possible.
- All Montanans are injury-free, healthy and have access to quality health-care.
- All Montanans can contribute to the above through community service

Furthermore, the MCHBG supports the Public Health and Safety Division (PHSD) **Vision:** Healthy people in healthy communities; and its **Mission**: Improve and protect the health of Montanans by creating conditions for healthy living. And notwithstanding, the MCHBG supports the FCHB Mission: To promote and improve the health and safety of Montana's women, men, children, and families.

Family and consumer engagement is gathered in a number of methods, which are detailed as follows:

Advisory Committees -

Children and Youth with Special Health Care Needs (CYSHCN) voices' are heard by the Consumer Advisory Council (CAC). The CAC aides in directing the efforts the Rural Institute of the University of Montana, in planning strategies to educate families about CYSHCN transition to adult services. The CAC is made up of 19 members who are primarily youth and young adults with special health care needs, and their parents. The most recent addition to the CAC is a representative from the Montana Developmental Disabilities Program.

The CAC recently completed a draft customer satisfaction and usefulness survey for the document "Planning Your Transition from Pediatric to Adult Health Care: A Workbook to Help You Take Charge of Your Health." Once the instrument is approved, it will be disseminated in both hard copy and electronic form, and the data collected will be used to update and revise the guide in the July 1, 2015-June 30, 2016 contract year.

The Women's and Men's Health (WMH) Section is Montana's Title X recipient, and a key partner for providing reproductive health planning services to the maternal and child health population. WMH has established the Family Planning Information & Education Committee (IEC). The IEC meets regularly throughout the year to review and plan family planning priorities.

The Public Health System Improvement Task Force (PHSITF), created when the Montana Legislature adopted the Public Health Improvements Act in 1995, serves as a source of information for MCHBG development. The PHSITF members include four local health department representatives, based on the different size populations of jurisdiction; Tribal Health Departments; Local Boards of Health; Indian Health Service (IHS); Montana Association of Counties (MACO); Montana Environmental Health Association (MEHA); Montana Public Health Association (MPHA); and the Montana University System. It is co-chaired by the PHSD Administrator and lead local public health official. The PHSITF was involved with the 2015-2020 MCHBG Needs Assessment, as well as previous editions.

Children's Special Health Services (CSHS) is developing a Cleft/Craniofacial Clinic Stakeholders Group which will have parent representation. This group will be responsible for providing recommendations to the Montana Cleft Team members for achieving American Cleft Palate Association (ACPA) Standards for team care, and for providing consultation to the department.

Strategic and Program Planning, and Quality Improvement -

In June 2013, the PHSD State Health Improvement Plan (SHIP) was approved by the Governor. The Governor also appointed a diverse, 16 member, Task Force to assist the PHSD in implementing the State Health Improvement Plan and monitoring progress in creating a *Healthier Montana*. The Task Force's work on the following will be used

to further shape and refine Montana's Title V Services:

- Focusing on ways to advance these four major strategies:1) Public health policy development; 2)Prevention and health promotion; 3) Access to health care, particularly clinical preventive services; and 4)Strengthening Montana's public health and health care system.
- Identifying opportunities to strengthen existing partnerships, build new partnerships, and encourage partner participation in creating a healthier Montana through local initiatives by implementing specific strategies outlined in the plan. Particular emphasis will be placed on increasing the use of evidence-based clinical preventive services and evidence-based public health programs and services to address documented health needs.

The SHIP plan formed the basis for the PHSD Strategic Plan, 2013-2018, which outlines measurable objectives and strategies to achieve these objectives. The PHSDSP is being implemented by the 31 programs in the PHSD using the Integrated Performance Management System, whereby all PHSD programs have developed operational plans and logic models that are aligned with the strategic plan objectives. Twice a year, each program provides a presentation on the status of their program's progress in reaching their objectives to the PHSD upper management team. The team is composed of the PHSD Division Administrator, PHSD Bureau Chiefs, the State Medical Director, state epidemiologist, and the Office of System's Improvement Supervisor. They provide feedback and suggestions on areas such as how to improve the quality of their program, data collection methods, and broadening the reach of their program.

Workforce Development -

Beginning in 2010, several FCHB and PHSD staff members have been involved with the Montana Health Care Workforce Advisory Committee (MHWAC), a project under the auspices of the Office of Rural Health/Area Health Education Center (ORH/AHEC). ORH/AHEC received a State Health Care Workforce Development Grant from HRSA (Health Resources and Services Administration in the US Department of Health and Human Services). The outcome of the grant was the development of a Healthcare Workforce Strategic Plan for Montana, published in November 2011.

The MHWAC continues to meet monthly and addresses workforce issues at both the community and state level. The public health perspective is provided by the FCHB and PHSD at the regular MHWAC meetings, which are now focused on the Montana HealthCARE Grant, a partnership with the Montana Department of Labor and Industry. For more information about the HealthCARE Grant, please see the February 9, 2015 Meeting Materials at: http://healthinfo.montana.edu/workforce-development/mt-workforce-advisory-committee.html

Maternal and Child Health Block Grant Development and Review –

Input from County Public Health Departments (CPHD) is gathered yearly from a Pre-Contract Survey (PCS). The PCS provides information about the current and emerging health needs of the county's maternal and child health population. This input serves as an important source of information for determining state performance measures.

The CPHDs are aided in determining their county's needs from the results of client surveys, which are a MCHBG contract requirement. The CPHD client surveys gather information about their consumer's current and future health care needs, and the results are used for determining which performance measure to choose, and what activities to implement for making a positive change.

The Public Health System Improvement Task Force (PHSITF) provides input on the MCHBG application and annual

review as well as the needs assessment. For the 2015-2020 Needs Assessment the PHSITF members completed either a face-to-face or phone interview.

Materials Development -

The CAC has provided an avenue for consumers to review and provide input on publications, i.e. the application process and guidelines for distribution of Community Investment Funds; the updated "Developmental Disabilities and Mental Health" brochure; and transition-related messages that are posted to the Rural Institute of Montana website at http://ruralinstitute.umt.edu/

The 2015 MCHBG Needs Assessment resulted in the creation of SPM 2—Family Support and Health Education. Six CPHDs are collaborating with the FCHB on a pilot project of this performance measure for FY 2016. The first meeting was held on June 2, 2015 which focused on the data reporting format.

Advocacy -

State employees are limited in their ability to advocate for or against any type of public health measures, which extends to providing guidance to or encouraging consumers to advocate themselves. For additional information: access the Political Activity Fact Sheet at: http://hr.mt.gov/newresources

II.F.4. Health Reform

Montana 2016 Annual Application and 2014 Report
Health Reform

In FFY12, Department of Public Health and Human Services (DPHHS) began working on implementing the Affordable Care Act (ACA). Montana's ACA approach was a partnership undertaken by the DPHHS Director's Office and the Montana Commissioner of Securities and Insurance (MT CSI). DPHHS and MT CSI staff held weekly program impact meetings to incorporate policy and system updates, and identify stakeholders' process and procedures, resulting in a collaborative and coordinated department wide approach in readying for ACA implementation.

During this time, DPHHS staff fielded questions from the public, providers, and other statewide partners about the ACA and the impact open enrollment would have on them. DPHHS and the MT CSI developed a formal internal and external stakeholder communication plans to assure optimal dialogue and outreach. The MT CSI provided information on state-specified Medicaid requirements to navigators and certified application counselors. They also assisted clients who needed help and wished to meet with those resource individuals/agencies.

Montana's partnership approach also produced cohesive ACA messages used by all the State of Montana Departments and Agencies, with a single point of contact. The MT CSI created an entire website to promote the ACA and help individuals maneuver the process of choosing a provider: www.montanahealthanswers.com. This site also includes the section: "Talk to a Human."

American Indians account for 6.5% of Montana's population. The DPHHS Director's Office Tribal Relations Manager organized efforts to provide education and outreach on all seven tribal reservations. The Tribal Relations Manager began work in August 2013 by meeting with the Indian Health Service and the MT CSI staff regarding ACA outreach in Indian Country.

Included on the DPHHS Director's and MT CSI stakeholders group was a Women's and Men's Health Section (WMHS) staff member, who remains involved with the ongoing activities supporting ACA in Montana. These activities include outreach, referrals, direct enrollment assistance, resource sharing, developing and maintaining partnerships, and training. By partnering with WMHS, the Title V program staff, housed in the Family and Community Health Bureau (FCHB) are able to share the stakeholder's group messages with County Public Health Departments (CPHDs), tribal health departments and other interested partners.

Outreach: An ACA and Marketplace e-newsletter is sent out to family planning providers, public health officials, and other interested parties throughout the state, with a distribution of 278 recipients. The newsletter was sent out weekly during open enrollment and monthly outside of open enrollment. Client educational and promotional materials about ACA, Medicaid, Healthy Montana Kids (Montana's CHIP) and Plan First (Montana's Medicaid family planning waiver) are distributed to agencies throughout the state including health departments, community health centers, and non-profits. These materials are also distributed to Certified Application Counselors and Navigators throughout the state as well as partners such as local job service corps, domestic violence service organizations, volunteer tax assistance programs, and other social service organizations.

The WMHS will be part of the DPHHS Medicaid Expansion Outreach and Communications Team in 2015-2016. DPHHS will also be a sponsor for www.covermt.org, a Montana branded consumer friendly website which will include information about how to apply for health coverage, how to find an assister, and a calendar of local events.

Direct Enrollment Assistance and Education: WMHS is the sole Title X grantee in Montana. During the second open enrollment period, WMHS received funding under the Title X Outreach and Enrollment Project, to provide direct enrollment assistance to current and prospective family planning clients at five service sites in the state. The five clinics have provided enrollment assistance to over 2300 clients during the first 3 quarters of the grant period. WMHS has applied for a second year of funding to begin August 1, 2015. Clinics also provide education to clients who are new to insurance about how to use their new insurance and the basics of health literacy.

Referrals: Title V and Title X agencies provide referrals to healthcare.gov, Medicaid offices, the MT CSI, and local assisters as appropriate.

Resource Sharing: WMHS participates in conference call and webinar meetings hosted by HHS Region VIII, the Montana Primary Care Association (PCA), and the three Navigator grant recipients in the state, to share resources and best practices. The three Navigator grant recipients are: Montana/Wyoming Tribal Council; Montana Health Network; and Planned Parenthood of Montana.

Partnerships: The WMHS has developed and maintained strong partnerships with organizations outside of DPHHS including the three Navigator grant recipients; the Montana PCA, and the MT CSI. Within DPHHS, WMHS has partnered with the Office of Intergovernmental Affairs, the Office of Indian Affairs, and Medicaid. Local agencies maintain partnerships with hospitals, community health centers, and other social service agencies to partner on events and provide cross-referrals.

Training: The WMHS has provided in-person and webinar trainings on the ACA and Plan First to the Montana Family Planning Administrators, family planning clinic staff, Maternal Infant Early Childhood Home Visiting (MIECHV) contractors, and health providers throughout the state. Basic ACA trainings have been provided to the supervisors and bureau chiefs throughout the Public Health and Safety Division at DPHHS. The WMHS was a participant at the

Montana Outreach and Enrollment Summit during the second enrollment period, a training opportunity for Montana assisters. WMHS is currently part of the planning team for the 2nd Annual Outreach and Enrollment Summit planned for October 2015.

CPHDs and Tribal Health Departments serve as very important partners in serving the maternal and child population in Montana. Recognizing this fact generated work by the PHSD Systems' Improvement Office to further explore how the PHSD could develop a strategy for supporting and strengthening CPHDs and Tribal health departments. Working from the Public Health Accreditation Board national standards and the state health improvement plan, the PHSD developed a survey to understand board of health function and the capacity of CPHDs and Tribal health departments.

II.F.5. Emerging Issues

Emerging Issues

Emerging needs were identified as a part of the 2015 Statewide 5-Year Needs Assessment process. These were carefully considered while selecting the National Performance Measures (NPM) and developing the State Performance Measures (SPM). A more detailed narrative of health priorities and emerging issues for the 2016-2020 time period is provided in Montana's *State Selected Priorities* narrative.

Emerging maternal and child health needs are oftentimes addressed by other DPHHS programs and private and public organizations, which the Title V/MCH staff maintains partnerships with. For example, MCH Staff worked closely with the Children's Mental Health Bureau and Early Childhood Services Bureau on the Montana Project LAUNCH Initiative (MT-PLI), a grant opportunity from the Substance Abuse and Mental Health Services Administration (SAMHSA). Montana is beginning the 2nd year of a five year grant cycle, developing mental health consultation services and infrastructure for young children and families. This is done by utilizing the Center for Social and Emotional Foundations for Early Learning's Pyramid Model for Promoting Social Emotional Competence in Infants and Young Children as a framework.

MCH Staff also assisted the Second Season, a non-profit organization on the Northern Cheyenne Reservation, on their FY 2015 Healthy Tomorrows grant application, "Families That Care (FTC)". If their FTC proposal had been funded, members of the Northern Cheyenne Tribe would have received access to culturally appropriate Native American resources that promote MCH initiatives. These included breastfeeding, prenatal care, oral health care, and immunizations. The MCH Staff has committed to providing technical assistance on another Healthy Tomorrows grant application.

The Title V/MCH Staff are cognizant of the emerging health care needs of not only the maternal and child health population but also the health care needs identified in the State Health Improvement Plan and further delineated in the Public Health and Safety Division (PHSD) Strategic Plan. The Strategic Plan includes three action areas which lend themselves to the PHSD's ongoing work to proactively address emerging health care needs in Montana. These three areas are: 1) Prevention and health promotion efforts; 2) Access to care, particularly clinical preventive services; and 3) Strengthening Montanan's public health and health care system. PHSD staff members are encouraged to seek new funding opportunities that support the strategic plan priorities and to partner with other PHSD programs or non-governmental programs so as to expand the reach and scope of the funding.

An example of this partnering can be illustrated by the Family & Community Health Bureau, Medicaid, and the Montana March of Dimes Chapter pooling their resources to offer the Coming of the Blessing training. The Coming of the Blessing is a March of Dimes initiative to support prenatal education for American Indian and Alaska Native families. Prenatal education, training and resources are designed based on traditional beliefs, lessons from their ancestors and their partners in their circle of support during pregnancy. The circle of support helps women make healthy choices for themselves and their babies, by honoring the strong culture and traditions of Native people. The training was an outgrowth of the work completed by Montana's Infant Mortality CoIIN team. The team recognized the disparity between American Indian and White infant mortality rates. On August 4, 2015, an all-day training is planned for organizations who work with Native American families, i.e. Indian Health Services staff. The training will also include a presentation on Neonatal Abstinence Syndrome, which anecdotally has been identified as an emerging health care need among our Native American families.

The State of Montana, Office of the Governor issued Executive Order No. 06-2015 in June 2015, which established a State Office of American Indian Health. The Office of American Indian Health will be housed within the Department of Public Health and Human Services within the Director's Office. The Executive Order further defined the Office's responsibilities which support the efforts of the PHSD State Health Improvement Plan and Strategic Plan and the 2015 Statewide 5-Year Needs Assessment. Executive Order No. 06-2015 is accessible at: http://governor.mt.gov/Home/Governor/eo

II.F.6. Public Input

Montana 2016 Annual Application and 2014 Report
Public Input

During March of 2015, five regional trainings were presented to county public health departments (CPHDs) around Montana on a number of MCHBG topics. These departments are the state's main partners for delivering MCHBG services. The trainings were an opportunity to introduce the 2015 Pre-Contract Survey (PCS), which provided an avenue for formal comments and feedback on the new MCHBG performance measure choices, and Family and Community Health Bureau activities and support. Printed copies of the survey were presented to the attendees and explained, in order to give them time to formulate their responses before going online.

One open-ended question on the PCS is: "How can the FCHB improve its services to local Health Departments?" Twenty-four counties responded, and while many were appreciative and complementary of the support which is already given, the area mentioned where they still need the most help is with data.

The PCS is conducted every year, and comments are taken seriously. The regional trainings are a result of feedback received in previous years. Before 2014, one central training was given as a part of a larger conference. FCHB staff is also available and responsive to CPHD input throughout the year. The CPHD submit quarterly reports, and challenges to service delivery are reviewed to provide support for problem solving. All information and comments gathered are taken into account during the development of the MCHBG Annual Application and Report.

The 2015 Statewide 5-Year Needs Assessment was introduced at the regional trainings in 2014. An in-depth online Needs Assessment survey was explained, and printed copies were provided. Thirty-nine CPHDs completed the Needs Assessment during May 2014. In the Needs Assessment survey an "Other" category was provided for additional feedback and comment on each question. Members of the Montana Hospital Association and the Montana Primary Care Association also completed the Needs Assessment survey. In all, 58 surveys were

submitted. The comments received for the 5-Year Needs Assessment played an integral role in the development of this year's application, especially for the selection of National Performance Measures and initiation of new State Performance Measures.

As another part of the assessment process, the FCHB interviewed key informants throughout the state who are members of the Public Health System Improvement Task Force (PHSITF). Face-to-face or phone interviews were conducted in December of 2014. The questions covered the five MCHBG population categories, and the interviews took between 30 to 45 minutes.
These public health professionals have unique perspectives and insights into MCH issues. Members include four representatives of CPHDs with populations of differing size; and representatives from the following agencies or statewide associations:

- Association of Montana Public Health Officials
- Billings Area Indian Health Service
- Montana Association of Counties / Local Boards of Health
- Montana Environmental Health Association
- Montana Public Health Association
- Montana University System
- Tribal Health Departments
- Two ad hoc members - from the Montana Department of Environmental Quality, and the PHSD.

A good example of the input solicited from the PHSITF is the question: "If you could choose one public health intervention to improve the health of these groups (one for each), what would it be and why?" The following is the top answer received for each of the specific MCH population groups:

- Infants – Home Visiting
- Children – Immunizations
- Adolescents – Increased Links to Community Organizations and Law Enforcement
- Women of Childbearing Age – Access to Care
- CYSHCN – Access to Care

The PHSITF is also involved in providing on-going input to Montana's Annual MCHBG Application and Report. They are given a copy to review, and invited to comment through email and by phone. After the final submission in September, special attention is given to the plans for the upcoming year. MCHBG staff also provide periodic updates to the PHSITF as a part of conference calls scheduled by the PHSD. As part of preparation for the key informant interviews, they were instructed on the changes for MCH Transformation 3.0.

One health care issue that has come to the forefront since the 2010 Needs Assessment is the social determinants of health. The FCHB created a State Performance Measure with the title "Family Support and Health Education" to assist the CPHDs with meeting this need. The CPHDs which have chosen this as their performance measure for FY 2016 have been involved with the details for implementation. They provided feedback on draft documentation, and were a part of a conference call to discuss practical application on a day-to-day basis.

Another on-going need clearly identified by MCHBG stakeholders is the support of access to public health services. A new state performance measure has been created to help the CPHDs from counties with especially small-size MCH populations. Additional involvement by representatives of CPHDs from a cross-section of population sizes is planned. This group will discuss the funding formula, and MCHBG contract requirements.

A part of the MCHBG contract requirements for the CPHDs is a client survey. The results of these surveys are to be

taken into account when the CPHDs choose their performance measure each year, and in the types of activities undertaken.

The portion of the MCHBG Annual Application and Report which specifically addresses CYSHCN includes a family input process. The remainder of this narrative provides more information on the details.
Three families participated in the rules hearing for the implementation of screening for Critical Congenital Heart Defects (CCHD), providing testimony in support of CCHD screening for all newborns. Sharing personal family stories, they emphasized that early identification and treatment of their child's critical congenital heart disease would have made a difference in their child's outcome.

The Rural Institute of the University of Montana continued work with the Consumer Advisory Council (CAC), which directed the efforts of the Institute in planning strategies to educate families about CYSHCN transition to adult services. The CAC is made up of 19 members who are primarily youth and young adults with special healthcare needs and their parents.

A parents-as-mentors program called *The HALI Project* has been implemented in three pediatric practices and one FQHC in Montana. There are seven parent mentors currently working in the practices. The goal of the HALI Project parent partners is to support and empower families of CYSHCN when making decisions about their child's care and accessing services.

The HALI Project was developed and has been implemented in parts of Texas, Wyoming and now Montana, by the program developer, Brad Thompson. Mr. Thompson provides annual in-person training, monthly group calls, and individual support calls to the parent mentors. Mr. Thompson is a licensed counselor and the parent of a child with special health care needs. A CSHS staff-person attended in-person training in June, 2014 with Mr. Thompson and the Parent Partners.

Parent Partners told personal stories about their interactions with other CYSCHN parents and brainstormed ideas to better serve CYSHCN families. In addition to one-on-one work with families, the parent partners do outreach and education to the community and the providers they work with. Providers consistently report parent partners are a great asset to their practices, and they continually refer families at a higher frequency.

A cooperative effort between the Wyoming Department of Health, Mountain States Genetic Regional Collaborative, the HALI Project and CSHS is currently under way to evaluate the HALI Project. The evaluation is meant to gauge the effectiveness of the parent partners in their efforts to assist CYSHCN families to navigate the healthcare system, access community and government resources and provide ongoing mentoring and generally support and empower CYSHCN families. A survey was given to CYSHCN parents before and after a period of time when the CYSHCN family received services from a parent partner. A compilation of results are expected in late summer, 2015.

CSHS is developing a Cleft/Craniofacial Clinic Stakeholders Group which will have parent representation. This group will be responsible for providing recommendations to the Montana Cleft Team members for achieving American Cleft Palate Association (ACPA) Standards for team care, and for providing consultation to the department.

II.F.7. Technical Assistance

The Montana Title V/MCHBG Program has determined the need for potential technical assistance in developing the

State Action Plans for the National and State Performance Measures.

Montana requests technical assistance with incorporating evidence-based or evidence-informed strategy measures with the goal to develop measurable objectives. The measureable objectives will need to address the diverse needs which range from the 20% of the maternal and child health population living in the 41 rural and frontier counties, to the 60% of the population that reside in the six largest counties. Additionally, Montana's measurable objectives must be culturally appropriate to meet the needs of the American Indian population which is approximately 6.5 % of the population.

III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 2,430,627	$ 2,430,627	$ 2,292,158	$ 2,236,161
Unobligated Balance	$ 0	$ 0	$ 0	$ 0
State Funds	$ 1,816,886	$ 1,816,886	$ 2,305,719	$ 1,828,948
Local Funds	$ 3,871,097	$ 3,871,097	$ 3,698,449	$ 3,667,846
Other Funds	$ 0	$ 0	$ 0	$ 0
Program Funds	$ 1,666,306	$ 1,666,306	$ 1,788,920	$ 1,812,882
SubTotal	$ 9,784,916	$ 9,784,916	$ 10,085,246	$ 9,545,837
Other Federal Funds	$ 20,206,929	$ 20,206,929	$ 26,178,702	$ 23,262,107
Total	$ 29,991,845	$ 29,991,845	$ 36,263,948	$ 32,807,944

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 2,154,629	$ 2,284,817	$ 2,219,096	$
Unobligated Balance	$ 0	$ 0	$ 0	$
State Funds	$ 2,012,550	$ 1,828,951	$ 2,536,688	$
Local Funds	$ 3,698,449	$ 3,645,934	$ 3,667,846	$
Other Funds	$ 0	$ 0	$ 0	$
Program Funds	$ 1,912,489	$ 1,888,322	$ 1,845,771	$
SubTotal	$ 9,778,117	$ 9,648,024	$ 10,269,401	$
Other Federal Funds	$ 25,302,717		$ 29,368,223	$
Total	$ 35,080,834	$ 9,648,024	$ 39,637,624	$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
Federal Allocation	$ 2,284,817	$
Unobligated Balance	$ 0	$
State Funds	$ 2,538,188	$
Local Funds	$ 3,755,312	$
Other Funds	$ 0	$
Program Funds	$ 1,933,508	$
SubTotal	$ 10,511,825	$
Other Federal Funds	$ 28,072,980	$
Total	$ 38,584,805	$

III.A. Expenditures

Montana MCHBG 2016 Application and 2014 Report
Expenditures

The Family and Community Health Bureau (FCHB) Financial Specialist, the Maternal and Child Health Supervisor and the Public Health and Safety Division's Fiscal Budget Analyst maintain the budget documentation for Montana's Maternal and Child Health Block Grant, including assuring compliance with state and federal regulations and completion of the Financial Status Reports.

Montana's MCH Block Grant instituted the use of Quarterly County Progress Reports in 2014, submitted by the local health departments to the MCH Block Grant Coordinator. These progress reports provide a snapshot of the health departments' challenges or issues working towards their selected NPM or SPM. Technical assistance has been provided to these health departments as needed.

Montana's 2016 Application reflects the importance of local partners for providing MCH Services to the population. County progress reports have been adjusted to reflect new information to be collected for reporting requirements as defined in the grant guidance. This reporting consists of Direct Service expenditures; specific to service type. These are defined as the following:

- Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age one;
- Preventive and Primary Care Services for Children;
- Services for CSHCN.

Approximately 45% of the MCHBG will be distributed through contracts with 50 of the state's 56 County Public Health Departments (CPHDs) for the FY 2016 allocation. The MCHC staff has endeavored to work with the local health

departments on their 2014 annual reports with a primary focus on new SPM's and NPM's and how they must align with the NOM's. The MCH Grant Coordinator has offered regional training to local health departments to address concerns such as Direct Services and the new method of reporting these services. It has been communicated during these regional trainings that the MCHBG is the last resort payer of these services and that detailed information will be needed for the reason for these services, i.e. services were not covered or reimbursed through another provider.

The FCHB receives state general funds to support MCH services. In FY 2016 these funds will support: 50% of the State FICMMR Coordinator's salary; 80% and 25% respectively of two Public Health Nurse Consultant salaries; and the Healthy Montana Families Project (HMFP), which awarded funds to eight CPHDs in FY 2015. These communities have implemented the Home Visiting curriculums of Nurse Family Partnership (NFP) or Parents As Teachers (PAT).

The following is a summary of forms 2, 3a, and 3b.

Form 2:

Montana's state funds, local funds, and program income has increased since 2014, and federal support has also increased within this time frame. Increases in these categories can be contributed to:

- an ongoing commitment of local funds to MCH services;
- state funding to support a newborn screening follow up program;
- genetic testing;
- contraceptive support;
- Evidence-based home visiting;
- and medical billing to support cystic fibrosis, cleft-craniofacial clinics, and metabolic clinics for children with special health care needs.

Form 3a:

Montana's CPHD expenditures by population group showed a slight difference from 2013 to 2014. Projected increases for services to children 1-22 years of age continue to increase, whereas services to pregnant women are projected to decline.

Form 3b:

Expenditures for direct health care, enabling, population-based, and infrastructure building services vary from year to year, due to the local MCH contractor's yearly reporting. State staff has worked diligently during the past two years to explain the definition of direct services to local partners as a part of the regional trainings. Montana has not collected data, in the past, on the following categories for direct services: pharmacy, physician/office services, hospital charges, dental care, durable medical equipment and supplies, and laboratory services. Estimates based off of expenditures reported from local CPHDs, as well as state office level expenses have been used to report this information. State MCH staff enhanced reporting documentation for FY 2016, and CPHDs will be including this information going forward. Please reference the notes that were included in the electronic form for estimates.

III.B. Budget

Montana MCHBG 2016 Application and 2014 Report
Budget

Montana's proposed Maternal and Child Health (MCH) Block Grant budget for FFY 2016, as reflected on Form 2, includes the following budget items:

Preventive and Primary Care for Children: This budget item includes the anticipated amount to be spent for infants, children and their families. At the state level, this line item reflects the Maternal Child Health Section and the CPHD MCH contractors who are responsible for providing these services. The FFY 2016 amount is $1,220,291.

Children with Special Health Care Needs: This budget item includes the Children's Special Health Services Section budget of $685,445 plus $160,000 from the county level MCH contractors. The FFY 2016 amount is $845,445.

Title V Administrative Costs: This budget item includes the state indirect estimate of $144,304, plus an estimate of $74,777 from the CPHD MCH contractors. The CPHD are allowed to use up to 10% of their award for administrative costs per the MCH Administrative Rule 37.57.1001. The FFY 2016 amount is $219,081.

The unobligated FY 2016 balance is $0. Montana continues to budget and expend to the level of the annual award.

State MCH Funds: This budget amount for FFY 2016 is $2,538,188 which includes state general funds for the Healthy Montana Families Project ($713,966); the state special revenue funds for the genetics program ($1,289,565); the state general funds for the family planning contraceptives program ($499,999); the state special revenue for the Montana WIC farmer's market program ($9,000), and the state special revenue for support to the Children with Special Health Care Needs clinics, ($25,658).

Local MCH Funds: This budget amount for FFY 2016 is $3,755,312, which is an anticipated projection based on past years. The MCH contractors have historically over-matched the required amount needed for this funding source.

Program Income: This budget amount for FFY 2016 is $1,933,508. One component is income generated by the CPHDs through donations and Medicaid billing. The additional amount for this budget is for our Children with Special Health Care Needs specialty clinics. These clinics support cystic fibrosis, cleft-cranio facial and metabolic disorders. Revenue is generated at the state level from offering these clinics and services, through clinic billing.

Montana's FFY 2016 Maintenance of Effort remains at $485,480, resulting in a Federal-State Title V Block Grant Partnership total amount of $10,511,825.

Montana receives additional federal funding towards the common goals of the MCHBG. These additional funding sources include SSDI, EMSC, WIC, HIV Prevention, STD Prevention, Oral Health Workforce Development, Immunization, ACA-MIECHV Expansion, ACA-MIECHV Formula, WIC-Farmers Market, WIC-Breastfeeding Peer Counseling, Universal Newborn Hearing Screening Intervention, Early Hearing Detection Intervention, Title X, Title X Outreach & Enrollment, and ACA-PREP. All of these funding sources total $28,072,980.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MT IAA.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - MontanaSHIPandPHSDSP.pdf

Supporting Document #02 - MT_DPHHS_FCHB_OrgCharts.pdf

Supporting Document #03 - MontanaMCHBG_SHIP_PHSDSP_PM_DataCrosswalk.pdf

Supporting Document #04 - MT_MCHBG_FY16app_CouintyHealthDeptMapsPlans.pdf

Supporting Document #05 - MT_MCHBG_FY16applicationSPM2exampleForms.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Montana

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION	$ 2,284,817	$ 2,284,817
(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)		
A. Preventive and Primary Care for Children	$ 1,220,291	$ 1,121,034
B. Children with Special Health Care Needs	$ 845,445	$ 946,880
C. Title V Administrative Costs	$ 219,081	$ 216,903
2. UNOBLIGATED BALANCE	$ 0	$ 0
(Item 18b of SF-424)		
3. STATE MCH FUNDS	$ 2,538,188	$ 1,828,951
(Item 18c of SF-424)		
4. LOCAL MCH FUNDS	$ 3,755,312	$ 3,645,934
(Item 18d of SF-424)		
5. OTHER FUNDS	$ 0	$ 0
(Item 18e of SF-424)		
6. PROGRAM INCOME	$ 1,933,508	$ 1,888,322
(Item 18f of SF-424)		
7. TOTAL STATE MATCH	$ 8,227,008	$ 7,363,207
(Lines 3 through 6)		
A. Your State's FY 1989 Maintenance of Effort Amount	$ 485,480	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL	$ 10,511,825	$ 9,648,024
(Same as item 18g of SF-424)		
9. OTHER FEDERAL FUNDS		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS	$ 28,072,980	
(Subtotal of all funds under item 9)		
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL	$ 38,584,805	$ 9,648,024
(Partnership Subtotal + Other Federal MCH Funds Subtotal)		

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$ 2,154,629
A. Preventive and Primary Care for Children	$ 760,547
B. Children with Special Health Care Needs	$ 798,288
C. Title V Administrative Costs	$ 215,409
2. UNOBLIGATED BALANCE	$ 0
3. STATE MCH FUNDS	$ 2,012,550
4. LOCAL MCH FUNDS	$ 3,698,449
5. OTHER FUNDS	$ 0
6. PROGRAM INCOME	$ 1,912,489
7. TOTAL STATE MATCH	$ 7,623,488

	FY16 Application Budgeted
9. OTHER FEDERAL FUNDS	
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > SSDI;	$ 95,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > EMSC;	$ 130,000
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC Program;	$ 16,229,849
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > HIV Prevention ;	$ 855,760
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health ;	$ 500,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Immunization;	$ 858,610
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA-MIECHV;	$ 6,224,070
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA- PREP;	$ 250,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Farmers Market;	$ 59,782

US Department of Agriculture (USDA) > Food and Nutrition Services > Peer Breastfeeding;	$ 172,710
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > UNHSI;	$ 249,989
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > EHDI;	$ 7,709
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Title X;	$ 1,976,100
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Title X Outreach ;	$ 199,800
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > STD Prevention;	$ 263,227

Form Notes For Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: The amount listed as expended is the actual amount that was expended at the State and Local agency level as based on budget reports and what the local agencies have reported to the State Office for this category.	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: The amount listed as expended is the actual amount that was expended at the State and Local agency level as based on budget reports and what the local agencies have reported to the State Office for this category.	

Data Alerts:

None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Montana

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF INDIVIDUALS SERVED		
IA. Federal MCH Block Grant		
1. Pregnant Women	$ 36,000	$ 62,000
2. Infants < 1 year	$ 107,470	$ 73,764
3. Children 1-22 years	$ 1,220,291	$ 1,121,034
4. CSHCN	$ 845,445	$ 946,880
5. All Others	$ 69,000	$ 69,375
Federal Total of Individuals Served	$ 2,278,206	$ 2,273,053
IB. Non Federal MCH Block Grant		
1. Pregnant Women	$ 865,626	$ 863,333
2. Infants < 1 year	$ 737,046	$ 536,518
3. Children 1-22 years	$ 2,386,698	$ 2,623,413
4. CSHCN	$ 1,321,771	$ 1,106,497
5. All Others	$ 1,174,999	$ 900,158
Federal Total of Individuals Served	$ 6,486,140	$ 6,029,919
Federal State MCH Block Grant Partnership Total	$ 8,764,346	$ 8,302,972

Form Notes For Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts:

None

Form 3b
Budget and Expenditure Details by Types of Services

State: Montana

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	$ 117,302	$ 782,007
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 16,082	$ 107,211
B. Preventive and Primary Care Services for Children	$ 5,717	$ 38,112
C. Services for CSHCN	$ 95,503	$ 636,684
2. Enabling Services	$ 986,257	$ 644,166
3. Public Health Services and Systems	$ 1,181,258	$ 858,644
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 18,182
Physician/Office Services		$ 500,923
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 145,601
Dental Care (Does Not Include Orthodontic Services)		$ 117,301
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Total		$ 782,007
Federal Total	$ 2,284,817	$ 2,284,817

IIB. Non-Federal MCH Block Grant

1. Direct Services	$ 407,338	$ 2,716,347
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 104,520	$ 696,802
B. Preventive and Primary Care Services for Children	$ 294,818	$ 1,965,454
C. Services for CSHCN	$ 8,000	$ 54,091
2. Enabling Services	$ 2,571,168	$ 1,371,760
3. Public Health Services and Systems	$ 5,248,502	$ 3,275,100
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 1,419,996
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 40,000
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 1,256,351
Direct Services Total		$ 2,716,347
Non-Federal Total	$ 8,227,008	$ 7,363,207

Form Notes For Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. - 4. Pharmacy**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Montana does not collect this data at the local level. This amount is based off of CSHS Prescription Services, Medical Services, and Direct Pays that the program does at the state level.	
2.	**Field Name:**	**IIA. - 4. Physician/Office Services**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: This number is based off of a percentage of population served in Direct Services that is reported to the State Office. This information is not collected. The State Office has made a note to start collecting this information for 2016.	
3.	**Field Name:**	**IIA. - 4. Hospital Charges (Includes Impatient and Outpatient Services)**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: This number is based off of a percentage of population served in Direct Services that is reported to the State Office. This information is not collected. The State Office has made a note to start collecting this information for 2016.	
4.	**Field Name:**	**IIA. - 4. Dental Care (Does Not Include Orthodontic Services).**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: This number is based off of a percentage of population served in Direct Services that is reported to the State Office. This information is not collected. The State Office has made a note to start collecting this information for 2016.	
5.	**Field Name:**	**IIB. - 4. Physician/Office Services**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**

	Field Note: The remaining amount of Direct Care Services was placed in this category as we do not collect data based off of these categories. The State office has made note to collect this data.	
6.	**Field Name:**	**IIB. - 4. Dental Care (does not include Orthodontic Services)**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: This amount is based off of State General Fund that is used as a match requirement for our Oral Health grant.	
7.	**Field Name:**	**IIB. - 4. Laboratory Services**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: This amount is based off of the State Offices Genetics and Newborn Screening budget for State Special Revenue for laboratory services.	

Form 4

Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Montana

Total Births by Occurrence 12,392

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
3-Hydroxy-3-methyglutaric aciduria	12,336 (99.5%)	6	0	0 (0%)
Carnitine uptake defect/carnitine transport defect	12,336 (99.5%)	8	1	1 (100.0%)
Citrullinemia, type I	12,336 (99.5%)	0	0	0 (0%)
Maple syrup urine disease	12,336 (99.5%)	1	0	0 (0%)
Homocystinuria	12,336 (99.5%)	1	0	0 (0%)
Classic phenylketonuria	12,336 (99.5%)	2	2	2 (100.0%)
Tyrosinemia, type I	12,336 (99.5%)	4	0	0 (0%)
Primary congenital hypothyroidism	12,336 (99.5%)	5	3	3 (100.0%)
Congenital adrenal hyperplasia	12,336 (99.5%)	4	0	0 (0%)
S,S disease (Sickle cell anemia)	12,336 (99.5%)	22	0	0 (0%)
Biotinidase deficiency	12,336 (99.5%)	0	0	0 (0%)
Cystic fibrosis	12,336 (99.5%)	10	3	3 (100.0%)
Classic galactosemia	12,336 (99.5%)	0	0	0 (0%)

1b. Secondary RUSP Conditions

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	11,742 (94.8%)	0	0	0 (0%)

3. Screening Programs for Older Children & Women

4. Long-Term Follow-Up

The Montana Newborn Screening (NBS) program tracks infants with conditions identified through newborn screening in the Child Health Referral Information System (CHRIS) database. Demographic information is recorded in CHRIS, as well as diagnosis and primary care provider.\r\n\r\nThe NBS program contracts with providers to deliver immediate and long-term follow-up. Care plans and additional diagnosis and treatment information is entered into the CHRIS database by providers. The NBS program uses CHRIS to monitor visits, and care plans for individuals who attend clinics for long-term NBS follow-up, to ensure children and youth are receiving comprehensive follow-up care and are linked to a medical home. Youth are monitored until age nineteen. \r\n

Form Notes For Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2014**
	Column Name:	
	Field Note: Preliminary 2014 birth data, no final data yet for 2014	
2.	**Field Name:**	**3-Hydroxy-3-methyglutaric aciduria - Receiving At Lease One Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Acylcarnitine profile for (9) organic aciduria disorders (HMG,3MCC,BKT,GA1,IVA,CblAB,MUT,MCD,PROP)	
3.	**Field Name:**	**Carnitine uptake defect/carnitine transport defect - Receiving At Lease One Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Acylcarnitine profile for (5) fatty acid oxidation disorders (CUD,MCAD,LCHAD,VLCAD,TFP)	
4.	**Field Name:**	**Citrullinemia, type I - Receiving At Lease One Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Arginosuccinic acidemia/ citrullinemia (ASA/CIT)	
5.	**Field Name:**	**S,S disease (Sickle cell anemia) - Receiving At Lease One Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Hemoglobinopathy (HbSS, S/βth, SC)	
6.	**Field Name:**	**S,S disease (Sickle cell anemia) - Positive Screen**
	Fiscal Year:	**2014**

	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Abbreviations consistent with ACMG report - Newborn Screening: Towards a Uniform Screening Panel and System. Genet Med. 2006; 8(5) Suppl: S12-S252. * Includes 22 carriers of abnormal Hgb traits (SCDE) referred for contractor consultation.	
7.	**Field Name:**	**Newborn Hearing - Receiving At Lease One Screen**
	Fiscal Year:	**2014**
	Column Name:	**Other Newborn**
	Field Note: newborns who have been screened for hearing before hospital discharge.	

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Montana

Reporting Year 2014

		Primary Source of Coverage				
Types Of Individuals Served	**(A) Title V Total Served**	**(B) Title XIX %**	**(C) Title XXI %**	**(D) Private / Other %**	**(E) None %**	**(F) Unknown %**
1. Pregnant Women	3,761	58.0	7.0	7.0	8.0	20.0
2. Infants < 1 Year of Age	5,560	54.0	6.0	16.0	5.0	19.0
3. Children 1 to 22 Years of Age	28,693	33.0	9.0	35.0	9.0	14.0
4. Children with Special Health Care Needs	6,964	62.0	3.0	13.0	2.0	20.0
5. Others	53,498	20.0	1.0	35.0	25.0	19.0
Total	98,476					

Form Notes For Form 5a:

None

Field Level Notes for Form 5a:

None

Form 5b

Total Recipient Count of Individuals Served by Title V

State: Montana

Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	3,761
2. Infants < 1 Year of Age	5,560
3. Children 1 to 22 Years of Age	28,693
4. Children with Special Health Care Needs	6,964
5. Others	53,498
Total	98,476

Form Notes For Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2014**
	Field Note: This amount is the amount of infants reported to the State office from the local county health departments. This is the amount of infants that were served using MCHBG funds.	

Form 6

Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Montana

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	12,397	10,208	60	1,480	132	15	286	216
Title V Served	12,397	10,208	60	1,480	132	15	286	216
Eligible for Title XIX	4,387	2,869	27	1,009	24	5	87	366
2. Total Infants in State	12,140	10,312	244	1,413	171	0	0	0
Title V Served	12,140	10,312	244	1,413	171	0	0	0
Eligible for Title XIX	7,144	3,538	28	1,066	25	14	56	2,417

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	11,862	490	45	12,397
Title V Served	11,862	490	45	12,397
Eligible for Title XIX	3,896	133	358	4,387
2. Total Infants in State	11,526	614	0	12,140
Title V Served	11,526	614	0	12,140
Eligible for Title XIX	6,972	172	0	7,144

Form Notes For Form 6:

2013 Final Data; 2014 population sets are not available yet

Field Level Notes for Form 6:

None

Form 7

State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Montana

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(877) 543-7669	(877) 543-7669
2. State MCH Toll-Free "Hotline" Name	Public Assistance Help Line	Public Assistance Help Line
3. Name of Contact Person for State MCH "Hotline"	David Crowson	David Crowson
4. Contact Person's Telephone Number	(406) 444-7887	(406) 444-7887
5. Number of Calls Received on the State MCH "Hotline"		43,056
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	apply.mt.gov	apply.mt.gov
4. Number of Hits to the State Title V Program Website		101,833
5. State Title V Social Media Websites	https://www.facebook.com/MTDPHHS	
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes For Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Montana

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name	Denise Higgins
Title	Family and Community Health Bureau Chief
Address 1	1400 E. Broadway, Room A-116
Address 2	PO box 202951
City / State / Zip Code	Helena / MT / 59620
Telephone	(406) 444-4743
Email	dehiggins@mt.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Rachel Donahoe
Title	CSHS Section Supervisor
Address 1	1400 E. Broadway, Room A-116
Address 2	PO Box 202951
City / State / Zip Code	Helena / MT / 59620
Telephone	(406) 444-3617
Email	rdonahoe@mt.gov

3. State Family or Youth Leader (Optional)

Name	
Title	
Address 1	
Address 2	
City / State / Zip Code	
Telephone	
Email	

Form Notes For Form 8:

None

Form 9
List of MCH Priority Needs

State: Montana

Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Family Support and Health Education	New	
2.	Access to Care	Continued	
3.	Immunization Rates	Continued	
4.	Child Injuries	Continued	
5.	Smoking During Pregnancy and Household Smoking	Continued	
6.	Breastfeeding Rates	New	
7.	Oral Health	Continued	
8.	Teen Pregnancy Prevention	New	
9.	Low-Risk Cesarean Deliveries	New	
10.	Infant Safe Sleep	New	

Form Notes For Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Montana

Form Notes for Form 10a NPMs and NOMs:

Montana's FCHB will be working with stakeholders during FFY 16 to refine these objectives. NPM 5 - baseline data is being collected through the "2015 Health Survey of Montana's Mothers and Babies."

NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	71.1 %	0.4 %	8,700	12,235
2012	73.5 %	0.4 %	8,774	11,941
2011	73.4 %	0.4 %	8,757	11,928
2010	73.9 %	0.4 %	8,654	11,718
2009	73.4 %	0.4 %	8,074	10,996

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-1 Notes:

None

Data Alerts:

None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	152.4	12.3 %	155	10,172
2011	147.9	11.9 %	154	10,415
2010	166.0	12.4 %	180	10,844
2009	131.0	10.9 %	144	10,996

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

NOM-2 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2013	27.9	6.8 %	17	60,881
2008_2012	21.3	5.9 %	13	61,098
2007_2011	24.4	6.3 %	15	61,419
2006_2010	16.2	5.1 %	10	61,858
2005_2009	16.3	5.2 %	10	61,381

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

NOM-3 Notes:

None

Data Alerts:

None

NOM-4.1 Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.4 %	0.2 %	913	12,370
2012	7.4 %	0.2 %	891	12,109
2011	7.2 %	0.2 %	867	12,061
2010	7.5 %	0.2 %	901	12,054
2009	7.1 %	0.2 %	865	12,247

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.1 Notes:

None

Data Alerts:

None

NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	0.9 %	0.1 %	110	12,370
2012	1.1 %	0.1 %	129	12,109

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	1.0 %	0.1 %	118	12,061
2010	1.3 %	0.1 %	154	12,054
2009	1.0 %	0.1 %	125	12,247

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.2 Notes:

None

Data Alerts:

None

NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.5 %	0.2 %	803	12,370
2012	6.3 %	0.2 %	762	12,109
2011	6.2 %	0.2 %	749	12,061
2010	6.2 %	0.2 %	747	12,054
2009	6.0 %	0.2 %	740	12,247

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.3 Notes:

None

Data Alerts:

None

NOM-5.1 Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	9.0 %	0.3 %	1,111	12,356
2012	9.4 %	0.3 %	1,136	12,099
2011	8.8 %	0.3 %	1,065	12,052
2010	10.2 %	0.3 %	1,222	12,042
2009	9.0 %	0.3 %	1,101	12,225

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.1 Notes:

None

Data Alerts:

None

NOM-5.2 Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.2 %	0.1 %	270	12,356
2012	2.5 %	0.1 %	297	12,099

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	2.3 %	0.1 %	273	12,052
2010	2.7 %	0.2 %	320	12,042
2009	2.3 %	0.1 %	280	12,225

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.2 Notes:

None

Data Alerts:

None

NOM-5.3 Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.8 %	0.2 %	841	12,356
2012	6.9 %	0.2 %	839	12,099
2011	6.6 %	0.2 %	792	12,052
2010	7.5 %	0.2 %	902	12,042
2009	6.7 %	0.2 %	821	12,225

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.3 Notes:

None

Data Alerts:

None

NOM-6 Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	23.0 %	0.4 %	2,837	12,356
2012	23.8 %	0.4 %	2,879	12,099
2011	24.5 %	0.4 %	2,953	12,052
2010	25.0 %	0.4 %	3,008	12,042
2009	26.2 %	0.4 %	3,197	12,225

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-6 Notes:

None

Data Alerts:

None

NOM-7 Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013/Q2-2014/Q1	8.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM-7 Notes:

None

Data Alerts:

None

NOM-8 Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.3	0.7 %	66	12,415
2012	6.4	0.7 %	78	12,158
2011	6.0	0.7 %	72	12,103
2010	5.5	0.7 %	66	12,094
2009	5.5	0.7 %	68	12,294

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

NOM-8 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.6	0.7 %	69	12,377
2012	5.9	0.7 %	72	12,118
2011	6.0	0.7 %	72	12,069
2010	6.0	0.7 %	72	12,060
2009	6.2	0.7 %	76	12,257

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

NOM-9.1 Notes:

None

Data Alerts:

None

NOM-9.2 Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.9	0.5 %	36	12,377
2012	3.5	0.5 %	42	12,118
2011	4.4	0.6 %	53	12,069
2010	3.5	0.5 %	42	12,060
2009	3.4	0.5 %	41	12,257

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

NOM-9.2 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.7	0.5 %	33	12,377
2012	2.5	0.5 %	30	12,118
2011	1.6	0.4 %	19	12,069
2010	2.5	0.5 %	30	12,060
2009	2.9	0.5 %	35	12,257

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

NOM-9.3 Notes:

None

Data Alerts:

None

NOM-9.4 Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	113.1	30.3 %	14	12,377
2012	132.0	33.0 %	16	12,118

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	124.3	32.1 %	15	12,069
2010	141.0	34.2 %	17	12,060
2009	146.9	34.6 %	18	12,257

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

NOM-9.4 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	129.3	32.3 %	16	12,377
2012	165.0	36.9 %	20	12,118
2011	132.6	33.2 %	16	12,069
2010	165.8	37.1 %	20	12,060
2009	228.4	43.2 %	28	12,257

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

NOM-9.5 Notes:

None

Data Alerts:

None

NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

FAD Not Available for this measure.

NOM-10 Notes:

None

Data Alerts:

None

NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	8.3	0.9 %	84	10,172
2011	7.1	0.8 %	74	10,415
2010	5.8	0.7 %	63	10,844
2009	7.0	0.8 %	77	10,996

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

NOM-11 Notes:

None

Data Alerts:

None

NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-12 Notes:

None

Data Alerts:

None

NOM-13 Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-13 Notes:

None

Data Alerts:

None

NOM-14 Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.7 %	1.4 %	41,011	207,814

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-14 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	18.7	4.1 %	21	112,420
2012	25.2	4.8 %	28	111,151
2011	28.9	5.1 %	32	110,879
2010	29.7	5.2 %	33	111,031
2009	30.0	5.2 %	33	109,878

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

NOM-15 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	48.4	6.2 %	61	125,995
2012	35.7	5.3 %	45	126,186
2011	46.9	6.1 %	60	127,899
2010	58.7	6.8 %	75	127,848
2009	51.7	6.3 %	67	129,656

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

NOM-16.1 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	25.0	3.6 %	49	196,016
2010_2012	26.2	19.6 %	52	198,457
2009_2011	31.3	24.0 %	63	201,589
2008_2010	33.3	25.9 %	68	204,191
2007_2009	33.7	26.3 %	70	207,573

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

NOM-16.2 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	19.9	14.2 %	39	196,016

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010_2012	17.1	11.9 %	34	198,457
2009_2011	18.9	13.3 %	38	201,589
2008_2010	17.1	11.9 %	35	204,191
2007_2009	13.5	9.0 %	28	207,573

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

NOM-16.3 Notes:

None

Data Alerts:

None

NOM-17.1 Percent of children with special health care needs

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	20.2 %	1.4 %	44,515	220,046
2007	18.0 %	1.2 %	40,975	227,966
2003	15.1 %	0.9 %	32,448	214,360

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

NOM-17.1 Notes:

None

Data Alerts:

None

NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	13.1 %	1.9 %	3,585	27,424

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.2 Notes:

None

Data Alerts:

None

NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	2.5 %	0.6 %	4,748	187,371
2007	1.1 %	0.4 %	2,104	190,565

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.3 Notes:

None

Data Alerts:

None

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	8.4 %	1.1 %	15,731	186,642
2007	6.1 %	0.8 %	11,539	190,707

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.4 Notes:

None

Data Alerts:

None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	59.9 %	5.7 %	12,195	20,366
2007	67.9 %	5.1 %	11,477	16,903
2003	69.0 %	5.0 %	10,043	14,555

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

NOM-18 Notes:

None

Data Alerts:

None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	89.7 %	1.0 %	197,292	220,046
2007	88.3 %	1.0 %	201,191	227,806
2003	90.1 %	0.8 %	193,141	214,360

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-19 Notes:

None

Data Alerts:

None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	29.0 %	2.2 %	27,468	94,620
2007	25.6 %	1.9 %	26,668	103,994
2003	27.3 %	1.7 %	28,305	103,610

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

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	27.1 %	0.5 %	2,139	7,892

Legends:
Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	22.4 %	0.9 %	9,188	41,112
2011	21.3 %	0.9 %	9,020	42,261
2009	22.1 %	1.4 %	9,595	43,345
2007	23.4 %	0.7 %	10,728	45,914
2005	22.1 %	0.9 %	10,223	46,302

Legends:
Indicator has an unweighted denominator <100 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-20 Notes:

None

Data Alerts:

None

NOM-21 Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	10.3 %	1.5 %	23,082	223,805
2012	10.9 %	1.3 %	24,004	219,888
2011	12.7 %	1.3 %	28,123	220,707
2010	12.7 %	1.2 %	28,315	222,903
2009	13.3 %	1.2 %	29,339	220,142

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-21 Notes:

None

Data Alerts:

None

NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	65.4 %	4.2 %	11,245	17,205
2012	66.5 %	3.6 %	11,335	17,053
2011	59.6 %	4.5 %	10,492	17,599
2010	50.0 %	3.6 %	8,781	17,573
2009	38.7 %	3.9 %	7,012	18,121

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.1 Notes:

None

Data Alerts:

None

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2014	50.4 %	2.2 %	106,072	210,648
2012_2013	45.8 %	2.2 %	96,850	211,476
2011_2012	42.4 %	2.3 %	87,608	206,624
2010_2011	37.3 %	4.0 %	77,543	207,890
2009_2010	33.9 %	2.4 %	69,998	206,484

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.2 Notes:

None

Data Alerts:

None

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

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	45.8 %	4.9 %	13,602	29,724
2012	55.1 %	5.0 %	16,627	30,188
2011	52.9 %	6.1 %	16,174	30,596
2010	45.5 %	4.5 %	14,226	31,240
2009	35.0 %	4.5 %	11,078	31,660

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	23.8 %	4.1 %	7,564	31,846
2012	16.8 %	3.6 %	5,374	32,002
2011	NR	NR	NR	NR

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.3 Notes:

None

Data Alerts:

None

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	84.3 %	2.6 %	51,921	61,570
2012	90.2 %	1.9 %	56,070	62,190
2011	85.0 %	3.1 %	53,577	63,063
2010	76.1 %	2.6 %	49,007	64,401
2009	63.8 %	3.1 %	41,526	65,085

Legends:

🏴 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

ϟ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.4 Notes:

None

Data Alerts:

None

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	51.6 %	3.4 %	31,763	61,570
2012	58.7 %	3.4 %	36,472	62,190
2011	39.8 %	4.3 %	25,114	63,063
2010	40.2 %	3.0 %	25,884	64,401

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	26.9 %	2.9 %	17,524	65,085

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.5 Notes:

None

Data Alerts:

None

Form 10a
National Performance Measures (NPMs)

State: Montana

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	24.0	24.0	24.0	24.0	24.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	92.0	92.0	92.0	92.0	92.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	24.0	24.0	24.0	24.0	24.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50.0	50.0	50.0	50.0	50.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	225.0	225.0	225.0	225.0	225.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	80.0	80.0	80.0	80.0	80.0

NPM-12 Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	50.0	50.0	50.0	50.0	50.0

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	22.0	22.0	22.0	22.0	22.0

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	78.0	78.0	78.0	78.0	78.0

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	16.0	16.0	16.0	16.0	16.0

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	25.0	25.0	25.0	25.0	25.0

Form 10b

State Performance/Outcome Measure Detail Sheet

State: Montana

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c

Evidence-Based or Informed Strategy Measure Detail Sheet

State: Montana

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Montana

Form Notes for Form 10d NPMs and SPMs

None

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	3	7	11	9	
Denominator	3	7	11	9	
Data Source	Mt Newborn Screening Program	Mt Newborn Screening Program	Mt Newborn Screening Program	Mt Newborn Screening Program	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

   Field Note:
   In January 2008, Montana began screening all newborns by bloodspot testing for the 28 metabolic, endocrine, hematologic, and genetic conditions recommended by the American College of Medical Genetics and the American Academy of Pediatrics.

2. **Field Name:** **2013**

   Field Note:
   In January 2008, Montana began screening all newborns by bloodspot testing for the 28 metabolic, endocrine, hematologic, and genetic conditions recommended by the American College of Medical Genetics and the American Academy of Pediatrics.

3. **Field Name:** **2012**

   Field Note:
   In January 2008, Montana began screening all newborns by bloodspot testing for the 28 metabolic, endocrine, hematologic, and genetic conditions recommended by the American College of Medical Genetics and the American Academy of Pediatrics.

4.	**Field Name:**	**2011**

Field Note:
In January 2008, Montana began screening all newborns by bloodspot testing for the 28 metabolic, endocrine, hematologic, and genetic conditions recommended by the American College of Medical Genetics and the American Academy of Pediatrics.

Data Alerts:

None

NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

	2011	2012	2013	2014	2015
Annual Objective	56.5	72.9	72.9	72.9	72.9
Annual Indicator	72.9	72.9	72.9	72.9	
Numerator					
Denominator					
Data Source	CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were

wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	50.0	40.0	40.0	40.0	40.0
Annual Indicator	39.1	39.1	39.1	39.1	
Numerator					
Denominator					
Data Source	CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey	
Provisional Or				Final	

	2011	2012	2013	2014	2015
Final ?					

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were

used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	55.2	53.3	53.3	53.3	53.3
Annual Indicator	53.3	53.3	53.3	53.3	
Numerator					
Denominator					
Data Source	CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	88.6	54.3	54.3	54.3	54.3
Annual Indicator	54.3	54.3	54.3	54.3	
Numerator					
Denominator					
Data Source	CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs

(CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2011	2012	2013	2014	2015
Annual Objective	46.5	48.6	48.6	48.6	48.6
Annual Indicator	48.6	48.6	48.6	48.6	
Numerator					
Denominator					
Data Source	CSHCN Survey	CSHCN Survey	CSHCN Survey	CSHCN Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease

Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

	2011	2012	2013	2014	2015
Annual Objective	65.0	65.0	70.0	70.0	70.0
Annual Indicator	67.0	67.0	74.2	74.2	
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: The source of data is the National Immunization Survey (NIS), Data are from 2013, data for 2014 (4:3:1:3:3) are not yet available. The confidence interval is +/- 6.9.	
2.	**Field Name:**	**2013**
	Field Note: The source of data is the National Immunization Survey (NIS), Data are from 2013. The confidence interval is +/- 6.9.	
3.	**Field Name:**	**2012**
	Field Note: The source of data is the National Immunization Survey (NIS), Data are from 2011, data for 2012 (4:3:1:3:3) are not yet available. The confidence interval is +/- 8.4.	
4.	**Field Name:**	**2011**
	Field Note: The source of data is the National Immunization Survey (NIS), Data are from 2011. The confidence interval is +/- 8.4..	

Data Alerts:

None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	17.0	17.0	12.0	12.0	11.0
Annual Indicator	12.4	12.6	12.6	13.0	
Numerator	231	229	229	236	
Denominator	18,584	18,234	18,135	18,135	
Data Source	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2014 Provisional Birth Data. 2014 population estimates unavailable. 2013 population estimates used in demoninator.	
2.	**Field Name:**	**2013**
	Field Note: 2013 Final Birth and Population Data. 2013 population estimates used in demoninator.	
3.	**Field Name:**	**2012**
	Field Note: 2012 Provisional Birth Data. 2012 population estimates unavailable. 2011 population estimates used in demoninator.	
4.	**Field Name:**	**2011**
	Field Note: Finalized data reported for 2011.	

Data Alerts:

None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	46.0	46.0	46.0	46.0	46.0
Annual Indicator	45.9	45.0	49.7	55.2	
Numerator	4,908	4,872	5,384	5,975	
Denominator	10,693	10,825	10,825	10,825	
Data Source	05 06 Statewide OH Study, OPI 3rd Grade Enrollment	11 12 Statewide OH Study, OPI 3rd Grade Enrollment	12-13 Statewide OH Study, OPI 3rd Grade Enrollment	14 Statewide OH Study, OPI 3rd GrPop	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Numerator data are from a 2014 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2011-2012 school year from the Montana Office of Public Instruction.

2. **Field Name:** **2013**

Field Note:
Numerator data are from a 2012-2013 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2011-2012 school year from the Montana Office of Public Instruction.

3. **Field Name:** **2012**

Field Note:
Numerator data are from a 2011-2012 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2011-2012 school year from the Montana Office of Public Instruction.

4. **Field Name:** **2011**

Field Note:
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2010-2011 school year from the Montana Office of Public Instruction.

Data Alerts:

None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	5.4	5.4	6.0	6.0	6.0
Annual Indicator	6.0	3.3	2.7	4.8	
Numerator	11	6	5	9	
Denominator	183,924	184,236	186,272	186,272	
Data Source	MT Office of Vital Statistics & NCHS	MT Office of Vital Statistics & NCHS	MT Office of Vital Statistics & NCHS	MT Office of Vital Statistics & NCHS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Provisional 2014 death data. 2014 census estimates unavailable--2013 estimates used in denominator.	
2.	**Field Name:**	**2013**
	Field Note: Final 2013 death data. Final 2013 estimates used in denominator.	
3.	**Field Name:**	**2012**
	Field Note: Provisional 2012 birth data. 2012 census estimates unavailable--2011 estimates used in denominator.	
4.	**Field Name:**	**2011**
	Field Note: Finalized 2011 data.	

Data Alerts:

None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	57.0	57.0	58.0	58.0	58.0
Annual Indicator	61.1	45.4	59.3	50.7	
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
The data reported for 2014 are from the CDC/National Immunization Survey Breastfeeding Report Card — United States, 2014. These data are reported as a percentage and numerator and demonator information is not available.

2. **Field Name:** **2013**

Field Note:
The data reported for 2013 are from the CDC/National Immunization Survey Breastfeeding Report Card — United States, 2013. These data are reported as a percentage and numerator and demonator information is not available.

3. **Field Name:** **2012**

Field Note:
The data reported for 2012 are from the CDC/National Immunization Survey Breastfeeding Report Card — United States, 2012. These data are reported as a percentage and numerator and demonator information is not available.

4. **Field Name:** **2011**

Field Note:
The data reported for 2011 are from the CDC/National Immunization Survey 2011, for children born in 2008. The 2008 data is final.

Data Alerts:

None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	98.5	98.5	98.2	98.5	98.6
Annual Indicator	98.0	98.5	99.0	98.7	
Numerator	11,323	11,379	11,627	11,742	
Denominator	11,553	11,557	11,739	11,892	
Data Source	Newborn Hearing	Newborn Hearing Screening Program	Newborn Hearing Screening Program	Newborn Hearing Screening Program	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
The numerator data source for this measure is HI*TRACK, the Newborn Hearing Screening Program software. The numerator includes hearing screenings for infants born in hospitals in Montana. The denominator is from the Montana Office of Vital Statistics and includes births that occured in Montana hospitals in 2014. It does not include births to Montana residents that occurred in hospitals out of state or births that occured outside hospitals..

2.	**Field Name:**	**2013**

Field Note:
The numerator data source for this measure is HI*TRACK, the Newborn Hearing Screening Program software. The numerator includes hearing screenings for infants born in hospitals in Montana. The denominator is from the Montana Office of Vital Statistics and includes births that occured in Montana hospitals in 2013. It does not include births to Montana residents that occurred in hospitals out of state or births that occured outside hospitals..

3.	**Field Name:**	**2012**

Field Note:
The numerator data source for this measure is HI*TRACK, the Newborn Hearing Screening Program software. The numerator includes hearing screenings for infants born in hospitals in Montana. The denominator is from the Montana Office of Vital Statistics and includes births that occured in Montana hospitals in 2012. It does not include births to Montana residents that occurred in hospitals out of state or births that occured outside hospitals..

4.	**Field Name:**	**2011**

Field Note:
The numerator data source for this measure is HI*TRACK, the Newborn Hearing Screening Program software. The numerator includes hearing screenings for infants born in hospitals in Montana. The denominator is from the Montana Office of Vital Statistics and includes births that occured in Montana hospitals in 2011. It does not include births to Montana residents that occurred in hospitals out of state or births that occured outside hospitals..

Data Alerts:

None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	11.0	11.0	12.1	12.1	12.1
Annual Indicator	10.2	13.7	7.6	7.6	
Numerator	24,197	32,330	20,021	20,021	
Denominator	237,267	236,440	265,081	265,081	
Data Source	US Census; CPS II	US Census; CPS II	US Census; CPS II	US Census; CPS II	
Provisional Or Final ?				Provisional	

	2011	2012	2013	2014	2015

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Current Population Survey Annual Social and Economic Supplement, conducted 2014 Refers to status in 2013	
2.	**Field Name:**	**2013**
	Field Note: Current Population Survey Annual Social and Economic Supplement, status for 2013	
3.	**Field Name:**	**2012**
	Field Note: Current Population Survey Annual Social and Economic Supplement, conducted 2012 Refers to status in 2011	
4.	**Field Name:**	**2011**
	Field Note: from Current Population Survey Annual Social and Economic Supplement, conducted 2011 Refers to status in 2010	

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	31.0	31.0	31.0	31.0	31.0
Annual Indicator	40.6	31.7	32.5	32.5	
Numerator	5,274	4,170	4,173	3,896	
Denominator	12,978	13,174	12,840	11,976	
Data Source	WIC Program Enrollment	WIC Program Enrollment	WIC Program Enrollment	WIC Program Enrollment	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: The source is the Montana State WIC Program. Data are for FFY 2014. MT WIC only has kids on until 4 years old, 5 year olds are not on MT WIC.	
2.	**Field Name:**	**2013**
	Field Note: The source is the Montana State WIC Program. Data are for FFY 2013.	
3.	**Field Name:**	**2012**
	Field Note: The source is the Montana State WIC Program. Data are for FFY 2012.	
4.	**Field Name:**	**2011**
	Field Note: The source is the Montana State WIC Program. Data are for FFY 2011.	

Data Alerts:

None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	13.0	13.0	13.0	13.0	13.0
Annual Indicator	13.6	13.4	13.8	12.9	
Numerator	1,634	1,593	1,685	1,563	
Denominator	11,981	11,915	12,185	12,104	
Data Source	Live birth data, MT Office of Vital Statistics	Live birth data, MT Office of Vital Statistics	Live birth data, MT Office of Vital Statistics	Live birth data, MT Office of Vital Statistics	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note:	

2014 Provisional Birth Data.

2.	**Field Name:**	**2013**
	Field Note: 2013 Final Birth Data.	
3.	**Field Name:**	**2012**
	Field Note: 2012 Final Birth Data.	
4.	**Field Name:**	**2011**
	Field Note: Final 2011 data.	

Data Alerts:

None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	12.5	12.5	14.0	14.0	14.0
Annual Indicator	18.0	13.8	28.0	15.6	
Numerator	12	9	18	10	
Denominator	66,748	64,985	64,283	64,283	
Data Source	MT Office of Vital Statistics and NCHS	MT Office of Vital Statistics and NCHS	MT Office of Vital Statistics and NCHS	MT Office of Vital Statistics and NCHS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2014 Provisional Death data. 2014 census population estimates unavailable. 2013 estimates used in denominator.	
2.	**Field Name:**	**2013**

Field Note:
2013 Final Death and Population data. 2013 final population estimates used in denominator.

3. **Field Name:** **2012**

Field Note:
2012 Final Birth data. 2012 census estimates used in denominator.

4. **Field Name:** **2011**

Field Note:
2011 Final Data.

Data Alerts:

None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	65.0	65.0	78.5	78.5	78.5
Annual Indicator	85.1	83.3	87.3	89.6	
Numerator	114	120	96	146	
Denominator	134	144	110	163	
Data Source	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
2014 Provisional data. Facilities for high-risk deliveries are neonates in Montana: Benefis Health System in Great Falls, Community Medical Center in Missoula, St. Vincent Healthcare in Billings, and KALISPELL REGIONAL HOSP.

2. **Field Name:** **2013**

Field Note:
2013 Final data. Facilities for high-risk deliveries are neonates in Montana: Benefis Health System in Great Falls, Community Medical Center in Missoula, St. Vincent Healthcare in Billings, and KALISPELL REGIONAL HOSP.

3.	**Field Name:**	**2012**
	Field Note: 2012 Final data. Facilities for high-risk deliveries are neonates in Montana: Benefis Health System in Great Falls, Community Medical Center in Missoula, and St. Vincent Healthcare in Billings.	
4.	**Field Name:**	**2011**
	Field Note: 2011 Finalized data. Facilities for high-risk deliveries are neonates in Montana: Benefis Health System in Great Falls, Community Medical Center in Missoula, and St. Vincent Healthcare in Billings.	

Data Alerts:

None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	75.0	75.0	75.0	75.0	75.0
Annual Indicator	71.1	71.3	69.2	69.7	
Numerator	8,557	8,595	8,549	8,507	
Denominator	12,039	12,052	12,351	12,202	
Data Source	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2014 Provisional data.	
2.	**Field Name:**	**2013**
	Field Note: 2013 Final data.	
3.	**Field Name:**	**2012**
	Field Note:	

	2012 Final data.	
4.	**Field Name:**	**2011**
	Field Note: 2011 Final data.	

Data Alerts:

None

Form 10d

State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Montana

SPM 1 - The percent of children with cleft lip and/or palate receiving care in interdisciplinary clinics.

	2011	2012	2013	2014	2015
Annual Objective	90.0	90.0	90.0	90.0	90.0
Annual Indicator	90.0	65.0	89.5	100.0	
Numerator	18	13	17	27	
Denominator	20	20	19	27	
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

   Field Note:
   Data source: CSHCN Program. The data reflect the number of infants born during *** Calender year 2014 **** and identified as having a cleft lip and/or palate by the Children's Special Health Services (CSHS) Section (the state CSHCN program), who were seen in a cleft/craniofacial clinic. MT does not have a birth defects registry.

2. **Field Name:** **2013**

   Field Note:
   Data source: CSHCN Program. The data reflect the number of infants born during *** Calender year 2013 **** and identified as having a cleft lip and/or palate by the Children's Special Health Services (CSHS) Section (the state CSHCN program), who were seen in a cleft/craniofacial clinic.

3. **Field Name:** **2012**

   Field Note:
   Data source: CSHCN Program.
   The data reflect the number of infants born during FFY 2012 and identified as having a cleft lip and/or palate by the Children's Special Health Services (CSHS) Section (the state CSHCN program), who were seen in a cleft/craniofacial clinic.

4. **Field Name:** **2011**

   Field Note:
   The data reflect the number of infants born during FFY 2011 and identified as having a cleft lip and/or palate by the Children's Special Health Services (CSHS) Section (the state CSHCN program), who were seen in a cleft/craniofacial clinic.

Data Alerts:

None

SPM 2 - The percent of Medicaid clients 0 through 6 years of age who have had a dental screening during the year.

	2011	2012	2013	2014	2015
Annual Objective	1.0	30.0	30.0	30.0	30.0
Annual Indicator	38.7	35.2	36.5	37.8	
Numerator	13,101	15,460	17,087	19,224	
Denominator	33,813	43,862	46,816	50,794	
Data Source	Medicaid	Medicaid	Medicaid	Medicaid	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

   Field Note:
   Data are from the Montana Medicaid Program (HMK+) and include all children enrolled during July 1, 2013 through June 30, 2014 (SFFY 2014). Data include children who received an oral evaluation by a dentist.

2. **Field Name:** **2013**

   Field Note:
   Data are from the Montana Medicaid Program (HMK+) and include all children enrolled during July 1, 2012 through June 30, 2013 (SFFY 2013). Data include children who received an oral evaluation by a dentist.

3. **Field Name:** **2012**

   Field Note:
   Data are from the Montana Medicaid Program (HMK+) and include all children enrolled during July 1, 2011 through June 30, 2012 (SFFY 2012). Data include children who received an oral evaluation by a dentist.

4. **Field Name:** **2011**

   Field Note:
   Data are from the Montana Medicaid Program (HMK+) and include all children enrolled during July 1, 2010 through June 30, 2011 (SFFY 2011). Data include children who received an oral evaluation by a dentist.

   NOTE: The 2011 indicator of 1 is an error and per the HRSA Call Center, it can not be corrected for the 9/12 submission. The 2011 indicator should have been 30, as it is for 2012 through 2016.

Data Alerts:

None

SPM 3 - The percent of Medicaid clients who have gestational diabetes and have their blood glucose measured during the time period of six weeks to six months postpartum.

	2011	2012	2013	2014	2015
Annual Objective	12.0	12.0	12.0	12.0	12.0
Annual Indicator	8.0	9.0	14.7	8.9	
Numerator	10	12	21	16	
Denominator	125	133	143	180	
Data Source	Linked Medicaid-birth certificate data.	Linked Medicaid-birth certificate data.	Linked Medicaid-birth certificate data.	Linked Medicaid-birth certificate data.	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

   Field Note:
   2014 Provisional Data. Data sources are the MT Office of Vital Statistics and Medicaid Information System. Data include the Montana occurring births to Montana resident mothers with Gestational Diabetes Indicated. Medicaid Claims Data include CPT codes: 82947, 82962, 82950, 82951, 83036, 82952. Linked within 42 And 180 days of birth on mother's birthdate and mother's maiden name, infants last name or father's name to recipient's last name.

2. **Field Name:** **2013**

   Field Note:
   2013 Final Data. Data sources are the MT Office of Vital Statistics and Medicaid Information System. Data include the Montana occurring births to Montana resident mothers with Gestational Diabetes Indicated. Medicaid Claims Data include CPT codes: 82947, 82962, 82950, 82951, 83036, 82952. Linked within 42 And 180 days of birth on mother's birthdate and mother's maiden name, infants last name or father's name to recipient's last name.

3. **Field Name:** **2012**

   Field Note:
   2012 Final Data. Data sources are the MT Office of Vital Statistics and Medicaid Information System. Data include the Montana occurring births to Montana resident mothers with Gestational Diabetes Indicated. Medicaid Claims Data include CPT codes: 82947, 82962, 82950, 82951, 83036, 82952. Linked within 42 And 180 days of birth on mother's birthdate and mother's maiden name, infants last name or father's name to recipient's last name.

4.	**Field Name:**	**2011**

Field Note:
The data reported are for 2010. Data for 2011 are not yet final. They are expected to be finalized later in 2012. Data source are the MT Office of Vital Statistics and Medicaid Information System. Data include the Montana occurring births to Montana resident mothers, and YEARFIRST to YEARMAX, With Gestational Diabetes Indicated. Medicaid Claims Data include CPT codes: 82947, 82962, 82950, 82951, 83036, 82952. Linked within 42 And 180 days of birth on mother's birthdate and mother's maiden name, infants last name or father's name to recipient's last name.

Data Alerts:

None

SPM 4 - The rate of death to children 0 through 17 years of age caused by unintentional injuries.

	2011	2012	2013	2014	2015
Annual Objective	13.0	13.0	12.0	12.0	12.0
Annual Indicator	21.9	13.1	9.4	10.3	
Numerator	49	29	21	23	
Denominator	223,563	221,980	223,981	223,981	
Data Source	MT Office of Vital Statistics & NCHS	MT Office of Vital Statistics & NCHS	MT Office of Vital Statistics & NCHS	MT Office of Vital Statistics & NCHS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
2014 MT Death Provisional Data. No 2014 Population data yet, used 2013.

2.	**Field Name:**	**2013**

Field Note:
2013 Final Data

3.	**Field Name:**	**2012**

Field Note:
2012 Final Data

4.	**Field Name:**	**2011**

Field Note:
The data reported are for 2010. Data for 2011 are not yet final. They are expected to be finalized later in 2012.

Data Alerts:

None

SPM 5 - The precent of women who smoke during pregnancy

	2011	2012	2013	2014	2015
Annual Objective	15.0	15.0	14.0	14.0	14.0
Annual Indicator	16.3	16.2	16.5	16.0	
Numerator	1,954	1,927	2,010	1,942	
Denominator	11,991	11,921	12,190	12,106	
Data Source	Birth certificates	Birth certificates	MT VS Birth Data	MT VS Birth Data	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: 2014 Provisional Data	
2.	**Field Name:**	**2013**
	Field Note: 2013 Final Data	
3.	**Field Name:**	**2012**
	Field Note: 2012 Final Data	
4.	**Field Name:**	**2011**
	Field Note: The data reported are for 2010. Data for 2011 are not yet final. They are expected to be finalized later in 2012.	

Data Alerts:

None

SPM 6 - The percent of children 19-35 months of age who have received the 4th immunization in the diphtheria, tetanus, and pertussis (DTaP) series.

	2011	2012	2013	2014	2015
Annual Objective	80.0	80.0	80.0	80.0	80.0
Annual Indicator	82.6	86.6	79.0	79.0	
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: The source of data is the National Immunization Survey (NIS), Q1/2013-Q4/2013. The confidence interval for this indicator is +/- 6.4. The data for 2014 are unavailable at this time.	
2.	**Field Name:**	**2013**
	Field Note: The source of data is the National Immunization Survey (NIS), Q1/2013-Q4/2013. The confidence interval for this indicator is +/- 6.4.	
3.	**Field Name:**	**2012**
	Field Note: The source of data is the National Immunization Survey (NIS), Q1/2012-Q4/2012. The confidence interval for this indicator is +/- 4.4.	
4.	**Field Name:**	**2011**
	Field Note: The source of data is the National Immunization Survey (NIS), Q3/2010-Q2/2011. The confidence interval for this indicator is +/- 5.1. The data for 2011 are not yet final.	

Data Alerts:

None

SPM 7 - The percent of children 19-35 months of age who have received an immunization against varicella.

	2011	2012	2013	2014	2015
Annual Objective	82.0	82.0	83.0	83.0	83.0
Annual Indicator	85.7	85.3	87.1	87.1	
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Data are from the Q1/2013-Q4/2013, NIS. The confidence interval is +/- 5.2. The data for 2014 are unavailable at this time.	
2.	**Field Name:**	**2013**
	Field Note: Data are from the Q1/2013-Q4/2013, NIS. The confidence interval is +/- 5.2.	
3.	**Field Name:**	**2012**
	Field Note: Data are from the Q1/2012-Q4/2012, NIS. The confidence interval is +/- 5.2. The data for 2012 are provisional.	
4.	**Field Name:**	**2011**
	Field Note: Data are from the Q3/2010-Q2/2011, NIS. The confidence interval is +/- 4.4. The data are provisional.	

Data Alerts:

None

Form 11

Other State Data

State: Montana

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: Montana

Please click the link below to download a PDF of the State Action Plan Table.
State Action Plan Table