



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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1.4 Overview of the State

Geographic and Population Data

Montana is the fourth largest state in the United States, encompassing 147,046 square miles. The vast size of the state can be illustrated by the observation that Ekalaka, a small town in the southeastern portion of Montana is closer to Texas than it is to Libby, a town in the northwest portion of the state. Western Montana is mountainous, dotted with many rivers and small lakes and includes both Yellowstone and Glacier National Parks. There are 17,000,000 acres of national forest and 15,000 miles of prime fishing waters, primarily in western Montana. The eastern two thirds is characterized as the Great Plains; the land is arid with access to water often a concern. Annual precipitation in Montana is less than 15 inches.

In Montana, “geography is destiny” indeed (Dartmouth Atlas of Health Care in the United States). The immensity of the land is both a blessing and a curse. The majestic beauty provides endless opportunities for recreation; there are 88 golf courses, 215 resorts and dude ranches, 15 downhill ski areas, 15,000 miles of blue ribbon fishing waters, 17,000,000 acres of national forest, and two national parks. In fact, tourism is a major industry, with non-state residents spending 1.6 billion dollars in the state in 1999. On the down side, distances, isolation, plus difficult and changeable weather make travel including to health services extremely difficult and often dangerous. Winter travel can be particularly hazardous over icy mountain passes or through ground blizzards on the plains. Montanans think nothing of driving 200 miles to a basketball game or see a movie just as they consider travel over hundreds of miles to deliver a baby or see a dentist a routine inconvenience. Public transportation is limited, with many areas in the state totally void of air, rail or even bus transportation. Accessibility to primary care givers is inconsistent. The larger population centers have adequate numbers of primary care providers and accessible specialty care, especially for those with health insurance. Rural areas fair much more poorly. Small hospitals are converting to MAF status limiting access to critical and sophisticated care when it is needed quickly. Older physicians and dentists looking toward retirement may have difficulty finding providers interested in taking over their practices.

Montana has abundant natural resources. The majority of the land is used for agricultural purposes. In 1997 there were 24,279 farms and ranches, 10,189 of which encompassed more than 1,000 acres. The state ranks second in the nation for barley production, third for wheat, sixth for beef cattle and ninth for sugar beets. The state produces oil, gas, lumber and coal. Mining for copper, silver and gold continues with the addition in the last five years of one of the world’s largest palladium/ platinum mine in central Montana. One of the country’s largest vermiculite mines is located in Libby and has been the focus of recent national interest. Estimates by CDC indicate hundreds of residents have been exposed to dangerous levels of asbestos over several decades. Implications for the MCH population are being investigated.

The state has 56 counties (Appendix A), ranging in area from 719 square miles to 5,529 square miles; 46 counties are considered frontier, 8 are considered rural and 2 are considered urban. Nine counties have no private medical services at all. There are seven Indian reservations for 11 Indian tribes occupying 8.4 million acres.. All but two reservations are found in eastern Montana. (Appendix A)

In 1990 the population of Montana was 799,065; that has risen to 882,779 in 1999, an increase of almost 84,000 people, up 10.5% in that period. The population density is 6.1 person per square mile, split almost equally between urban (52.5%) and rural (47.5%). Thirty-six percent of Montana’s

people reside in the eight population centers of Billings, Great Falls, Missoula, Helena, Bozeman, Butte, Kalispell and Hamilton. The remainder of the population is dispersed in 470 smaller communities and on farms and ranches. Over 3/4th of the state's population is age 18 and over with 13.3 % over 65. The proportion of Montana's population classified as elderly is expected to increase to 24.5% by 2025, which will be the 3rd highest proportion of elderly in the nation. The median age is in 1999 is 37.5 years. Sixty percent of Montanans were born in the state. The following table gives the race and ethnic breakdown of the population in 1999. (Montana Census and Economic Information Center, Department of Commerce):

RACE/ETHNICITY	% OF POPULATION
WHITE	92.7
BLACK	0.3
AMERICAN INDIAN	6.0
ASIAN	0.5
OTHER	0.5
HISPANIC ORIGIN	1.5

According to 1998 census data and Indian Health Services, there are approximately 56,000 American Indians living in Montana. A large portion still live on reservations; reservation population numbers (1990) are shown in the following table.

RESERVATION	1998 POPULATION
Blackfeet	8,643
Crow	10,615
Flathead	9,139
Fort Belknap	3,567
Fort Peck	7,536
Northern Cheyenne	4,531
Rocky Boy	3,727

Almost 90% of Montanans finish high school, with Montana ranking 5th in the nation for percent of adults finishing the 12th grade. For the past five years, Montana's high school graduates placed 4th in the nation for ACT scores. The university system recently integrated the two universities, four colleges and five Vocational-Technical centers into one state wide comprehensive university system. In addition, there are six private colleges, seven tribal colleges and three community colleges. Twenty four percent of the population in Montana earns a bachelors degree or higher.

The state is a magnet for artists and writers. In recent years, Montana has been featured in many feature films, documentaries, TV features and still shots. Given Montana's sparse population and huge distances, the cultural explosion over the past decade is truly amazing: there are eight symphony orchestras in the state, six professional theater companies, four professional dance companies and one professional opera company. There are over 200 art galleries, 80 art museums and an historical

museum in almost every little town. Of note, however, Montana ranks 50th for state spending for the arts. (Congressional Quarterly, State Fact Finder, 2000)

Economic Characteristics

Over the past 40 years, farming, forestry and fishing jobs have declined. The strongest growth in jobs has been in the professional, technical, sales and service sectors. The largest growth in private service jobs has been in the health industry which is now an important part of Montana’s economy. Private service jobs employ 38 percent of Montanans of which, health jobs make up 7 percent. Retail trade employs 17 percent, government, including education, employs 14 percent and manufacturing employs 13 percent; 8.2 percent of Montana residents earn their living from farming, forestry and fishing, four times the national average.

In Montana, average wages for payroll jobs have failed to keep up with inflation for all but three of the past 22 years. In 1950 the average Montana worker made \$19,499 a year (adjusted for inflation in 1998 dollars). Wages rose only \$3,017 to \$22, 516 over the next 48 years. Per capita income in 1998 was \$20,247 and median household income was \$30,348. Montana ranks 49th in average annual pay and 27th in the country for cost of living. Montana is first in the nation for people holding down two jobs. Montana is listed as 5th in the country for percent of the population in poverty; our child poverty rate ranks 9th nationally, according to the Congressional Quarterly, State Fact Finder, 2000.

The 1999 unemployment rate in Montana was 5.2, ranking 11th in the nation. On the seven Indian reservations, however, unemployment figures are much higher.

RESERVATION	UNEMPLOYMENT RATE 1999
Blackfeet	21.7%
Crow	14.7%
Flathead	5.8%
Fort Belknap	22.6%
Fort Peck	10.6%
Northern Cheyenne	18.6%
Rocky Boy	28.3%

(Source: Montana Department of Labor and Industry)

Minority Data

Eleven tribes of American Indians make up the largest minority population in Montana, representing approximately 6% of the total population. Health care for this minority is provided by a network of services including hospitals, clinics and practitioners including, but not limited to, Indian Health Service systems as well as tribal health services located on the seven reservations. It is estimated that approximately half the Indian population lives off reservation and receives health care by way of the mainstream health care system. There are three urban Indian full service medical clinics located in Billings, Great Falls and Helena and two referral based clinics in Missoula and Butte.

The Hutterite population, a religious group similar to the Amish, makes up another minority segment of the population of Montana. The Hutterites live on approximately 30 to 35 self contained and rather isolated, agriculturally founded colonies scattered across Montana. It is difficult to identify Hutterites via vital records or census charts because of their Caucasian ethnic background but it is estimated there are approximately 3000 to 4000 Hutterites in Montana. German is the primary language. Children attend colony schools. All colony business is conducted by the men; women play a very subservient role in colony management. Cultural isolation, health care practices (such as routine delivery by lay midwives) and the potential for genetic disorders exacerbated by intermarriage put the Hutterite population at risk for a variety of poor outcomes.

There are isolated pockets of other minority groups including a southeast Asian cluster of about 200 to 300 persons in western Montana as well as about 300 Russians. The Hispanic population is increasing. Local health departments have had to examine policies and procedures in order to respond to the needs of these populations; access to care is often difficult, the need for translation services has increased as well as heightened surveillance of tuberculosis and other communicable diseases.

The number of people of Hispanic origin has been growing faster than other minority groups with the exception of Native Americans, with an increase of 3521 individuals of Hispanic origins having moved into the state since 1990. This represents 4.2% of the increase in population over that time span. Currently, Montana ranks 37th in the nation for percentage of Hispanic people in the population. The state ranks 50th in the nation for African-American people with an estimate of about 1% of Montana's population being of this racial background.

Major Preventable Health Problems

According to the Congressional Quarterly State Fact Finder 2000, the following are “risk factors” for Montana with potential negative impacts on the population, including mothers and children:

RISK FACTOR	NATIONAL RANK
Hunters with firearms	1
Toxic chemical release per capita	2
Polluted rivers and streams	4
Percent in poverty	5
Child poverty rate	9
Children in foster care	10
Alcohol consumption	10
Murder rate	27
Percent of single parent families	35
Percent of adult smokers	38
Percent overweight	39
Violent crime rate	46
Average annual pay	49

Leading causes of death in Montana are heart disease, cancer, cardiovascular disease, chronic obstructive pulmonary disease and accidental deaths due to unintentional injuries. These have remained the same for several years. Montana's age adjusted mortality rates for many of the chronic diseases, such as heart disease, cancer, cerebrovascular disease, pneumonia and influenza, nephritis

and chronic liver disease and cirrhosis were lower than those for the US over the past ten years. However, Montana's rates for diabetes, Alzheimer's, and COPD including bronchitis, emphysema, asthma and related diseases were notably higher; Montana's death rate from diabetes was higher than that of the US for four of the past ten years, and COPD was higher all ten years. Montana's rates for traumatic causes of death, accidents and suicide were higher than those for the nation in all ten years. For Montana Indians, accidents, diabetes and chronic liver disease and cirrhosis follow heart disease and cancer in leading cause of death. Whites typically died at a older age than Indians. Particularly striking is the fact that one quarter of the white decedents died at or below the age 65 while one quarter of Indians died at or below the age 40. The median age of death for white women was 80, for Indian women it was 65. The median age of death for white men was 74 and for Indian men it was 57.5. (Montana Bureau of Records and Statistics, 1998)

Maternal death in Montana is a rare occurrence. According to Montana vital records, there were only two maternal deaths in the five years from 1994 through 1998 and no maternal deaths in 1999. One death occurred in early 2000. All maternal deaths are reviewed. It has been suggested that maternal death review be incorporated in the fetal, infant and child death review teams responsibilities.

The violent crime rate is of concern. While it continues to rank 46th in the nation in magnitude, it has the fifth fastest growing rate in the country. Montana ranks 27th in the nation for murders. Gangs and gang related violence has increased rapidly in the past several years. "Since popping up on police radar in 1994, gangs have grown more active, more violent and are moving from selling marijuana to cooking and distributing methamphetamine." (Great Falls Tribune, May 21, 2000). The Indian reservations are particularly hard hit. In Browning on the Blackfeet Reservation with a population of 2000, tribal police estimate 150 teens claim gang affiliation. "For the same reasons as children growing up in urban ghettos--few jobs, raging substance abuse and fatherless homes--boys and girls on Montana's reservations are vulnerable to gang influences... With scant law enforcement capabilities ,urban gangs have found there is an easy and very lucrative market for drugs. The big city gangs like small communities because basically were ignorant, for lack of a better word, to the gang situation...they can come in and take over a community." (Great Falls Tribune, May 21, 2000)

Methamphetamine use has been a particular concern in 2000, gaining national attention, including that of the White House Office of Drug Control Policy. The Billings area has an active methamphetamine task force while other communities scramble to become informed about the implications of meth use and the potential impact on the maternal and child populations in their areas. Senator Baucus is leading the effort to secure national designation as a high risk area for meth use.

Domestic violence continues to grow in scope. Public health nurses responding to the annual spring needs assessment survey have ranked domestic violence in the top five public health needs for the past several years. Many of the nurses estimated that between 20% to an astonishing 85% of the women in their case loads have experienced domestic violence on an ongoing basis. On one Indian reservation, the tribal juvenile department reported an increase in child abuse cases from 10 in 1988 to 1605 in 1998 and over 900 cases of domestic violence in 1998. On the same reservation, 40 students were expelled from second and third grades for violence and/or illegal drug possession. In fourth and fifth grades, there were 99 long term suspensions from school in one year.

Health Care Resources

Hospitals and Medical Assistance Facilities

Montana has sixty two licensed hospitals, forty eight are not for profit acute care community hospitals and 14 are Critical Access Hospitals (CAHs) with limited services usually provided by a midlevel practitioner. All hospitals provide access to care for low income, indigent, Medicaid and Medicare patients. In most communities, the hospital is at the center of the provision of health care as well as being an important economic resource. There are two hospitals which provide pediatric mental health care, five provide care exclusively for veterans and American Indians and are federally owned and operated. There is a hospital at Malmstrom Air Force Base in Great Falls which serves the military personnel and their families.

All but the hospitals in Billings and Great Falls are classified as rural facilities by HCFA. Thirty-two of the 48 hospitals delivered babies in 1999. Three hospitals, located in Billings, Missoula and Great Falls are classified as "level III" centers for perinatal purposes. Thirty-nine are considered sole community providers and four as rural referral centers. Forty-five hospitals and CAHs also provide long-term care services. The maintenance of these rural hospitals is critical to providing access to inpatient, emergency room and outpatient services within the county. Technical assistance and education of providers continues to be a major need for rural health facilities.

According to the Montana Board of Medical Examiners there are an estimated 686 primary care physicians with a total of 1843 total physicians licensed in Montana. Sixty percent of the primary care physicians are located in Silver Bow, Yellowstone, Missoula, Gallatin, Cascade, Lewis and Clark and Flathead counties, the seven most populated counties in Montanan. Recruitment of physicians to staff the smaller hospitals in Montana continues to be a critical problem.

Rural Health Clinics

Establishment of Rural Health Clinics (RHC) under the provisions of PL. 95-210 has improved access to health care in many counties and communities. There are 29 Rural Health Clinics in Montana and several additional sites are currently considering conversion/establishment of a RHC. Some are in counties with no hospitals and no physicians. In counties with a CAH, the addition of a rural Health Clinic has served the dual purpose of increasing access to primary care services and improving the financial position of the CAH.

Community Health Centers

The number of Community Health Centers (CHCs) is extremely limited in Montana. CHCs are located in Billings/Yellowstone County, Butte/Silver Bow County, Missoula/ Missoula County, Helena/Lewis and Clark County, Great Falls/Cascade County and Livingston/Park County. These centers provide essential services in some of the largest communities and counties with the largest populations in Montana. In 1998, these facilities served 32,659 patients across Montana.

Migrant Health Centers

There is one Migrant Health Center (MHC) in Montana located administratively in Billings. Satellite services have been provided over the last several years in six locations: Fairview/Richland County,

Glendive/Dawson County, Bridger/Carbon County, Flathead-Lake Counties, Hardin/Big Horn County and Hysham/Treasure County. This year services are expanding to Beaverhead and Madison Counties. In 1999, these centers served 12,400 migrant workers.

Indian Health Services

The Billings Area Indian Health Services provides services to approximately 60,021 Native American people living in Montana and Wyoming. Seven of the eight service areas are located in Montana.(Appendix A). All the service units, with the exception of the Rocky Boy and the Flathead Tribal Service Unit, provide direct ambulatory, emergency, dental, environmental health, community health and preventive health services. Blackfeet, Crow and Fort Belknap service units provide both inpatient and outpatient health services. The Billings Area Indian Health Service contracts with five non-profit corporations to provide a variety of health care services to Indians living in the Billings, Butte, Helena and Missoula areas and include health education, nutrition education, school mental health programs, public health nursing, community health representatives, care coordination and special projects and initiatives.

Managed Care

Montana ranks 42 in the nation for population in HMOs thus the penetration continues to be small. The Montana Medicaid HMO which had operated in Billings and Great Falls for the past four years has been discontinued effective July 1, 2000. The Department and the HMO mutually decided that, with enrollment lower than expected and with increasing federal regulations, it is no longer feasible to continue to offer this Medicaid option. The approximately 2000 enrollees in the HMO will move to the statewide Passport to Health program where they will continue with their same primary care providers.

County Health Departments

County health departments are central to provision of public health services in Montana. Of the 56 counties in Montana, 52 of them provide some sort of public health services. Public health departments range in size from a large system including primary care services for the under served population as well as traditional population based public health services including environmental services to the very small, limited, part time provision of services. Four counties (Carter, Golden Valley, Musselshell and Petroleum) have no public health nurse; sanitarian services are available in all counties, however. The pool of trained public health nurses is very small and recruitment continues to be a problem. The loss of just one nurse significantly impacts the delivery of services to the maternal and child population across the state.

Title V funding plays a central role in supporting public health activities in Montana counties. For many counties, along with the required three fourths county match, it is the only funding available to carry out core public health functions.

1.5 The State Title V Agency

The Family and Community Health Bureau, located in the Health Policy and Services Division of the Montana Department of Public Health and Human Services, is the designated State Title V Agency. (Appendix B)

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

The Montana Department of Public Health and Human Services (DPHHS) is the state agency responsible for the programs and services which safeguard the health and welfare of Montanans. It is empowered to carry out its mission to “improve, preserve, strengthen and protect the health, well-being and self reliance of all Montanans.” In the 1995 reorganization of state agencies, the environmental component of public health was separated and those functions now are carried out by the Department of Environmental Quality.

DPHHS includes eight divisions:

- Addictive and Mental Disorders Division
- Child and Family Services Division
- Child Support Enforcement Division
- Disability Services Division
- Health Policy and Services Division
- Operations and Technology Division
- Quality Assurance Division
- Senior and Long Term Care Division

The majority of state level activities and services to the maternal and child population take place within the Health Policy and Services Division. The mission of that division is to “Improve and protect the health and safety of Montanans.” Nancy Ellery is the division administrator and oversees the activities of five bureaus:

- Financial, Operations, and Support Services Bureau
- Health Systems Bureau
- Family and Community Health Bureau
- Medicaid Services Bureau
- Communicable Disease Control and Prevention Bureau

A Directory of the Division is included as Appendix B.

Maternal and child health services at the state level are coordinated out of the Family and Community Health Bureau (FCHB). JoAnn Walsh Dotson is Chief of the Bureau. The mission statement for that Bureau is “to assure the health of all Montanans, with special emphasis on children, women and families.”

The Family and Community Health Bureau is made up of four service sections and an administrative unit. The sections are:

- Child, Adolescent and Community Health (CACH)
- Special Health Services (Montana’s CSHCN program)
- WIC/Nutrition

Women's Health

The Family and Community Health Bureau is responsible for all MCHBG funding, which, with the exception of \$15,000, is accounted for in the budgets of three of the sections and the administrative unit. The Bureau also supports the efforts of the Health Systems Bureau in health planning and Public Health Improvement by committing staff time toward the creation of planning documents, participating on taskforces and committees including the Public Health Training Institute. A recent publication entitled "A Strategic Plan for Public Health Improvement" outlines the plan to improve the public health system in Montana and is included as Appendix C.

The Montana Initiative for the Abatement of Mortality in Infants (MIAMI) program and Follow Me for at risk children provide services similar to those outlined in the Federal Healthy Start model. MIAMI and Follow Me are supported by Title V and state general funds and are primarily contract activities of the counties. The state receives a Title V Abstinence Grant which is administered in the Women's Health Section of the Bureau.

The Family and Community Health Bureau budget of approximately \$17.2 million includes Title V funding, WIC, Title X, Preventive Health Block Grant, CDC, CISS, SSDI and state general funds. The Bureau staff continue to explore and consider how such a variety of funding sources and intents can be melded to create dynamic and responsive programs that continue to adhere to the funding source requirements. The Bureau manages approximately 300 contracts with local providers for MCH services including primary and preventive services for women, infants and children including those with special health care needs, family planning services, tribal programs and WIC. Approximately 88% or \$15.5 million of the total bureau budget is expended at the local level.

The Bureau works very closely with related programs including the Immunization Program which is located in the Communicable Disease Control and Prevention Bureau, the Injury Prevention Program which is administered through the Health Systems Bureau and with the Integrated Data for Evaluation and Assessment project located in the Financial, Operations and Support Services Bureau.

Authority for Maternal and Child Health Services

Authority for maternal and child health activities within the Department is found in the Montana Codes Annotated ((MCA), 50-1-202, General powers and duties: "The department shall:

... (3) at the request of the governor, administer any federal health program for which responsibilities are delegated to the states;

...(9) develop, adopt and administer rules setting standards for participation in and operation of programs to protect the health of mothers and children, which rules may include programs for nutrition, family planning services, improved pregnancy outcomes, and those authorized by Title X of the federal Public Health Service Act and Title V of the federal Social Security Act...

...(16) accept and expend federal funds available for public health services...

...(17) have the power to use personnel of local departments of health to assist in the administration of laws relating to public health..."

Rules implementing the above authority are found in Title 16, Chapter 24, sections 901 through 1001 of the Administrative Rules of Montana (ARM). These rules define the State Plan for Maternal and Child Health, including crippled children, family planning and school health. A 1996 addition to the Rules describes the Standards for Receipt of Funds for Maternal and Child Health Block Grant. Newborn screening is required through ARM 16.24.201 through 215. MCH 50-19-301 through 323 authorized and describes the MIAMI project. Administrative rules describing and authorizing case management for high risk pregnant women are contained in ARM 46.12.1901 through 1925.

1.5.1.2 Program Capacity

Capacity to perform MCH activities is established in two ways: The state MCH staff provides oversight, program planning and development, policy and procedure development and definition, monitoring, and quality assurance activities. Capacity to carry out MCH priorities depends on the state-local structure with the local public health workers actually performing the activities needed to achieve the state goals. For the purposes of this section, capacity is addressed according to the target populations served by the MCHBG.

Pregnant Women: Pregnant women in Montana are served primarily through the MIAMI program (Montana Initiative for the Abatement of Mortality in Infants). Funding for these services combines state general funds with Title V funding. The goals of the MIAMI program were specified in the MIAMI act passed by the Montana Legislature in 1989 and include: assurance that mothers and children, particularly those with low income or with limited availability of health services, have access to quality maternal and child health services, the reduction of infant mortality and the number of low birth weight babies and the prevention of the incidence of children born with chronic illnesses, birth defects or severe disabilities as a result of inadequate prenatal care. The Legislature supports the MIAMI project with approximately \$500,000 in general funds. The Child, Adolescent and Community Health Section is responsible for the program activities of MIAMI while the Administrative Unit oversees and monitors the local contracts for MIAMI services.

The MIAMI project combines four primary components:

1. Local care coordination of services for high risk pregnant women
2. Public education regarding the importance of early and continuous prenatal care and the impacts on healthy pregnancy outcomes
3. Fetal and infant mortality review. Child mortality review was added during the 1995 legislature.
4. Medicaid changes which assure access to services which improve the health of pregnant women, mothers and infants.

MIAMI services are implemented through efforts to support and coordinate the public health system in Montana to more effectively serve the perinatal population and address the issues in each community that impact the low birth weight and infant mortality

rates. MIAMI services include home and office visiting by a team composed of a public health nurse, social worker and dietitian directed toward ensuring a successful term pregnancy, improving access to perinatal services by helping with transportation and initial physician costs when no other resources are available, client education directed toward decreasing the potential for low birth weight and other negative outcomes and, finally, community education regarding the need for early and continuous prenatal care. In addition, each local MIAMI project coordinates a local fetal, infant and child mortality review team charged with reviewing all fetal and infant and child deaths in the service area.

Local health departments that do not have MIAMI projects also provide an array of services to pregnant women, by assessing need and coordinating resources and care. In addition, since 1986 Montana has maintained a contract with the University of Utah Pregnancy Risk Line. The 1-800 line provides teratology information to health care providers and the public in Montana. Since FY 2000, the risk line has been administered by the Women's Health Section.

Mothers and Women of Childbearing Age: The state continues to increase its efforts to address the health needs of mothers and women of childbearing age. The Women's Health section provides the structure in which health concerns of women may be addressed including, but not limited to, family planning services. The Women's Health Section is the location of the Montana Unit of the US Public Health Service's Office on Women's Health which coordinates activities and participates in data collection efforts addressing women's health issues. This section also initiates and participates in activities focused on prevention of sexual assault and domestic violence and supports local efforts such as implementation of local SANE (Sexual Assault Nurse Examiner) programs. The Women's Health Section also participates and coordinates with the Montana HIV/STD section for health education/risk reduction and all 15 local family planning sites have an agreement to provide STD services and are thus designated as state STD clinics. Expanding the effort to prevent STDs, the Women's Health section participates in Montana's efforts in the Region VIII Chlamydia Project. All Title X agencies provide Hepatitis B vaccine on site to adolescents under age 19 and assess risk for those clients over 19 with either immunization provided or referrals made. Six of the 15 Title X family planning sites provide direct clinical breast and cervical screening services. An additional four family planning sites provide comprehensive breast and cervical cancer screening services that serve women in an identified target population.

The Women's Health Section participates on the Family and Community Health Bureau's folic acid education committee along with representatives from WIC, CACH and Healthy Mothers/Healthy Babies. The section also coordinates efforts to prevent osteoporosis.

Approximately \$76,000 of state Title V funds were designated to support the work of the Women's Health program in Montana. The funds included about \$22,000 to support the Pregnancy Risk line, \$32,000 for local family planning services and \$20,000 in staff and contracted funds to support perinatal and general women's health issues; however, the major women's health issue supported by the section is family

planning. Many counties use a portion of their MCHBG funds to support family planning activities at the local level.

The goal of Montana's family planning services is complimentary to the mission of the Bureau. Family planning seeks to maintain or improve the reproductive health of Montana's people during their reproductive years. Each family planning program functions under the medical supervision of a licensed physician.

Montana's WIC program provides nutrition education, supplemental food and referrals to other services at 107 full and part time WIC clinic sites. These services are provided to pregnant women as well as children. Local public health nurses are frequently the designated "qualified professional" in small communities and Title V funds support and enhance the work of the WIC programs. A special initiative funded by USDA is presently underway in Montana to pilot a regional dietitian service plan which will enhance access to professional dietetic services in counties without resident dietitians.

Infants: Title V funding addresses the needs of infants in a number of different ways including universal newborn screening for inborn errors of metabolism, newborn hearing screening, home visiting programs such as the Follow Me program, statewide immunization campaigns, and mortality reviews. WIC provides nutritional services and food commodities for infants. Several counties still provide well child/baby exams although that services is no longer a mainstay of the local health department structure.

SIDS continues to be an issue of concern in Montana. The state rate has been above the national rate for all years in this decade. (Appendix D) The state was the recipient of a CJ Foundation for SIDS, Inc. Grant in 1999 to be used to develop a statewide parent network and support structure of families experiencing the death of a child, particularly from SIDS. A CJ Foundation grant had been received in 1998 and was used to develop a home visiting guide for public health nurses to use when working with families following a SIDS death (Appendix D).

An ongoing public education campaign, Montana's Child was developed and produced by the Healthy Mothers Healthy Babies Coalition via a contract with the FCHB. Television, radio and newspaper columns focus on common issues of infancy, early childhood, and most recently early adolescence. The quality of the TV spots is excellent and the information well received across the state. Viewers are referred to the MCH information 1- 800 line for additional materials and for a referral to local resources if they are needed.

The Fetal, Infant and Child Mortality review process continues to review deaths with the intent to identify potential areas for expanded prevention efforts. Montana receives a HRSA Healthy Start grant to support mortality and morbidity review. There is a very active state team as well as 17 local teams participating in the review process. This effort is partially supported by a MCHB-HRSA grant as well as Title V and activities are coordinated out of the Child, Adolescent and Community Health Section.

Children: There are several ways in which services to children are provided. The fluoride mouth rinse program serves school children across the state. The Follow Me

program, including assessment, home visiting and case management, addresses the needs of infants and children identified as being “ at risk.” WIC serves children across the state in 107 WIC clinics located in all counties in Montana. Immunization clinics are coordinated at the local level by county health nurses. School nursing services are provided in many counties by local county health nurses and funded by MCHBG dollars. Screening of vision, hearing and scoliosis continue to be carried out to a large number of children across the state.

The state receives funding from a Lead Surveillance grant from CDC and active lead screening continues. This activity is coordinated out of the WIC/Nutrition section and utilizes local WIC clinics as screening sites. The state also receives funding from a CISS grant which funds the Healthy Child Montana project which provides coordination of health services between local public health nurses and local child care providers. Child mortality is reviewed by local FICMR teams. Bi-monthly meetings with staff from the Office of Public Instruction are held to discuss and resolve common child health and school related concerns.

More recently, efforts to assess the burden of asthma in children has begun. A survey of providers, public health nurses, school nurses and day care providers was conducted in order to assess the extent of the problem.

Adolescents: Efforts to develop strong adolescent health services continues with emphasis on access to care, and prevention of suicide and mortality and morbidity related to motor vehicles, alcohol and drug use and fire arms. Adolescent health issues were a focus of debate during the development of Montana’s CHIP program and resulted in adolescents being included in CHIP covered services. Work on legislation to develop a graduated drivers license law continues as does the development of a statewide suicide prevention plan. Adolescent issues are coordinated out of the CACH section and have involved close collaboration with a number of partners such as the abstinence coordinator, the Women’s Health section, the injury prevention coordinator in the Emergency Medical Services section, the Juvenile Justice programs as well as the Addictive and Mental Disorders Division. Asthma in adolescents and the need for immunization for Hepatitis B are two additional focuses of efforts directed toward improving the health of Montana’s adolescent population. In addition, activities of the abstinence grant coordinator are coordinated with the adolescent program on a daily basis.

Children with Special Health Care Needs (Special Health Services - SHS): Direct, enabling and population based services are provided to Montana children with special health care needs by the Special Health Services section and their contractors. Services include coordination and quality assurance for statewide outreach clinics and, during 1999, the establishment of regional clinic coordination (a list of clinics is included in Appendix E). The program continues to provides direct payment for medical services for eligible children who have no source of payment for needed care. The number of children receiving direct pay services has decreased as insurance coverage becomes more available. SHS activities are coordinated with SSI, Part C and the Medicaid staff in the Department. The section reviews SSI eligible clients and assures client eligibility for SHS services. The section also coordinates and facilitates referrals to and from

local public health staff in the communities through their clinics and by direct communication with local public health providers. The section acts as an information and referral source, responding to requests from hospitals, private providers, families and others.

The section has established strong and long standing relationships with specialists and agencies who provide services to children with special health care needs. Those providers include Part C, teachers, schools, local public health, pediatric specialists in metabolic disorders, genetics, cardiology, neurology, allergy/asthma, developmental pediatrics and pediatric surgical specialists in craniofacial, ENT and orthopedics; other health care specialists such as physical therapy, occupational therapy, speech and language therapy, audiology, dentists and orthodontists. Institutional partners include Shriners' Hospitals, the Montana Medical Genetics Program, primary, secondary and tertiary medical centers in Salt Lake City, Denver, Spokane, Seattle and elsewhere.

The SHS section is developing a birth defects monitoring system funded in part by CDC. Close collaboration with the state vital records bureau and the Montana Medical Genetics Program resulted in the development of a passive system to identify and track birth defects; the program will begin with four defects - cleft-craniofacial, cardiac, and neural tube defects as well as congenital hypothyroidism. Computer support of this system is also being developed in conjunction with an update of the SHS data system.

Newborn screening is coordinated out of the SHS section as well with assurance that abnormal tests results are followed and families referred to appropriate services.

Administrative Unit: The administrative unit which was established in late 1998 continues to monitor, develop and oversee the Maternal and Child Health Block Grant (MCHBG) as well as managing the MCHBG contracts to counties. This unit coordinates and oversees much of the communication between the state and local health departments by generating the newsletter, presenting the spring state wide MetNet and organizing and conducting the five regional meetings each Summer or early Fall. This unit also participates in the planning and presenting the annual Spring public health meeting as well as participating in MPHA in the Fall. The unit is responsible for the collection of all data required for the federal and state performance measures and more recently the health status indicators. Efforts are ongoing to simplify the contracting and reporting processes for counties in order to ensure timely and accurate reporting. The administrative unit has worked very closely over the last several years with the development of the public health data system, assuring data capture of all necessary items for the MCHBG as well as helping with the planning of the "roll out" of the system at the local level and evaluating its impact. This unit continues to work closely with other bureaus in the HPS division as an innovative integrated funding project is developed and implemented in four counties across the state.

1.5.1.3 Other Capacity

As noted above, Title V funding and staff are accounted for primarily in the Family and Community Health Bureau. The Bureau includes a staff of 33 employees with 17 of

those employees supported all or in part by Title V. Vitae for key MCH staff are included as Appendix B. In addition, Title V funds a small portion of the work of the Department's Medical Officer, Dr. Michael Spence, based on a cost allocation formula. Title V funding supports a portion of the development of the Public Health Data System, described in Appendix F, primarily with staff participation in this intense, time consuming process. The Bureau supports the production and distribution of a newsletter, a public health nurse directory and a "who to call" list. These resources are updated regularly and distributed widely across the state. The Bureau also supports in part two statewide public health meetings, the spring public health meeting and the fall meeting of Montana Public Health Association.

The Bureau also maintains a contract with the Montana Healthy Mothers/Healthy Babies Coalition to operate a toll free MCH information line as well as with the Utah Pregnancy Riskline described earlier.

1.5.2 State Agency Coordination

The staff of the Family and Community Health Bureau are active participants on many intra and inter departmental committees. They are also represented on statewide and national planning organizations. Bureau staff also participate on committees and councils at the request of agencies and departments in the state, including a statewide Initiative on Nursing Transformation funded by the RWJ Colleagues for Caring Program, and on an RFP review committee on a competitive grant for designation of Drug Free Schools for the Office of Public Instruction.

Participation on intra division committees and councils requires a large time commitment by bureau staff. The IDEA-Public Health Data System alone has taken an extensive amount of work on the part of SHS, CACH, Women's Health and the Administrative Unit over the past two to three years. Staff is continuing to devote extraordinary amounts of time to this project.

Staff also devote a great deal of time and energy to the Public Health Improvement and Turning Point projects. Bureau staff continue to participate on the Public Health Training Institute committee which was the priority identified by Turning Point for 1999. Bureau staff also serve on the State Incentive Grant Advisory Council and on the management team for that \$3 million grant which provides funding to local communities to help them decrease substance abuse particularly in adolescents.

1999 saw the full implementation of the MCH Advisory Council with election of officers and generation of bylaws. The Advisory Committee was instrumental in the development of the Strategic Plan for the Family and Community Health Bureau.

The WIC section supports a local WIC directors group and also facilitates statewide exchange of information for nutritionists through their annual meetings.

The Women's Health section supports and staffs a Medical Advisory Committee. The family planning directors are a privately incorporated council who pay dues and maintain membership. These directors meet quarterly with Title X staff. This section

also supports a governor appointed Abstinence Advisory Council which was charged with monitoring and advising the Department on implementation of the Title V Abstinence Program Grant.

The Special Health Services section contracts with consultants both in and out of state and have been involved with an ad hoc committee to ensure universal hearing screening all newborns. SHS continues to contract for the Montana Medical Genetics Program activities. The section maintains a small Newborn Screening Task Force to assist them in review of state rules governing newborn screening. Collaboration with Medicaid and CHIP is ongoing.

The Child, Adolescent and Community Health Section maintains and coordinates the Fetal, Infant and Child Mortality Review Statewide Committee. This section traditionally coordinates the Spring Public Health Meeting. The section also monitors the Healthy Child Care CISS grant and works with the advisory council for that grant.

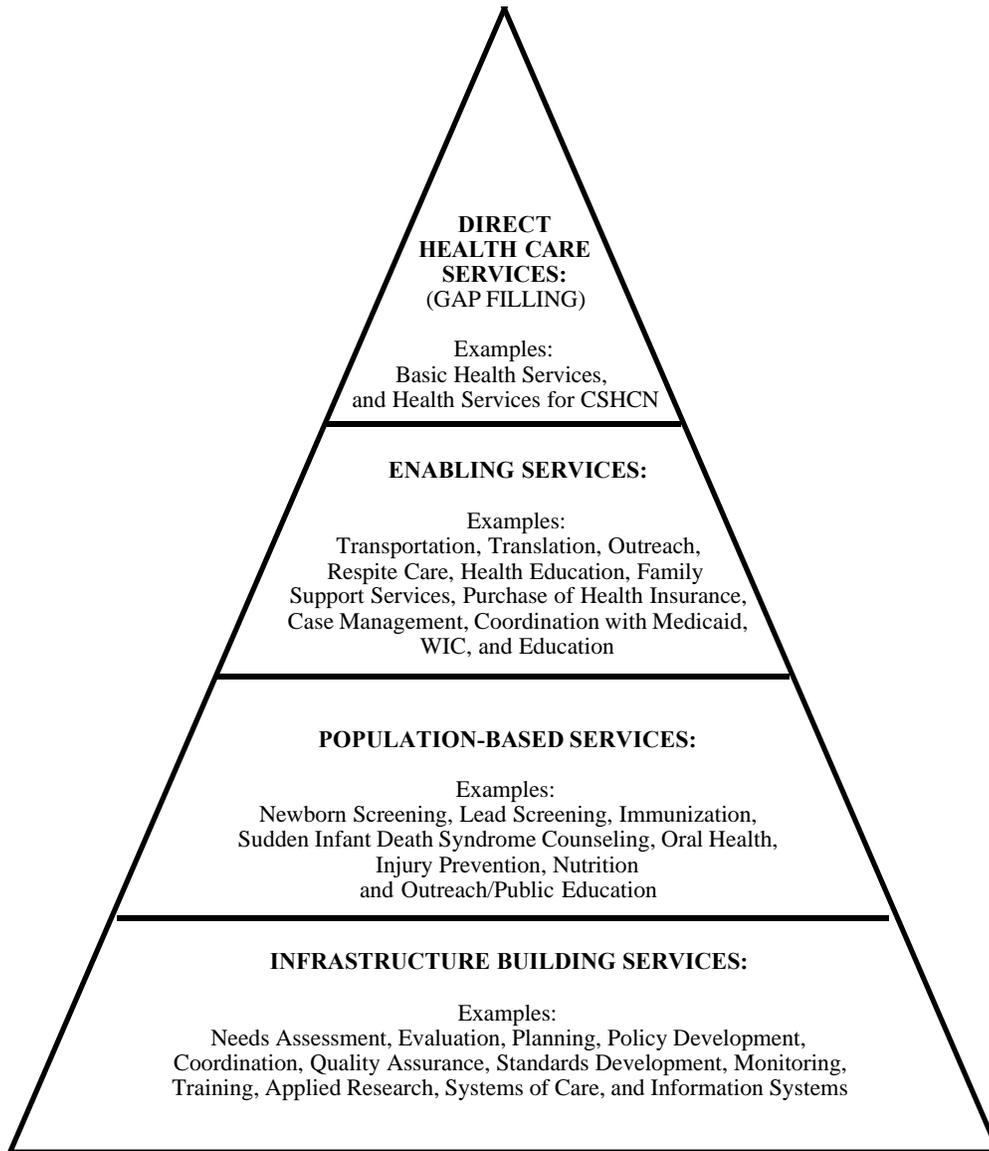
II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual expenditures

Annual expenditures are reported on ERP forms 3, 4, and 5. Progress was made during 1999 to help counties improve their fiscal tracking. New billing forms were created and implemented. Year end totals were tracked both by population category and pyramid level. Surprisingly, the two totals balanced for the most part for most counties. The staff of the administrative unit continues to work with county nurses and other county staff to answer questions and help resolve problems. This sort of technical assistance occurs daily. Meetings are held regularly to discuss ongoing issues and continue to resolve problems. During 1999, reporting was also much more timely and this will continue to be encouraged. During 1999, two small counties that had previously turned down MCH block grant funds due to the paper work involved were offered a simplified contracting process and they accepted. This effort will be continued and expanded to include the simplified process to counties that receive less than \$5000 in MCH block grant funds. This offer has been well received by the counties. During 2001, the billing process will be simplified.

Figure 2

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



2.2 Annual Number of Individuals Served

Annual numbers of individuals served are included in ERP forms 6, 7, 8 and 9. Form 7 summaries reporting from counties, with the exception of the CSHCN figure which includes numbers from the state program. The pregnant women count includes services provided by the University of Utah Pregnancy Riskline. The infant number represents the numbers of infants (newborns) screened for inborn errors of metabolism. Duplication continues to be an issue and until the Public Health Data System is operational, this will complicate our reporting. In 1999, the MCH Block Grant served 60,882 unduplicated clients. During that same time, 41,305 clients were served in situations where duplication occurred such as school screenings and other group encounters. The reporting form used in 1999 accommodated reporting of duplicated clients for the first time; in past years some of those duplicated numbers were probably incorporated into the unduplicated counts. The new reporting form was an effort to arrive at the most accurate unduplicated count as possible.

2.3 State Summary Profile

The state summary profile is included on ERP form 10. The statewide initiatives and partnerships addressing the core public health services delivered by MCH agencies are described in that document.

2.4 Progress on Annual Performance Measures

Each year it is easier to collect the necessary documentation to respond to the performance measures and the levels of the MCH pyramid of services. The MCH pyramid (included as Figure 2) has become a readily recognizable symbol of public health services across the state...it is used in presentations and distributed to locals as a means of describing how services are delivered and supported by MCH block grant funding. Programs providing MCH services are beginning to realize and appreciate the value of tracking performance over time. As a matter of fact, during regional meetings with local health departments in late 1999, counties were quite enthusiastic about the possibility of identifying one or two county specific performance measures or health status indicators to track for their own communities. Consideration is being given to including this effort as a requirement in county contracts for 2001.

Montana still struggles with some definitions and some of our targets indicators continue to seem too high or too low. We are considering eliminating at least two state performance measures (these will be identified when performance measures are discussed). Currently, an MPH graduate student from Emory University is working on MCH indicator trending and developing rolling averages for our performance and outcome measures which will assist in the reevaluation of our targets in the future. This effort is the result of a recommendation by Roger RoCHAT during an epidemiologic consultation visit in March 2000.

This narrative section is arranged first by pyramid level with population categories as a subsection with the performance measures applicable to that pyramid level included in

the discussion. This narrative section also includes “other” activities carried out during 1999 by the Family and Community Health Bureau.

DIRECT SERVICES

PREGNANT WOMEN

Local health departments no longer pay for direct services for pregnant women or deliveries. Initially local Montana Initiative for the Abatement of Mortality in infants (MIAMI) encouraged local health departments to use funding to pay for physician services to assure pregnant women early access to services but due to changes in Medicaid including presumptive and continuous eligibility, MCH funding for direct services is no longer necessary.

INFANTS

Some local health departments still provide limited well baby/child exams and an occasional individual immunization. During home visits, many “direct” service activities are performed during the course of the visit but are not tracked specifically nor are they reported as such to the state. Most home visit activities are reported under the enabling category.

CHILDREN

As noted above, limited numbers of local health departments continue to provide well child clinics for children. Well child clinics include services by pediatric or nurse practitioners which may serve as primary care services and in some areas a basic screening for health status. Especially in areas where there is limited access to primary care providers, these well child clinics continue to be an important part of assurance to adequate health care.

CSHCN (SPECIAL HEALTH SERVICES - SHS)

Direct services for children with special health care needs are considered to have been payment to providers for care. During 1999 SHS paid for/ or provided clinic services for 263 children with special needs. This year, with only 22 children eligible for CHIP from the SHS roster, SHS has continued to provide direct pay to those providers who have not become CHIP providers. In addition, SHS provides payment to public health nurses who are providing care coordination for these children. These activities continue during FY 2000. With continued savings for CSHCN who are CHIP eligible, expansion of care coordination through the local public health programs will take place. Payment of these services by the SHS program will expand. In addition, plans are being made to pursue diagnosis and treatment of Attention Deficit/Hyperactive Disorders using a standardized measure. Efforts may focus on payment of evaluation and pharmaceuticals.

WOMEN OF CHILD-BEARING AGE

In 1999, direct services were provided to 26,172 clients via contracts with 15 local family planning clinics and included physical exams, breast and cervical exams, STD exams, Pap smears, hypertension screenings, blood work including anemia screening, and other labs including urinalysis. During that year, the program detected:

- 683 abnormal Pap smears identified for referral
- 23 cases of anemia
- 81 abnormal urine chemistry results
- 646 cases of vaginal infections/STDs
- 471 cases of breast disease or other physical findings (heart, thyroid, etc)
- 249 cases of hypertension
- 485 cases of chlamydia

FEDERAL PERFORMANCE MEASURE 01

1999 TARGET 2% 1999 INDICATOR 3.2%

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

Note: In Montana, CSHCN services are called “Special Health Services” (SHS)

Accomplishments in 1999: There was continued contact with the SSI Bureau to refine the referral system between the two bureaus. The ability to interface data systems was discussed and found to be impossible due to the federal data system being a proprietary system. Currently we share hard copy data and input this into the SHS data system. Referrals are made to public health and SHS clinics for children no eligible for SSI.

Ongoing activities in 2000: One meeting is planned with the SSI bureau personnel to determine/refine this population. A meeting was held with SSI and arrangements made for additional documentation to accompany referrals that will document the medical providers for SSI referrals to SHS. There are plans to determine system of data input.

Plans for 2001: Further refine the definition of rehabilitative services and explore mechanism to link with SSI records and/or reduce the handling of paper required for management of SSI referrals.

FEDERAL PERFORMANCE MEASURE 02

1999 TARGET 6 1999 INDICATOR 6

The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

Accomplishments in 1999: There was negotiation with the CHIP program to determine if care coordination would be accessible for CSHCN. The number of children eligible for CHIP program who will no longer be receiving specialty care from SHS program was determined. Continued to contract care coordination services with a registered dietician for children with inborn errors of metabolism.

Ongoing activities in 2000: The program is refining the list of “covered” services including looking at the possibility of an ADD/ADHD pharmacy warehouse. The program is looking at the possibility of expanding coverage based on CHIP services.

Plans for 2001: The program plans to have a complete listing of covered services. The program plans to continue to provide and expand care coordination coverage based on the impact of and available funding related to CHIP/SHS coordination.

STATE PERFORMANCE MEASURE 1

1999 TARGET 66.8% 1999 INDICATOR 68.0%

Percent of unintended pregnancy

Accomplishments in 1999: A survey regarding intendedness of pregnancies was distributed to Title X Family Planning Clinics, Public Health Offices and private physicians in Montana. Patients who were determined to be pregnant were given the confidential survey to complete. The survey was completed in February, 2000 and results are being tabulated. Preliminary data suggest that 39% of the pregnancies were unintended. The most recent data available from the Alan Guttmacher Institute indicates that in the United States, 49% of pregnancies are unintended. Abortion numbers could be considered an additional indicator of unintendedness of pregnancy; there were 2,499 abortions reported in Montana in 1999 for a ratio of 232.5 per 1000 live births.

Ongoing activities in 2000: Unintended pregnancy is a priority issue in the Montana State Health Plan of 1998 and is a focus of the Women’s Health Section via contracts with local family planning providers.

A new effort to address unintended pregnancy was funded through a proposal for Title X Family Planning funds earmarked to eliminate racial and ethnic health disparities. These funds were awarded to DPHHS Women’s Health Section to develop and pilot a survey on the intendedness of pregnancy among Native American women residing on reservations and to assess the availability of family planning services. Native Americans are the largest minority group in Montana, making up about 6% of the state population according to the 1990 census. In 1995, Native Americans represented approximately 22% of total births. Among whites, 9 to 10 percent of births occur to women less than 20 years old. During the 1991 to 1995 time period, one out of five births to Montana teens was to a Native American.

There is a need to have reliable data on the Native American population in our state when it comes to reducing unintended pregnancy. We plan to work with Native

Americans to review and revise the unintended pregnancy survey which was conducted in 1999 to the general population. This survey will then be administered to the Native American population. We also plan to gather data and information from urban Indian centers on the availability and accessibility for family planning services and the number of users of family planning services. The Region VIII DHHS Office of Family Planning is also doing a region-wide needs assessment on family planning services among Native Americans. Our findings will complement the regional findings and give us both urban and reservation statistics to help us strategize and plan for reducing unintended pregnancy in Montana, especially at the county level.

Plans for 2001 Carry out the survey of reservation intendedness of pregnancy and develop culturally acceptable intervention activities

ENABLING SERVICES

PREGNANT WOMEN

Efforts to improve and simplify targeted case management processes began in 1999 with a rewrite of the TCM-Medicaid rules and an attempt to blend TCM for high risk pregnant women and TCM for high risk infants and children. It is hoped this effort will make it easier for counties to apply for a Medicaid number and to bill for TCM, adding funds to their strapped budgets. One new high risk pregnancy home visiting program was initiated on the Northern Cheyenne reservation and start up money for a high risk pregnancy home visiting program was set aside for the Rocky Boy reservation for capacity building. Thirty-two counties continue to provide home visiting and other enabling services to pregnant women on an ongoing basis. 1,630 pregnant women were followed by MIAMI programs in 1999. Planning is underway currently to utilize CASP funding for a four-state consortium for prevention of FAS/FAE. The Child, Adolescent and Community Health Section has developed goals, objectives and a work plan during FY 2000 and will hire a FAS/FAE coordinator to oversee implementation of Montana's planned activities.

WIC served 4,836 pregnant women during 1999.

INFANTS

A CJ Foundation grant received in 1998 was used to produce the SIDS intervention guide for public health nurses (Appendix D). Public Health Home Visiting which includes the MIAMI and Follow Me programs provides enabling services to infants and children up to the age of 5. These home visiting services include developmental assessment of children and environmental assessment, including family functioning. Funding for home visiting for children is available to 17 counties which served 3,640 infants and children in 1999.

WIC continues to focus efforts on referring WIC participants to CHIP and has been one of the most effective referring agencies for CHIP outreach. WIC served 4,799 infants during 1999.

CHILDREN

The Follow Me program provides enabling services to infants and children up to age 5. These services have been recognized by Montana's TANF program as a mechanism to assist local Families Achieving Independence in Montana (FAIM) coordinators to accurately assess families' abilities to comply with FAIM program requirements. A position paper outlining the role of public health in Montana's TANF program has been developed and is included as Appendix G.

The Caring Program for Kids, supported by charitable contributions matched by Blue Cross and Blue Shield, is considered a safety net for Montana children who are not eligible for Medicaid or CHIP. The program currently serves about 650 children. The provider network includes 1,721 participating providers. Due to recent changes instituted, in part, to the CHIP program, the Caring Program for Children has changed its eligibility to cover children up to 200% of poverty. The Caring Program shared its waiting list with the CHIP program and as of April of 2000, all children have either been enrolled in the CHIP program or the Caring Program.

WIC served 11,583 children during 1999.

CSHCN

The SHS outreach clinics provide referrals to additional services locally and statewide. The Newborn Screening Program personnel follow-up abnormal screens and make appropriate referral via local medical centers/offices. These are current and ongoing activities.

An agreement with the Montana State University nursing program was entered into with the SHS section to provide instruction in care coordination for children with special health care needs. Cascade County was the setting for this pilot project. Expansion to additional nursing students as well as an option for billing will be explored.

FEDERAL PERFORMANCE MEASURE 03

TARGET 60% 1999 INDICATOR 84%

The percent of Children with Special Health Care Needs (CSHCN) who have a medical/health home.

Accomplishments in 1999: The program continued data kept for SHS eligible children regarding medical home. There was discussion regarding definition of medical home.

Ongoing activities in 2000: The medical home concept was advocated and supported in the development of the CHIP program. "Medical home" was specifically identified as a required field during the development of the comprehensive data system (PHDS) and thus will need to be addressed by anyone entering data into the system on any child but specifically those with special health care needs. A meeting was held with SSI and arrangements made for additional documentation to accompany referrals that will document the medical providers for SSI referrals to CSHCN.

Plans for 2001: The program plans to monitor the medical home and plan for increased numbers in the CHIP and SSI populations. It also intends to advocate the primary care medical home as a standard of care. The national survey on CSHCN which will be initiated in 2000 will provide accurate data on numbers of CSHCN and the status of medical home in our state.

STATE PERFORMANCE MEASURE 4

1999 TARGET 38% 1999 INDICATOR 36%

Percent of infants who are breast fed at six months

Accomplishments in 1999: In 1999 WIC provided the following opportunities for training local staff:

- Building on the Basics of Breast-feeding (staff members)
- Lactation Counselor Certificate Training Workshop (2 staff members)
- Beyond the Basics of Breast-feeding (1 staff member)
- Establishing Breast-feeding Standards for Hospitals, Clinics and Communities (Funded by several sources including MCH) (1 staff member)
- WIC Breast-feeding Peer Counselor Training -Mountain Plains (1 staff member)
- Fundamentals of Lactation (1 staff member)
- Breast-feeding Supplies: Necessities or Gadgets (offered at MPHA conference)

In addition, WIC also purchased a number of nutrition and breast-feeding references to accompany the Competency Based Training Program modules and to update information. Discretionary money was received and distributed to local agencies to use to celebrate World Breast-feeding Week. Some of the items included water bottles to provide to women, fun walks, picnic gatherings, and breast-feeding pamphlets/brochures.

Ongoing activities in 2000: Continued support of breast-feeding is planned with specific training to be provided at a combined spring Public Health Conference. Additional funding is also planned to send one state and local representative to the National Breast-feeding conference. Montana is also implementing a regional dietitian pilot project to improve the quality and consistency of nutrition and breast-feeding education in the state. This project will allow WIC clinics greater access to higher quality consultation for high risk clients.

Plans for 2001: Montana plans to continue the above projects and implement the regional dietitian project statewide.

POPULATION BASED SERVICES

PREGNANT WOMEN

The Child, Adolescent and Community Health Section monitors on an ongoing basis the activity of Montana's direct entry midwives by means of a 72 hour mortality/morbidity report form. Of the 10,619 births in Montana during 1999, 160 were attended by direct entry midwives; 148 were in the home. Fifty two 72 Hour Mortality/Morbidity Reports were submitted (a three year summary is included as Appendix H). There are several quality issues which need to be addressed in the future. The 72 hour reports do not identify the midwife which makes it impossible to determine what percentage of each midwife's deliveries have associated mortality or morbidity. In addition, the report form stipulates that the direct entry midwife report within 72 hours any maternal, fetal or neonatal mortality or morbidity. Assurance that this requirement is carried out is not possible. There is no mechanism to track outcomes other than birth certificates (no way to tell if fetal death certificates or birth certificates are filed for all DME deliveries) and the "voluntary" submission of the 72 Hour Report. Recommendations for improving reporting and tracking outcomes of DEM activity are being prepared.

Mandated Hepatitis B screening for pregnant women has been identified as legislative proposal for the upcoming legislative session in January 2001.

There were 879 calls from Montanans to the pregnancy risk line in Utah.

INFANTS

SHS contracts with Shodair Childrens Hospital Medical Genetics Program for statewide genetics screening. Individuals receiving these services are charged based on ability to pay. Fees collected by Shodair are used as part of their match. In 1999, 5,425 clients were served by this program.

Over the Spring and Summer of 1999 CACH Section developed and published a SIDS follow up home visiting manual which was completed, printed and distributed in October 1999. It is included as Appendix D. A small grant from the CJ Foundation was received in the early Spring of 2000 and will be used for the development of a SIDS peer support network and SIDS risk reduction educational materials for day care providers, to be completed by June 2001.

The Newborn screening program will have a site visit and program review performed by a "SWAT" team in July of 2000. Several areas of concern have been identified for review. Plans for the site visit and the list of concerns is included as Appendix I.

A summary of Montana's Child statewide public education campaign accomplishments in 1999 are included in Appendix J. The Montana's Child Information phone line received 792 calls during the year.

In January 2000 the public health laboratory began a hemoglobinopathy pilot study, a newborn screen not currently done in Montana (Montana's Black population is 1%). The study is being conducted to help with the decision of whether or not to add hemoglobinopathy screening to the battery of screening tests provided for newborns in the state. As of early April 2000, 2,889 infants had been screened with seven abnormal results. Five of the seven abnormalities were determined to be insignificant. The pilot will continue to the end of the year and a decision made at that time regarding continuation of hemoglobinopathy screening.

CHILDREN

Beginning in 1999 with the hiring of a new dental health director, there has been a ground swell of activity around dental health and dental care in Montana. Dr. Jim Southerland, HRSA Regional Dental Consultant, made a site visit to Montana in the Spring of 1999 to meet with the new director and make recommendations for a plan of action. Activity around these issues culminated in a statewide Dental Summit in November 1999 which brought together a number of associations and diverse factions. The organization of the Montana Dental Access Coalition was the direct result of the summit. In May of 2000, an on-site review of Montana's DPHHS oral health program was conducted in Montana. It included three days of interviews with dental and health providers, dental and health associations and advocates from all over Montana. The final report is pending at the time of this report but the exit interview summarized recommendations and provided suggestions including increased data collection and surveillance capacity, increased access to dental care through the Montana Dental Access Coalition, increase community water fluoridation, increase the application of sealants and, finally, to continue to build the dental community in Montana.

The fluoride mouth rinse program carried out in schools across the state served 51,576 students during 1999.

The Healthy Child Care Montana grant activities continued during 1999 with the coordinator traveling across Montana to provide training to public health nurses and the day care referral agencies. In the Spring of 2000, the Child, Adolescent and Community Health Section developed a memorandum of understanding for this project which provided that 14 local health departments deliver public health nursing services to the child care providers in their regions through collaboration with the local child care referral agencies.

During 1999, seven new local fetal, infant and child mortality review teams were organized and trained and data collection started. In January 2000, the State Fetal, Infant and Child Mortality team began a preliminary analysis of data and found a variety of problems with the data collection system. A new system was designed and implemented with the initial data input scheduled for the end of June 2000. The priority activity for 2001 is to have expanded local mortality teams to all unserved

counties, allowing review of 100% of fetal, infant and child deaths in Montana. From this review, recommendations for preventive activities will be developed.

An asthma survey was developed by the CACH section during late 1999 and mailed to school nurses, primary care providers and day care providers in January 2000. Preliminary results are being analyzed at present. The CACH section currently is working with the Montana Hospital Association to obtain aggregate asthma hospital discharge data for ongoing surveillance. Educational interventions are planned for school nurses, day care providers and the medical community.

During 1999, the public health laboratory reported that 2,583 blood lead specimens were received with 203 specimens rejected. Of 2,380 specimens, 182 had results between 6 - 9 ug/dl and 57 had results 10 ug/dl or greater. The positive screens represented 49 patients. Geographically, the positive screens were scattered throughout Montana in Billings, Box Elder, Butte, Columbus, East Helena, Glendive, Great Falls, Hamilton, Helena, Kalispell, and Terry.

ADOLESCENTS

The development of a state suicide prevention steering committee began in April 1999 with the initial organizational meeting held in Bozeman with 18 key stakeholders attending. The committee is directing the creation of a Montana State Suicide Prevention Plan. The development of the plan is a joint effort of the CACH section, and the Emergency Medical Services and Injury Prevention Section. The draft of the plan is scheduled to be completed by September 2000. The draft will be presented for public comment and the final plan is expected by the end of the year.

A small survey was conducted by a graduate student intern in the Family and Community Health Bureau in the summer of 1999. The survey focused on the availability of community resources available for prevention, intervention and "postvention" of suicide. The study found that many of the smaller Montana counties have comparatively large suicide rates based on their population and, as expected, the smaller counties have the fewer prevention - intervention resources available. Even in counties with some available resources, many respondents did not know they existed or how to access them.

A review of the youth intentional injury/suicide rates and methods, covering deaths which occurred from December 1998 through December 1999 showed that 12 of the 13 deaths were male and 11 were by gunshot to the head, two were by hanging. The average age was 13 years.

In 1999, a Risk and Protective Factor Survey was conducted by the Addictive and Mental Disorders Division which surveyed 15,357 8th, 10th and 12th graders. Included in that survey, the analysis of which is still pending, were questions posed by the MCH adolescent coordinator regarding access to primary health care. Preliminary analysis of those questions indicate 31.6% of the students did not receive regular health care examinations. Ten percent of those that did not receive regular care indicated

the reason was that care cost too much, 4.1% had no insurance, 6.2% had no transportation to get care; 21.9 % indicated “other reasons”. Of those who indicated they got regular health care examinations, 50.3% got that care from a doctor and 17.7% from a community health care clinic, followed by family planning clinic at 6.5% and a nurse at 2.4%.

An analysis of adolescent risk behavior compares YRBS responses from alternative schools, reservation schools and public schools in 1997 and indicates the following behaviors:

	Alternative	Reservation	Public
Rarely or never use seat belts	55%	47%	22%
Rode with drinking driver	61%	57%	39%
Drove while drinking	37%	32%	15%
Seriously considered suicide	33%	18%	24%
Attempted suicide	18%	11%	9%
Smokes regularly	79%	40%	25%
Uses chewing tobacco	23%	30%	23%
Had at least one drink in lifetime	94%	81%	84%
Had a drink in last 30 days	67%	48%	59%
Used marijuana in lifetime	87%	75%	45%
Ever had sexual intercourse	88%	63%	46%
Condom use	40%	51%	55%

After an unsettled beginning, the Abstinence program stabilized during 1999. A social marketing scheme designed to give youth the skills to postpone sexual activity and to help parents communicate with and teach their children about abstaining from high risk behavior was the framework for the media campaign which was created and implemented in October. A statewide RFP was issued for community based abstinence programs and five were selected. Appendix K provides a summary of the Media Campaign Survey Results for 1999.

CSHCN

1999 saw the development of the regional concept for specialty clinics for CSHCN. Multi-disciplinary teams are available for diagnosis and ongoing follow up and recommendations for children with special health care needs in several locations around Montana. A full time nurse coordinator manages the logistics and administrative duties of each site. A physician is the medical director at each site. Staffing of clinics varies with the type of clinic and community resources available. The same model is operating at two Indian reservation sites. Currently there are two sites fully operational, Billings and Missoula. Clinics offered by Missoula include cleft lip and palate, metabolic, respiratory, Down syndrome, endocrine and neural tube defects. Feeding assessment, cerebral palsy and renal clinics are being developed. Billings offers cleft lip and palate, metabolic, respiratory and has the only certified cystic fibrosis clinic in the state. Great Falls is anticipating having a fully developed regional clinic system in the near future. Training for clinic coordinators will occur in the summer of 2000

with standardization of data collection processes and customer satisfaction surveys. In 2000, the SHS section had developed contracts with two sites and had hired coordinators and begun to hold specialty clinics. Clinic coordinator training is scheduled for summer of 2000.

There has been increased interest and investigation of birth defects in Montana over the last year. Mike Spence, the Medical Officer for the State, has investigated birth defects in two parts of northwestern Montana and after a review that included interviews with the families of children with defects in the area, found there was no conclusive evidence indicating a cluster event. Montana's small numbers continue to require careful analysis of reported events. Dr. Spence will be investigating a report of large numbers of birth defects over the last five years in the southeast part of the state in the summer of 2000. Initial discussions with MCH staff and the staff of Vital Records have revealed that the numbers are again very small and vital record reporting has included birth complications (such as respiratory distress) with actual congenital anomalies in reporting. Recommendations will include changing the reporting requirements of "birth defects" in the vital statistics reported by Vital Records.

In 1999 the SHS section wrote a HRSA grant to provide equipment and coordinator for a state wide newborn hearing screening program. There has been an existing statewide task force which had provided guidance to state personnel. Unfortunately, even though the program wrote an acceptable proposal, funding was unavailable. The grassroots efforts at screening continues, although the purchase of screening equipment continues to be a problem in the less populated regions of the state. A new CDC grant for newborn hearing screening is being written by the SHS section staff. If funded, this grant will provide much needed coordination for the local hospital based programs. Newborn screening will be included on the revised birth certificate, making tracking of this data easier.

WOMEN OF CHILD-BEARRING AGE

During 1999 an unintended pregnancy survey was conducted across Montana in private physician offices and family planning clinics; 587 responses were received and tallied. Preliminary results indicate approximately 40% of pregnancies were planned, 40% were not planned, not wanted now or ever and 20% of the respondents were uncertain about their response to a pregnancy. More analysis of the results will take place in 2000 and recommendations prepared.

During this last year, 436 educational sessions were held by local family planning programs with 15,143 persons attending. The Women's Health Section together with the Medicaid Bureau began work on a plan of action for requesting a Section 1115 waiver from the Health Care Financing Administration to expand Medicaid eligibility for family planning services. The WHS has contracted with a local consultant to gather information from other states, including approved applications and sample outreach materials. This contractor will also develop an assessment on budget neutrality in relation to the Section 1115 waiver, create a concept paper to submit to HCFA and assist in the procurement of a contractor to develop the waiver application.

FEDERAL PERFORMANCE MEASURE 4

1999 TARGET 99.9% 1999 INDICATOR 98.9%

Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies [(e.g. the sickle cell disease)(combined)]

Accomplishments in 1999: Approximately 97% of newborns have been screened for PKU, hypothyroidism and galactosemia.

Ongoing activities in 2000: The lab data system continues to be problematic in its ability to transfer data regarding newborn screening. Much of the data collection accomplished in 2000 was done by hand. Beginning in January 2000, a pilot project for hemoglobinopathies began at the urging of the state public health laboratory. No data is available. A recommendation to conduct a review of the newborn screening program and activities will be done by a federal SWAT team in July 2000.

Plans for 2001: The program plans to continue to work towards improved electronic linkages to the lab database. The program plans to continue the hemoglobinopathy screening as a baseline for further decision making. The program will implement recommendations made by the SWAT team.

FEDERAL PERFORMANCE MEASURE 05

1999 TARGET 90% 1999 INDICATOR 90.4%

Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Hemophilus Influenza, Hepatitis B

Accomplishments in 1999: A major milestone was achieved in 1999. Statewide immunization rates for children aged 24 - 35 months has exceeded the year 2000 goal of 90% coverage for the serial combination of 4 DTP:3 Polio; 3 Hib; 1 MMR. A collation of relevant data from all 187 provider sites throughout 54 counties representing 2,560 children (23% of the birth cohort) provides an estimated 90.4% coverage for our clinic based population. This is the highest level ever recorded and is an increase of 2% over 1998.

In January 1995, Montana implemented a “catch up program” for Hepatitis B vaccination. Statewide coverage for 2 year olds was assessed in 1996 at 67.3%. By the close of 1997, that figure had made an amazing jump to ~88% and in 1998 the goal of $\geq 90\%$ coverage for 3 doses was realized. Montana enters the new millennium with 94% of the clinic based population vaccinated against Hepatitis B.

The Montana Perinatal Hepatitis B Program has been following 26 pregnant women and newborns in 1999. Three of these cases were not identified prior to delivery. These infants are being followed very closely.

Ongoing activities in 2000: Efforts continue to implement universal prenatal serologic for Hepatitis B testing of all pregnant women during each pregnancy and routine universal vaccination of all newborns for Hepatitis B. Work on educational programs for parents continues.

Plans for 2001: Participate in legislative efforts to implement universal Hepatitis B testing of all pregnant women and routine universal vaccination of all newborns for Hepatitis B.

FEDERAL PERFORMANCE MEASURE 06

1999 TARGET 24 1999 INDICATOR 18.2

The rate of births (per 1,000) for teenagers aged 15 through 17 years

Accomplishments in 1999: The Trends in Montana Teen Pregnancies and Their Outcomes was updated and revised to include state and county data through 1997. This updated report will be distributed to county health department personnel, family planning clinics, media contacts and public policy makers. Analysis of the teen birth rate over time shows a 17.83% decrease in the rate of births among 15 to 17 year olds during the 1990-1998 time period. The birth rate for 15 to 17 year olds was 19.75 per 1000 live births in 1998 compared to 24.04/1000 in 1990.

In support of the Montana plan to reduce teen pregnancy and the rate of teen births, the Women's Health Section (WHS) developed a benchmark for Montana teen pregnancy, which is: "By the year 2005, reduce the pregnancy rate for 15-17 year old Montana females from 30 to 27 per 1,000." This was adopted by the State as one of the five key benchmarks by the Governor's Inter-agency Coordinating Council (ICC) on Prevention.

In addition, the Region XIII Office of Family Planning, DHHS and the Montana WHS sponsored a conference entitled, "Unintended Teen Pregnancy: Exploring Culture, Sharing Information, Discovering Solutions" in June 1999. The conference focused on the consequences of teen pregnancies, how communities are successfully addressing the issue and what impact culture has on the incidence of unintended pregnancy.

Ongoing activities in 2000: The Department and WHS continues to monitor and analyze trends in teen pregnancy and birth rates by updating the Trends in Montana Teen Pregnancies and Their Outcomes report. The WHS Teen Pregnancy Coordinator will continue to respond to requests for information, resources and library materials on teen pregnancy and teen births.

Also, during 2000 the WHS section developed educational packets to distribute to local Offices of Public Assistance. These packets, developed in conjunction with the

FAIM (Montana TANF) Partnership Project, contain information on family planning services, preconception counseling/information, contraception for males and females and abstinence. The effectiveness and impact of these educational materials on FAIM participants is currently being evaluated through surveys and focus groups by the family planning staff, Office of Public Assistance staff and the FAIM participants.

Plans for 2001: Because of the limited information is available regarding the intendedness of pregnancy, including teen pregnancy among Montana's Native American population, the survey on unintended pregnancy conducted by the Department will be expanded to target Native American women living on reservations.

FEDERAL PERFORMANCE MEASURE 07

1999 TARGET 15% 1999 INDICATOR 39.6%

Percent of third grade children who have received protective sealants on at least one permanent molar tooth

Accomplishments in 1999: The Montana Board of Dentistry formally agreed during their July 1999 meeting that dental screenings were a non-licensed function which in effect allows dental screenings to be completed by non-dentists (including school nurses and public health nurses who have been trained to do screenings).

A meeting was held in late summer with the Billings component of the Montana Dental Hygienists Association to discuss the dental screening program in Billings schools and invite participation in utilizing and developing a DPHHS supplied screening form. The Billings community provides a good model to consider for follow up coordination. It was agreed to consider utilizing a new form to help DPHHS in data collection and public education efforts.

Ongoing activities in 2000: Approximately 18,000 dental health screening forms were mailed to Montana schools for the 1999-2000 school year; over 10,000 screening forms have been returned and data is being compiled.. 135 flyers were sent on February 4, 2000 to school nurses, county public health nurses, dentists, dental hygienists, dental assistants, fluoride mouth rinse coordinators, volunteers and school staff who participate and/or coordinate school dental screenings. We requested that third graders be screened for dental sealant application on permanent molars and be documented on the comment portion of the current screening form.

Basic Screening Survey materials developed by the Association of State and Territorial Dental Directors will be utilized in developing a new oral health screening form. Four sets of the materials have been sent to public health department personnel and school nurses for review and input. There are ongoing efforts to collaborate with the Montana Dental Association, Montana Dental Hygienists Association, the Montana Dental Assistants Association, the Montana School Nurses Association, County Public Health Nurses and school administrators to develop a form that will provide the needed data and provide education and streamline follow up activities.

Medicaid data will also be utilized for a portion of the data collection.

Plans for 2001: The new screening forms will be sent in August 2000 to all participating schools along with the fluoride mouth rinse supplies for the 2000-2001 school year. A reminder notice will be sent in January 2001 to complete the forms and return to DPHHS for data collection.

Data collected will be utilized in needs assessments and shared with the Montana Dental Access Coalition to report findings to the Legislative Interim Committee on Children, Families, Health and Human Services.

Basic Screening Survey materials developed by the Association of State and Territorial Dental Directors will be utilized in developing a new oral health screening form. Four sets of the materials have been sent to public health department personnel and school nurses for review and input. There are ongoing efforts to collaborate with the Montana Dental Association, Montana Dental Hygienists Association, the Montana Dental Assistants Association, the Montana School Nurses Association, County Public Health Nurses and school administrators to develop a form that will provide the needed data and provide education and streamline follow up activities.

Medicaid data will also be utilized for a portion of the data collection.

FEDERAL PERFORMANCE MEASURE 08

1999 TARGET 7 1999 INDICATOR 4.1

The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

Accomplishments in 1999: There was an effort to introduce graduated driver licenses in 1999 Legislature which was not successful this time. Sixteen local Fetal, Infant, Child Mortality Review (FICMR) Teams reviewed infant and child death data from their communities. This information is being entered into a data base.

Ongoing activities in 2000; The Child, Adolescent and Community Health section (CACH) works closely with the EMS-C injury prevention coordinator and coordinates with the Department of Transportation programs directed at reducing the problem of deaths of children 1-14 in motor vehicle crashes. The Emergency Medical Services and Injury Prevention Program in conjunction with the Montana Adolescent program was awarded a grant in 2000 from the Montana Public Health Association to be used to purchase an information display set and to develop a brochure regarding traffic crash-related mortality and morbidity in Montana. The target audiences will be public and private providers as well as the public.

Plans for 2001: The primary seat belt law introduced to the 1999 legislature will be reintroduced in the new session with the expectation of passage at that time. Two

years of FICMR data will be reviewed and deaths specific to MVAs will be analyzed and geographic areas with high numbers will be targeted for prevention efforts.

FEDERAL PERFORMANCE MEASURE 09

1999 TARGET 71% 1999 INDICATOR 73%

Percentage of mothers who breast-feed their infants at hospital discharge.

Accomplishments in 1999: In 1999 WIC provided the following opportunities for training local staff:

- Building on the Basics of Breast-feeding (11 staff members)
- Lactation Counselor Certificate Training Workshop (2 staff members)
- Beyond the Basics of Breast-feeding (1 staff member)
- Establishing Breast-feeding Standards for Hospitals, Clinics and Communities (Funded by several sources including MCH) (1 staff member)
- WIC Breast-feeding Peer Counselor Training -Mountain Plains (1 staff member)
- Fundamentals of Lactation (1 staff member)
- Breast-feeding Supplies: Necessities or Gadgets (offered at MPHA conference)
- Breast-feeding Issues: Correct Latch and Frequency of Early Feeding (offered at the annual WIC meeting)

In addition, WIC also purchased a number of nutrition and breast-feeding references to accompany the Competency Based Training Program modules and to update information. Discretionary money was received and distributed to local agencies to use to celebrate World Breast-feeding Week. Some of the items included water bottles to provide to women, fun walks, picnic gatherings, and breast-feeding pamphlets/brochures.

Ongoing activities in 2000: Continued support of breast-feeding is planned with specific training to be provided at a combined spring Public Health Conference. Additional funding is also planned to send one state and local representative to the National Breast-feeding conference. Montana is also implementing a regional dietitian pilot project or improve the quality and consistency of nutrition and breast-feeding education in the state. This project will allow WIC clinics greater access to higher quality consultation for high risk clients.

Plans for 2001: Montana plans to continue the above projects and implement the regional dietitian project statewide.

FEDERAL PERFORMANCE MEASURE 10

1999 TARGET 32% 1999 INDICATOR 57.4%

Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Accomplishment in 1999: Several additional hospitals purchased screening equipment. Fifteen of the 44 birthing hospitals were screening in 1999. An algorithm was completed with input from the UNHS Task Force, a coalition of physicians, teachers, public health providers, parents and others interested in the issue.

Ongoing activities in 2000. Hearing screening question is to be included on birth certificates. A grant was written to support the hearing screening program; the request in year one is to increase to 32 the number of hospitals screening newborns..

Plans for 2001: Plan to increase to 70% the number of newborns screened. In addition, to increase to 44 the number of hospitals screening for newborn hearing. Authority for federal funds and state general funds will be requested to continue this work.

STATE PERFORMANCE MEASURE 7

1999 TARGET 5% 1999 INDICATOR 2.1 %

Percent of two year old children screened for lead.

Accomplishments in 1999: The percentage of low income Montanans who are screened for lead continues to grow as more WIC locations and public health departments expend their efforts to screen high risk populations. Some sites have established screens on the base children and are seeing a reduction in screens as the number of children who have not been screened drops. Regional coordinators have been established in all but one area in north central Montana and training of local WIC and public health staff was accomplished.

Ongoing activities in 2000: Plans are in place to evaluate the screening guidelines for identification of high risk children and to establish regional coordinator position in the remaining area in the state currently without coverage. Guidelines for screening children in other programs such as CHIP are planned.

Plans for 2001: Funding must be renewed to continue work in childhood lead prevention. In addition, refinement and evaluation of screening guidelines needs to be accomplished. Consider carrying out the recommendations of the MCH Epidemiology consultant to do a descriptive epidemiology study of positive lead tests in Montana.

INFRASTRUCTURE

During 1999 and continuing into 2000, Montana state government agencies have experienced a series of systems conversions and upgrades. The repercussions continue. Data linkages have not worked, the entire new fiscal management system failed in the first week of implementation and continues to experience problems with staggering cost overrides and the inability to produce accurate and timely data. The impact of these difficulties creates problem with grant reporting requirements. A similar predicament occurred with the company contracted to develop the public health data system with the ultimate dissolution of the contract for failure to meet requirements. This set the project back by at least a year.

The early months of 1999 were consumed with legislative activity. Actions taken by the Montana legislature continue to impact the MCH target populations. DPHHS continues to address the challenges of very limited general support of public health activities in the state. Montana continues to rely heavily, and in many cases, exclusively, on federal funds to support public health programs, including, but not limited to programs impacting the MCH target populations. Governmental agencies in Montana also continue to face the challenge to privatize services, resulting in very limited availability of new FTEs to implement new programs.

The following is a partial list of bills (and outcomes) introduced during the 1999 Montana Legislative Session which impact the Family and Community Health Bureau target populations.

- HB 2 **Approved.** All requests were approved, including the base budget and increases and including the Abstinence Education Grant (included a modified FTE), continuation of authority for funding the women's Health educator, authority for the Fetal, Infant and Child Mortality Review grant, primary and preventive health services for children (Caring Program) and increased funding for the WIC program.
- HB 4 **Approved.** Included authority for the Montana Birth Outcome Monitoring System, which will improve the ability of the department to identify and serve clients with birth defects and their families.
- HB 111 **Approved.** Prevents insurance companies from discriminating against individuals based on genetics testing.
- HB 266 **Approved.** Revised coverage and treatment coverage to require insurance companies to cover medicinal foods and services necessary to cover inborn errors of metabolism, including but not limited to phenylketonuria.
- HB 400 **Died.** Would have assured access to contraceptive drugs and devices, as part of the services covered by insurance companies.
- HB 497 **Died.** Would have eliminated the prohibition on discrimination in insurance based on sex or marital status.
- HB 530 **Approved.** Altered the 1997 law regarding partial birth abortions.
- SB 81 **Approved.** Passage of the CHIP bill, championed by the Division and the Department , will allow the department to contract for health insurance coverage for 10,000 children, aged 18 and under. Children's family income may not exceed 150% of poverty and may not qualify for Medicaid.

SB 108 **Approved.** Revised licensure laws, enabling CHCs and other facilities to employ dentists, thereby improving access, especially for the uninsured and under-insured.

SB 398 **Approved.** Protects the rights of nursing mothers.

Initial planning for the 2001 legislative session began in fall 1999 with a number of proposed activities which would impact the target populations. The list of proposals to date includes but is not limited to continuation of the FICMR and MBOMBS grant activities, additional funds to support family planning services, especially to the Native American population, funds to implement the developing Suicide Prevention Plan and the Montana Dental Access Coalition activities, authorization to implement the FAS Prevention plan, and a proposal to add a Minority Health Coordinator position to the DPHHS staff. The list developed by the Department is presently under consideration by the Governor's office.

The FCHB contracted for the development of a Public Health Nurse Orientation Manual, which was completed in September 1999 and distributed to all counties in the state. A new public health nurse orientation session was held in October 1999 during which the new orientation manual was used. Thirty-two new nurses attended the meeting; evaluations were unanimously positive. Follow up phone calls revealed the nurses felt the orientation was extremely helpful.

Five regional meetings were conducted in the summer of 1999 as well as a statewide MetNet in the spring prior to county budgeting deadlines. The MetNet in the spring allows county health department staff to hear about budgeting and reporting issues and to ask questions prior to presenting individual county MCH budget plans to their commissioners. The regional meetings are always a popular activity during which MCH data is shared, issues discussed and new information given to small groups of public health staff members, usually 20 to 30 participants. This allows for an informal sharing opportunity which is always viewed as beneficial. A public forum is scheduled during these regional meetings to allow an opportunity for local input. The public forum has not been well attended in the past. Efforts during the regional meetings in 2000 will schedule the public forum during the lunch hour to see if more people will attend rather than late in the afternoon which was when they were scheduled in the past. The spring MetNet and regional meetings are conducted every year.

Through a three year CDC grant. Special Health Services began the development of the Montana Birth Outcomes Monitoring system (MBOMS) in 1999. Data system specifications were written to interface with the newly implemented SHS data system. A statewide taskforce was formed that includes doctors, public health nurses, hospital association volunteers along with state department staff. A link with the Vital Statistics Bureau was established and finalized. In 2000, a statewide MBOMS coordinator was hired who will be based at the Montana Medical Genetics Program at Cheater Hospital in Helena. The CDC grant has funded a media campaign for the prevention of birth defects, particularly neural tube defects, which will take place during Birth Defects Prevention Month, January 2001. By the end of year three, the first data report regarding birth defects in Montana should be published.

In late September 1999 a formal, facilitated state and local health department working session was held in Butte to discuss and address issues having to do with communication and collaboration. Approximately 100 public health professionals attended the meeting. The results of the meeting were positive and less formal, monthly meetings with state and local staff continue. A summary of the meeting is included as Appendix L.

The Family and Community Health Bureau Advisory Council, initiated in April 1999, became a reality later in that year with appointment of 17 representatives of a variety of MCH related organizations and interests. The Advisory Council, appointed by the bureau chief participated with FCHB staff in a series of strategic planning meetings in late 1999, which culminated in the FCHB strategic plan which is included as Appendix M. The strategic plan for 2000-2--1 addressed the performance measures for the Title V MCH block Grant and Abstinence Programs, the WIC program and the Title X Family Planning Program. Goals and performance measures for other programs including Fetal, Infant Mortality Review, Healthy Child Care Montana (CISS), Integrated Data for Evaluation and Assessment (SSDI) and others are included to varying degrees and the plan will continue to be expanded to incorporate other programs. The chairperson of the Advisory Committee is Dan Dennehy, the local health officer of Butte/Silver Bow Health Department and the vice-chair is Yvonne Bradford, the director of community health services at Missoula City-County Health Department. Family and Community Health Bureau newsletter was initiated with one issue produced in the fall of 1999 and the second just completed. It is mailed to a wide audience and has been well received. The first two issues are included in Appendix M.

The University of Washington School of Public Health, on contract to the state, prepared a plan for a Montana public health training institute. The final report is included as Appendix N.

Approximately 120 public health providers attended a three day Spring Public Health Meeting in May 1999 on the Carroll College Campus in Helena. The meeting focused on adolescent issues and featured Michael Gurian from Spokane as the keynote speaker on the issues involved in raising healthy boys. The Spring Public Health Meeting in May 2000 was a combined effort between MCH and WIC and attracted a much wider audience; 208 public health workers from across the state attended the three day session in Billings and featured childhood obesity and home visiting as the primary topics. Deanna Gomby from the Packard Foundation was the keynote speaker on home visiting models and evaluation techniques.

WIC conducted their annual retailer survey in the spring of 1999; 310 retailers were surveyed with 75 (24%) responding to the mailed questionnaire. The survey collected information on training of store staff and cashiers as well as gathering information on issues for WIC participants. A great deal of Program information was collected with responses back to the retailers from WIC staff.

WIC provides ongoing local staff training and included eight different sessions related to breast-feeding in 1999. A number of nutrition and breast-feeding references were purchased for local clinic sites and funding was distributed to local sites to celebrate World Breast-feeding Week.

SHS began the development of the Montana Birth Outcomes Monitoring System in 1999.

Work on the Public Health Data System continued during 1999. The first two phases, the development of a comprehensive, robust public health data system (PHDS) and the sharing of public health information (SOPHI), were delayed by a contractor default and continue to be designed and are expected to be completed in late summer 2000. Those components will be jointly pilot tested in October 2000 and rolled out together in January 2001. A detailed description of the project and its current status is included as Appendix F.

FEDERAL PERFORMANCE MEASURE 11

1999 TARGET 80% 1999 INDICATOR 90%

Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

Accomplishments in 1999: Data system upgrade includes this information for children eligible for SHS services. This also included children attending specialty outreach clinics sponsored by SHS. Accuracy rate is very high.

Ongoing activities in 2000: Data system revision has been partially operationalized and will provide continued accuracy of program statistics. Program reporting statistics to include CSHCN receiving CHIP services.

Plans for 2001: Discuss data link with CHIP system to better report CSHCN with insurance.

FEDERAL PERFORMANCE MEASURE 12

1999 TARGET 9% 1999 INDICATOR 18%

Percent of children without health insurance

Accomplishments in 1999: The pilot phase of the Montana CHIP program was begun and served approximately 900 children. A Robert Wood Johnson Covering Kids grant was obtained by the Montana Healthy Mothers/Healthy Babies Coalition to address and assist with outreach and education.

Ongoing activities in 2000: The CHIP program was fully implemented in Montana beginning in October 1999 with enrollment as of June 2000 approximately 6000. In addition, the Caring for Children program coordinated enrollment with CHIP resulting

in all children on the Caring program waiting list being enrolled in either Medicaid, CHIP or Caring. The eligibility for Caring for Children has been raised to 200% of poverty and dental coverage in CHIP increased from \$200 to \$350 per year per child and the CHIP enrollment fee waived.

Plans for 2001: The state will continue enrollment efforts for CHIP and Caring for Children with program projections being to fill all available CHIP program openings by the end of calendar year 2000.

FEDERAL PERFORMANCE MEASURE 13

1999 TARGET 90% 1999 INDICATOR 90%

Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program

Accomplishments in 1999 The Bureau, particularly through the sections dealing directly with potentially eligible clients, continues to stress the need for and facilitate referral to Medicaid. Bureau staff worked to streamline targeted case management procedures to help counties become Medicaid case management providers. The programs and bureaus worked to make billing and review of denied bills easier and quicker.

Ongoing activities in 2000

Plans for 2001

FEDERAL PERFORMANCE MEASURE 14

1999 TARGET 8 1999 INDICATOR 9

The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

Accomplishments in 1999: The Advisory Council for SHS was formed and two meetings held. Two parents are on the Advisory Council. Technical assistance provided by Susan Burke from Arizona included suggestions for ways to include parents in program aspects.

Ongoing activities in 2000: Additional Advisory council meeting will be held. A parent participated in the Institute for Child Health Policy meeting in Phoenix. This parent was appointed the Family Voices representative for Montana (first time). A parent will attend the AMCHP meeting 2000 for the first time. A parent was involved in the development of family notebooks for metabolic clinic participants.

Plans for 2001: Parent contracts to be implemented in FT 2001. Parents will be recruited for contracts in the areas of: foundation development, Family Voices, family

support group development and parents of cleft children handbook. There will be continued representation on the Advisory Council.

FEDERAL PERFORMANCE MEASURE 15

1999 TARGET 1% 1999 INDICATOR 1.1

Percent of very low birth weight live births

Accomplishments in 1999: Montana's low birth weight prevention program, Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) began in 1986. In 1999 this program continued to strive to improve pregnancy outcomes and prevent infant mortality through provision of comprehensive health services, client and professional education, case management and infant mortality review.

Ongoing activities in 2000: MIAMI services with home visiting, targeted case management and educational outreach will continue in Montana. MIAMI services will be expanded to include at least one more Indian Reservation in 2000, bringing to six of the seven reservations participating in the MIAMI program.

Plans for 2001: An evaluation of the MIAMI data tool with changes as appropriate to support collection of complete and compressive data is planned. This would allow improved capability for data evaluation and recommendations for educational outreach.

FEDERAL PERFORMANCE MEASURE 16

1999 TARGET 17 1999 INDICATOR 12.2

The rate (per 100,000) of suicide deaths among youths aged 15 - 19

Accomplishments in 1999: In 1999 the Adolescent Health Coordinator worked cooperatively with the EMS-C injury prevention coordinator and the Critical Illness and Trauma Foundation in Bozeman. Statistics gathered include the incidence of adolescent suicide in Montana. A Suicide Prevention Steering Committee was organized and had an initial meeting in August 1999. Activities in the state included two "gatekeeper" training workshops held by private mental health and hospital organizations during the year. Approximately 5 to 10 people were trained in the gatekeeper suicide prevention techniques. Yellowstone County Mental Health Associated established a yellow ribbon campaign/program and public and private providers have worked to increase public awareness about the issue of suicide in general and adolescent suicide specifically.

Ongoing activities in 2000: The Suicide Prevention Committee will meet at least three times. One of the meetings will bring in an expert to educate the committee on suicide prevention. Suicide prevention plans from other states will be reviewed and work on a draft for Montana's prevention plan will take place via a contract with a plan writer.

Plans for 2001: Plans are to target HRSA funding to set aside an amount of funding to train clinical staff to more effectively screen clients for suicide risk. The state suicide prevention plan will be implemented statewide. The steering committee will continue to act as the vehicle to make recommendations re: suicide prevention.

FEDERAL PERFORMANCE MEASURE 17

1999 TARGET 81% 1999 INDICATOR 85.2%

Percent of very low birth weight infants delivered at facilities for high risk deliveries and neonates.

Accomplishments in 1999: Three hospitals in Montana, each located in a different county, provide care for high risk deliveries and very low birth weight neonates. These hospitals employ the only neonatologists and perinatologists in the state. The CACH section continues to maintain relationships with these specialists and also encourages local public health professionals to establish a working relationship with these high risk centers.

Ongoing activities in 2000: Continue to foster relationships between local public health departments and the hospitals which provide care for high risk deliveries and newborns.

Plans for 2001: Support increased Medicaid reimbursement for high risk obstetrics. Continue to educate/coordinate with pregnant women and facilities and public health professionals.

FEDERAL PERFORMANCE MEASURE 18

1999 TARGET 83% 1999 INDICATOR 83.6%

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Accomplishments in 1999: 83.6% of pregnant women began their prenatal care in the first trimester of pregnancy. This percent shows a very small increase over last year. MIAMI projects continued to help high risk pregnant women access early and continuous prenatal care. Access is particularly difficult on one of the Indian reservations; the MIAMI project on that reservation provides transportation to the nearest site for care which is 40 miles away. Presumptive eligibility also facilitates early entry into prenatal care for Medicaid eligible women.

Ongoing activities in 2000: Continuation of public education and outreach which includes targeted case management and presumptive eligibility to high risk pregnant women.

Plans for 2001: Continue to fund and possibly expand MIAMI services which include outreach and public education. Conduct an in depth evaluation of MIAMI services.

STATE PERFORMANCE MEASURE 2

1999 TARGET 2% 1999 INDICATOR 1.7%

Percent of women reporting alcohol use in pregnancy

Accomplishments in 1999: Work with the Montana Alcohol Related Birth Defects Association (MARBDA) resulted in development of a letter from DPHHS to providers of prenatal care. The intent of this letter was to urge health care providers to share the universal message with pregnant women that no alcohol use during pregnancy is safe.

Ongoing activities in 2000: Montana has been included in the Four State consortium for FAS/FAE prevention and intervention. Montana has worked with the other state partners of North Dakota, South Dakota and Minnesota to develop the four state proposal which will be submitted to SAMHSA/CSAP in July 2000. Individual state plans and activities continue to be developed.

Plans for 2001: The CACH section plans continued involvement in the planning and implementation of the above mentioned funding coming to Montana. Section staff will continue to work with other state and federal agencies to decrease the incidence of alcohol use among women of childbearing age and continue educational efforts to providers as well as the public. Continue to refine data collection methods in order to generate reliable data on substance use during pregnancy.

STATE PERFORMANCE MEASURE 3

1999 TARGET 3 1999 INDICATOR 3

Quality standards for the health care of the MCH population have been established by state staff and their local/community partners.

Accomplishments in 1999: The FCHB added a requirement to all contracts with counties for MCHBGF for at least one consumer satisfaction survey to be conducted. Customer satisfaction was addressed in the Pre-Contract survey sent to all counties. Data standards were established as part of the public health data system under construction. Standards for record documentation, retention and destruction were finalized and approved. Standard for working with students was developed. Home visiting standards were drafted. Standards for medication management in the schools were begun. The process for standard approval by the MCH Advisory Committee was established and implemented.

Ongoing activities in 2000: Home visiting standards are being review and revised. Standards for medication management are still being developed. Pre-contract survey continues to ask local departments to report on their development of local standards as well as the results of their consumer satisfaction surveys. A partner satisfaction survey

has been sent to 50 “MCH partners” and results are pending. Copies of the Scope and Standards of Public Health Nursing Practice by the Quad Council of Public Health Nursing Organizations have been purchased and will be distributed to all public health departments in Montana at our annual regional meetings. A contract was let for the production of a New Nurse Orientation manual. The manual was completed in time to be used with 17 new public health nurses at the annual new nurse orientation session in October. Standards were developed for the management of children with PKU. A small contract was let with an MCH epidemiology consultant to help the state set priorities for evaluation of programs such as MIAMI, FICMR and lead screening.

Plans for 2001: Continue to develop standards in each of the sections of the bureau and continue to provide guidance for local health departments as they develop their standards. Continue to participate in the development of the Public Health Training Institute with the new nurse orientation becoming a part of the training institute. Continue to conduct the pre-contract survey and partner survey to assess and evaluate the bureau’s impact on the public health community in Montana. Program evaluations will be conducted and results analyzed per the MCH Epidemiology consultant recommendations. Consider dropping this performance measure.

STATE PERFORMANCE MEASURE 5

1999 TARGET 25% 1999 INDICATOR 30%

Percent of counties establishing fetal/infant/child mortality review committees

Accomplishments in 1999: Funding for a three year fetal, infant and child mortality review system in Montana was received from HRSA. A statewide coordinator is on contract with DPHHS. Thirteen counties received technical support and training from the statewide FICMR coordinator. The first local coordinators’ meeting was convened and local project coordinators shared successes and solutions. The FICMR data collection tool was designed and piloted in local projects.

Ongoing activities in 2000: Eighteen counties representing approximately 82% of Montana’s population have access to the review of fetal, infant and child deaths. Sixteen local teams are reviewing deaths or are ready to begin. Two counties use neighboring county teams for their reviews. Three counties partner with Indian reservations in their counties to form one team. The State FICMR Team continues to meet quarterly to address issues and make recommendations to improve the outcomes of infants and children. Counties with smaller populations have formed standing teams and submit the minimum data set to DPHHS on each case reviewed. They may refer cases to the State Team for a second review if necessary. A SIDS manual for public health nurses was developed and distributed (Appendix D). Grief training was provided to local health department personnel at MPHA in the fall.

Plans for 2001: The statewide coordinator will lead expansion of FICMR into currently unserved counties and tribal entities to realize the goal of 100% review of Montana’s fetal, infant and child deaths. Planning is underway to establish sustainability of the

project at the state level. Recommendations by the MCH Epidemiology consultant to establish a linked birth-death file will be implemented and basic descriptive epidemiology will be performed.

STATE PERFORMANCE MEASURE 6

1999 TARGET 52% 1999 INDICATOR 58%

Percent of facilities using standardized domestic violence screening tool as a part of care assessment and planning

Accomplishments in 1999: The statewide domestic violence survey was completed and analyzed. RADAR screening cards were distributed at regional public health department meetings. A presentation on domestic violence was offered at the annual Spring Public Health meeting for local public health workers. The pre-contract survey collected data on the use of screening tools and the availability of referral resources at the local level.

Ongoing activities in 2000: The pre-contract survey again collected data on the occurrence of domestic violence in counties across the state as well as on the use of a standard screening tool and the availability of referral resources.

Plans for 2001: Continue to encourage health care providers to ask all women at each encounter about the occurrence of violence in their lives. Prepare and distribute an updated list of referral resources. Continue to include domestic violence questions in the pre-contract survey. Revise the new nurse orientation manual to include specific information on domestic violence. Consider rewording this performance measure in order to obtain more relevant data.

STATE PERFORMANCE MEASURE 8

1999 TARGET 25.1% 1999 INDICATOR 32.4%

Percent of Medicaid eligible children who receive dental services as a part of their comprehensive services

Accomplishments in 1999: A total of 13,258 unduplicated services (from EPSDT data) were provided to children ages 0 to 20 in 1999. DPHHS developed outreach program to enroll 10,000 children in the CHIP program which had a \$200 dental benefit during 1999..

Ongoing activities in 2000: The Medicaid Bureau and CHIP administrators participated in the Montana Dental Summit: Access to the Under served meeting held in November. The CHIP dental benefit to children has been increased to \$350 per enrolled child per benefit year and is retroactive to October 1, 1999 (taking into account CHIP reimbursement rates, this translates into \$412 in actual dental services). A “short form” of the CHIP application was designed which eliminated an identified barrier to

dental participation in the program. DPHHS is actively involved in efforts to recruit dentists for participation in the CHIP program.

DPHHS Medicaid Bureau continues to implement outreach to TANF families by sending reminder notices to continue preventive EPSDT medical and dental screenings. The Medicaid Dental Advisory council is meeting monthly to enhance collaboration and communication with the Department and providers of dental services. Medicaid Bureau administrators and dental services providers were among those participating in the Montana Dental Access Coalition (MDAC) meeting on January 28, 2000 at which there was a discussion regarding reimbursement rate increases for dental services. Continue to participate with the MDAC in discussion and implementation of a reimbursement rate increase through the Executive Planning Process for the 2001 legislative session and work with the Legislative Interim Committee on Children, Health and Families.

Plans for 2001: A public education program is planned to encourage parents to get children into the dentist for routine care.

STATE PERFORMANCE MEASURE 9

1999 TARGET 15% 1999 INDICATOR 17.3%

Percent of pregnant women who report cigarette smoking

Accomplishments in 1999: MIAMI projects collected data on the prevalence of smoking among the high risk pregnant population and on the incidence of women who decreased use or quit during pregnancy. The publication, "Counseling Women Who Smoke" was distributed by DPHHS to MIAMI providers.

Ongoing activities in 2000: CACH is working collaboratively with the Montana Tobacco Use Prevention program to develop a comprehensive plan that will work to reduce tobacco use among pregnant women and women of childbearing age. MIAMI projects continue to work on decreasing the incidence of cigarette use with the high risk pregnant and postpartum women and will be an important link for educational outreach for this collaborative effort.

Plans for 2001: CACH will continue to collaborate with the Montana Tobacco Use Prevention program and the governor appointed advisory council to reduce tobacco use among pregnant women and women of childbearing age. Information on smoking cessation will be available to public health professionals.

STATE PERFORMANCE MEASURE 10

1999 TARGET 5.75 1999 INDICATOR 8.99

Rate of firearm deaths among youth aged 5-19

Accomplishments in 1999 The Montana's Child Project prepared and ran TV spots on gun safety. There was a public awareness campaign for public awareness of firearm laws in Montana which are controlled primarily by local ordinance. (Montana has a liberal concealed weapon carry law which national statistics suggest lowers the incidence of deaths by firearms.) Pre-contract surveys to local health departments asked for information about discussing the issue of gun safety at every encounter.

Ongoing activities in 2000: Local FICMR teams are reviewing all deaths in their counties. Questions re; firearm deaths are on the FICMR minimum data collection tool. The State Team will continue to look at trends and make policy recommendations. Montana schools have increased in-school policing programs.

Plans for 2001: Support legislation for a more stringent gun control law. Continue to provide public education re: gun safety. Continue to urge public health nurses to discuss gun safety at all encounters.

2.5 Progress on Outcome Measures

Montana's progress on Outcome Measures has been slow but steady. The efforts by the Bureau, particularly the Child, Adolescent and Community Health Section in terms of promoting early and continuous prenatal care and in supporting fetal, infant and child mortality review, all focus on the ultimate achievement of the outcome measures. Strengthening gun safety efforts and work toward innovated legislative action regarding driving safety will help. Implementation of the suicide prevention plan will help address our high rate of youth suicide.

Indian infant mortality rates continue to be problematic. Continuing MIAMI efforts on reservations and implementation of the FAS/FAE Four State Consortium grant should help reduce this death rate. Careful analysis of Indian infant deaths by local mortality review teams will identify areas to focus preventive efforts.

The trending project being carried out in the summer of 2000 will allow us to assess our data more effectively and better define our targets.

OUTCOME MEASURE 1

1999 TARGET 7.0 1999 INDICATOR 6.1

The infant mortality rate per 1,000 live births

OUTCOME MEASURE 2

1999 TARGET 1.0 1999 INDICATOR 0

The ratio of the black infant mortality rate to the white infant mortality rate

OUTCOME MEASURE 3

1999 TARGET 4.5 1999 INDICATOR 2.8

The neonatal mortality rate per 1,000 live births

OUTCOME MEASURE 4

1999 TARGET 2.6 1999 INDICATOR 3.2

The postneonatal mortality rate per 1,000 live births

OUTCOME MEASURE 5

1999 TARGET 8 1999 INDICATOR 8.2

The perinatal mortality rate per 1,000 live births

OUTCOME MEASURE 6

1999 TARGET 20 1999 INDICATOR 26.7

The child death rate for 100,000 children aged 1-14

STATE OUTCOME MEASURE 01

1999 TARGET 7 1999 INDICATOR 12.6

Native American infant mortality rate

III. REQUIREMENTS FOR APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

Assessing the health needs of the Maternal Child Health (MCH) population in Montana is a continuous process of gathering data, analyzing data, and addressing priority needs. Statistical data for this needs assessment was gathered from several sources, which are listed under “Resources” below. The data is primarily from the years 1995 through 1999. Input from stakeholders was received through surveys and interviews with staff of related organizations. Public health provider input was received through regional meetings, focus groups, pre-contract surveys, and program statistics. Community collaboration was also solicited through focus groups around the state that were scheduled in conjunction with regional public health meetings, and by summarizing questions asked of the Health Mothers Healthy Babies 1-800 number.

MCH needs assessment planning meetings were held at the state level to elicit input from county and state public health staff beginning in January of 1999. Information was also solicited from the Family and Community Health Bureau Advisory Council. The advisory council consists of persons who represent a broad spectrum of concerned interest in maternal child health issues in Montana. The council includes representatives of health providers, parents, public health administrators, legislators, non-profit organizations, and various community health partners who are appointed by the Bureau Chief of the Family and Community Health Bureau.

Information in this report is organized based on the four levels of public health core services as defined by the federal MCH Bureau. These four levels of service are: direct services, enabling services, population-based services, and infrastructure building services. The federal MCH Bureau utilizes a pyramid symbol to show that the emphasis of the core public health services is providing an infrastructure base upon which other core services rely (see pyramid diagram below). The following section defines these four levels of core public health services.

CORE PUBLIC HEALTH SERVICES



Direct Health Services in Montana that are provided by public health staff are defined as “gap filling” services. Private sector health care providers provide the majority of direct health services in Montana. Examples of direct health care services provided through public health staff would be a basic health service, such as a well child visit, provided by a public health nurse. Another example would be an immunization given by a public health nurse for a specific child when it does not occur at a public health immunization clinic sponsored for the public. Children with special health care needs also may receive direct services through public health sponsored clinics such as a cleft palate clinic.

Enabling Services in Montana are health services that attempt to increase access for all families to public or private health care systems. Examples of these types of services would be the provision of transportation, translation, health education, purchase of health insurance, (CHIP), WIC, and case management.

Population-Based Services are broad-based programs aimed at the identification and prevention of health problems in Montana. Examples include public health screening programs such as the newborn screening programs, and lead screening programs. Also included in this category of services would be oral health prevention programs, SIDS counseling, nutrition education, and outreach.

Infrastructure Building Services are seen as the foundation of the above public health services. In Montana infrastructure services provide support and increase coordination of health services. Examples of infrastructure services include; needs assessment, evaluation of services, planning, policy development, development of standards of care for services, monitoring, training, applied research, and data management through information systems.

This report will address each of the above four levels of core public health services related to four target populations within the MCH population. The four target populations addressed are:

Pregnant women and infants
Children and adolescents
Children with special health care needs
Women of childbearing age

Establishing Priority Needs

After gathering information on the needs of the MCH population the state must then analyze the data and determine priority needs that can be addressed. Performance measures are statements of goals for the MCH population that allows the state to check progress towards increasing the health of the MCH population over time. The Montana Department of Public Health and Human Services (DPHHS) began the process of setting and prioritizing state performance measures based on a workshop directed by Ian Hill of Health Systems Research, Inc., under a contract with the U.S. Department of Health and Human Services Public Health Service in the summer of 1997. The conference was entitled “Data for Monitoring in State and Local MCH Programs in Montana.” Various public health stakeholders across the state attended this workshop including local health department directors, public health nurses, the Title V officer, the Bureau Chief for Family and Community Health, and other state department employees.

The workshop consisted of educational sessions on needs assessment strategies, performance monitoring and indicator development, resource allocation and evaluation strategies for MCH programs. There were a series of small-group exercises that allowed local MCH officials the opportunity to identify potential performance indicators for inclusion in their contracts with the state. The list that was developed at this meeting was then circulated throughout the state to receive feedback on the recommended measures. The Family and Community Health Bureau Advisory Council met to develop a strategic plan that has also helped to establish priority state needs. A final list of state performance measures was developed by DPHHS based in part on input from various stakeholders.

The Family and Community Health Bureau is currently contracting with an MCH epidemiologist to reexamine targets, improve methods of data collection, and assist with data analysis. The Bureau is also in the process of examining reallocation of MCH Block Grant funds in order to more efficiently use available resources to more equitably distribute funds based on changing population patterns across the state.

Resources

Resources Utilized for this report include the following; 1999 County Health Profiles, 1998 Montana Vital Statistics Tables, 1999 Youth Risk Behavior Survey (YRBS), the 1996 Montana Behavioral Risk Factor Surveillance System (BRFSS), the 1998 March of Dimes Community Perinatal Needs Assessment, 1998 Montana State Health Profile, Montana Health Agenda, 1996-1998 Kids Count Data Books, Congressional Quarterly State Fact Finder, 2000, U.S. Census data and publications from the Montana Census and Economic Information Center of the Department of Commerce, Healthy People 2010, Healthy Mothers Healthy Babies, Baby Your Baby Final Report 1991-1997 and the Montana Public Health Improvement Plan, Healthy People 2010, Indian Health Services website and various health related surveys conducted in Montana.

Strengths of the current methods

Strengths of the needs assessment methods include efforts to obtaining input from a variety of MCH stakeholders in Montana through surveys, interviews, and the participation of the Family and Community Health Advisory Council. Interns from various schools of public health have assisted over the past two years in the gathering of information, and provided valuable input to the needs assessment process.

Weaknesses of the current methods

In a large predominately rural state it has been difficult to obtain comprehensive participation of local communities across the state in the MCH planning process. In 1999 the Family and Community Health Bureau decided to hold regional focus groups to elicit community input on MCH concerns. These were met with limited success due to low participation the initial year but will be continued. Another weakness is the lack of precise data on some issues. Montana is still in the initial stages of developing an integrated public health data system that will improve the efficiency and accuracy of data collection.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health's Population's Health Status

Demographics: Montana is the fourth largest state in terms of land mass in the United States with 94.1 million acres. The Census Bureau in the Montana Department of Commerce recorded approximately 882,779 people as residents in 1999. This gives Montana a population density of 6.1 individuals per square mile, classifying it as a frontier state. Due to the low population over a large area, great distances are often involved in accessing health care services. The state is made up of 56 counties, with approximately three-quarters of the state residing in the top eight most populous counties.

Population Diversity: The largest minority group in Montana is the American Indian population, which accounts for 6% of the total population. There are seven reservations within the state with approximately 56,000 American Indians. These reservations are home to the Blackfeet, Crow, Salish-Kootenai, Cheyenne, Assiniboine, Chippewa-Cree, Gros Ventre, Little Shell, and Sioux American Indians. Each tribe has unique cultural and linguistic practices. The following table from the Census department and Indian Health Services (IHS) illustrates shifts in population on and off the reservations among tribes from 1990 to 1998.

Reservation	1990 Census Pop.	1998 IHS Estimate
Blackfeet	8,549	8,643
Crow	6,370	10,615
Flathead	21,259	9,139
Ft. Belknap	2,508	3,567
Ft. Peck	10,595	7,536
N. Cheyenne	3,925	4,531
Rocky Boy	1,954	3,727

Montana has a very small percentage of African Americans and Hispanics. However, both populations, according to census data, are projected to increase and approximately double their population within the coming years. The following table illustrates the distribution of population by race/ethnicity within the state by the five health care regions.

RACE/ETHNICITY	PERCENT OF POPULATION					
	State Total	Region I	Region II	Region III	Region IV	Region V
White	92.7%	86.1%	84.2%	90.4%	95.8%	93.6%
Black	0.4%	0.2%	1.0%	0.4%	0.2%	0.2%
Native American	6.2%	12.0%	12.5%	6.2%	1.8%	4.2%
Hispanic	1.7%	1.4%	1.5%	2.5%	1.6%	1.4%
Other	0.6%	0.3%	0.8%	0.5%	0.6%	0.6%

Source: Census Bureau 1998

Other minority populations include migrant and seasonal farm workers. The Billings Migrant Health Center estimates that it serves approximately 12,400 migrant workers and their families. There are also approximately 300 Russians and 200 Southeast Asians in the Missoula area. Translator services have actively been pursued in these areas to assist in meeting the health care needs of immigrant and migrant populations.

Montana also has a population of approximately 3,000 to 4,000 Hutterites living in 30 to 35 colonies across the state. Hutterites are not specifically identified in census data. They are of German-European descent, and are often confused with the Amish. The Hutterites experience a high incidence of agricultural related injuries, especially to children, and this has become a health concern. Potential health issues for this population are related to health care practices, cultural isolation, and the potential for genetic disorders due to intermarriage.

Economics: The unemployment rate for Montana was 5.6% for 1998 compared with a US rate of 4.5 percent. The average income for Montana residents was \$20,082. The Montana Department of Labor and Industry reports that Montana ranked lowest of the fifty states for annual average wages in 1998 and ranked 49th in 1999.. Reasons for this low ranking include: lower hourly wages, a higher percentage of Montana workers working part time, many Montanans working in industries where work is often seasonal, and many choosing to stay in Montana rather than move to other states for higher-wage jobs.

Montana is currently ranked 5th of the 50 states for a high number of people in poverty. Approximately 17% of the population live in poverty in Montana. The state has one of the highest ratings of poverty in the northwest (Department of Labor and Industry, 1998). The goods-producing sector, which includes agriculture, mining, construction and manufacturing, held 20 percent of the jobs in Montana in 1997. This is a decrease from 29 percent of jobs in the goods-producing sector in 1970. Service-producing sector jobs have been increasing since 1970 when 71 percent of all jobs were service related. Eighty percent of jobs were service related in 1997.

The economy in Montana does show growth according to the state Department of Labor and Industry. Employment increased by 8,000 nonagricultural payroll jobs between 1997 and 1998 and per capita personal income rose nearly twice the rate of inflation during this time period.

The Indian Health Service reports that American Indians in the Billings Service Area have the third highest percent of population below the poverty level (44.6%) when compared to the twelve IHS service areas in the US. This is based on 1990 census data. The Billings Service Area also has the highest percent of unemployment for both males and females of the Indian Health service areas with males at 29.8 percent unemployed (age 16 and older), and females 21.0 percent unemployed (age 16 and older). The median household income for the Billings Service area was \$14,249. Indian families below the poverty level are most likely living in sub-standard housing, have poor nutrition and contend with hardships that are harmful to their health and well being.

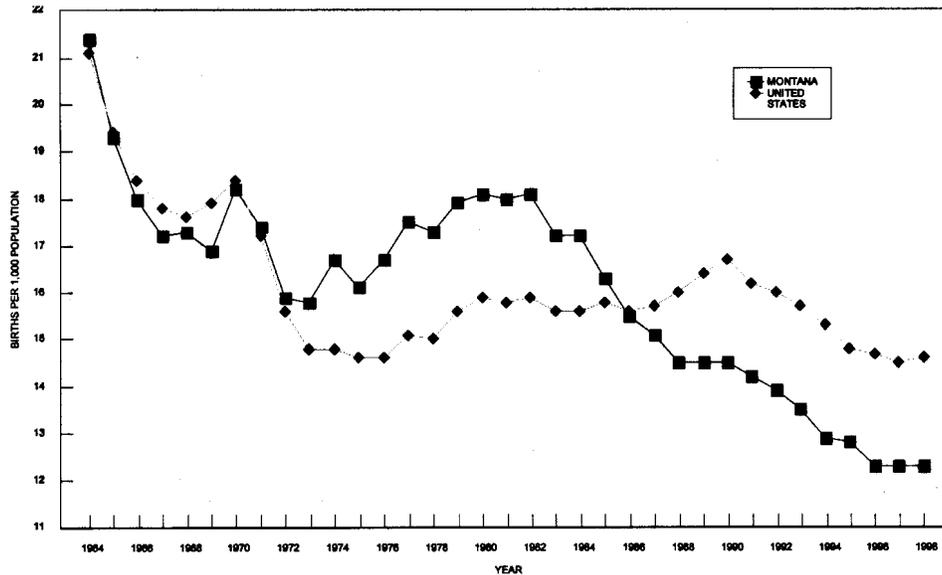
Shifts in Census: Shifts in census data provide important information for public health professionals, especially for a frontier state like Montana. The addition or subtraction of individuals from a county can have major impacts on the resources available in a community. The state population increased 10.2% from 1990 to 1998. Population growth in Montana however has been uneven over various parts of the state. Between 1990 and 1998 the Department of Labor and Industry reports that 34 Montana counties gained population and 22 counties lost population. The 17 counties that grew by more than 10 percent are in western and south central Montana. Most of the counties losing population are located in eastern and north central Montana. Fluctuations in the job market in Montana have also lead to dramatic population changes in some counties. This is especially seen when mining operations open or close in the state.

The following table shows the percent change in the top eight most populous counties from 1990 to 1998.

COUNTY	1998 POPULATION	% CHANGE '90-'98
Yellowstone	126,158	11.2%
Missoula	88,989	13.1%
Cascade	78,983	1.7%
Flathead	71,831	21.3%
Gallatin	62,545	23.9%
Lewis and Clark	53,655	13.0%
Ravalli	35,156	40.6%
Silver Bow	34,560	1.8%

Birth Rate The Montana birth rate for 1998 was 12.3 per thousand. This is one of the lowest rates ever recorded for the state, but part of a trend in declining birth rates since 1984. Montana birth rates have consistently been lower than that of the nation as a whole since 1986 (MT Vital Statistics, 1997). The following is a graph of the resident birth rates for the time period of 1989 to 1998, regardless of race.

Resident Birth Rates Montana and the United States, 1964-1998

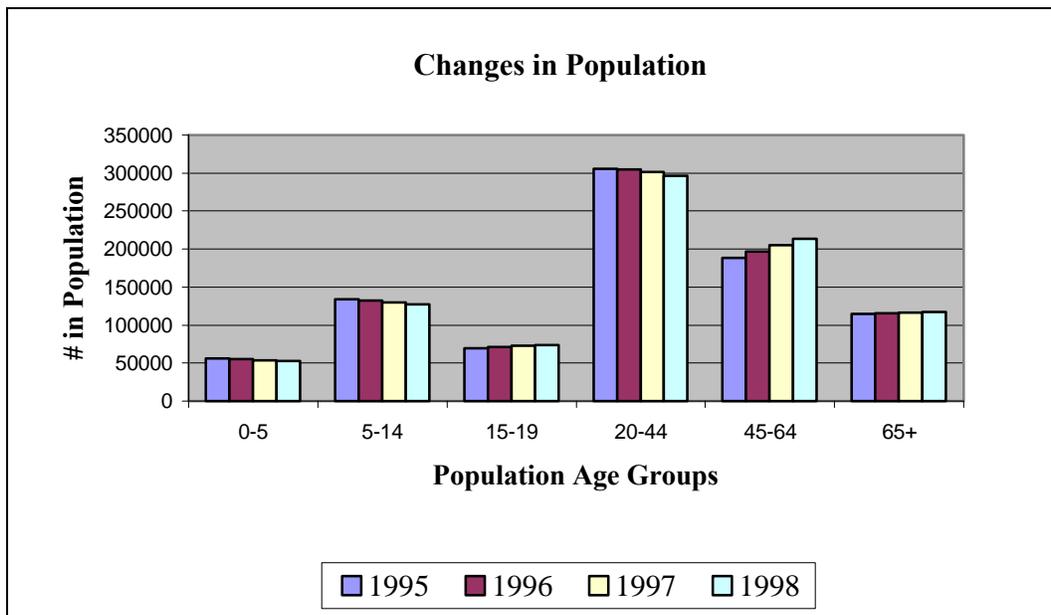


Source: MT Vital Statistics, 1998

During the 1980s, a migration of people in their 20's, out of the state of Montana caused a decrease in the number of births in the state. In the 1990s, there was an increase in the number of people aged 35-45 back into the state. With an increase of people in this age group there has been an increase in school-aged children within the state. This flux in population may be related to the economy and the difficulty of obtaining a viable job in Montana for many younger persons.

Age Structure: According to census projections, Montana's proportion of adolescents is expected to decline. The state had the 12th largest proportion of adolescents in 1995. The proportion of adolescents is expected to decrease dropping Montana to the 40th of the 50 states by 2025. If this projection is correct a further decline in the birth rate would be expected.

Changes in specific age groups can be seen the graph below.



Source: Census Bureau 1998

It is of interest to note that Montana's dependency ratio (youths under age 20, and elderly 65 and older) is expected to increase to the 3rd largest in the nation in 2025, from where it was the 13th largest in 1995. This ratio will have consequence for women in Montana. Throughout time women have been socialized to take on the burden of caring for the young and elderly alike therefore, health practitioners can expect to see more women dealing with social issues related to family dynamics and the stress of increased care giving demands as the dependency ratio rises.

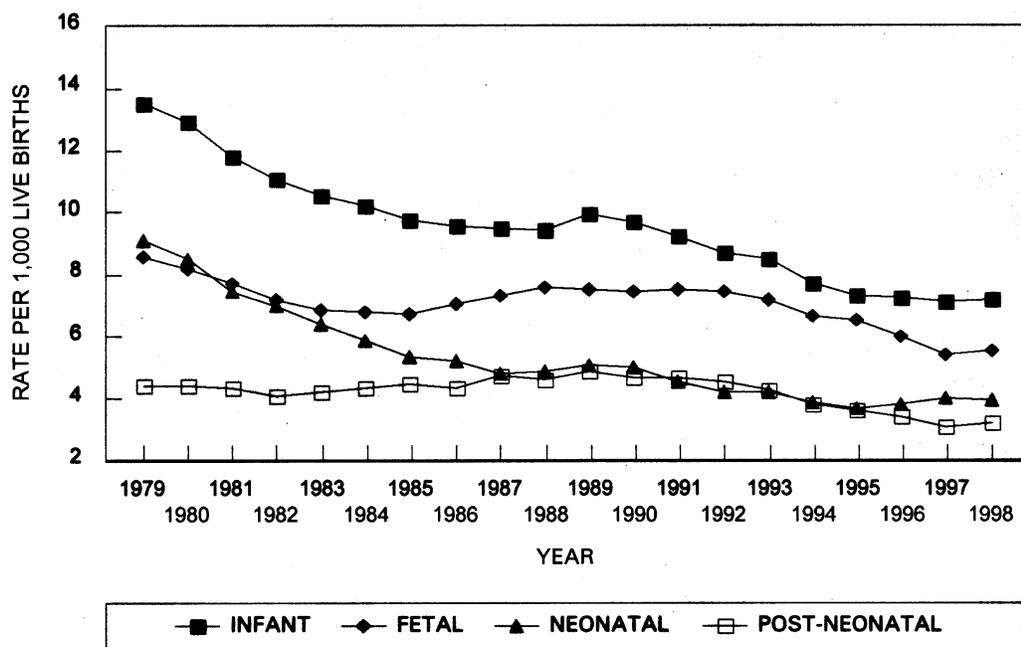
Health Status of the Montana MCH Population

The following is a synopsis of issues and health indicators that directly or indirectly affect the health status of the MCH target population groups.

Pregnant Women, Mothers, and Infants

Infant Causes of Death: The infant mortality rate is defined as the number of infants that die before their first birthday per 1,000 live births. Below is a graph of mortality rates from 1989 to 1998 for infants in Montana. The overall infant mortality rate has decreased for newborns of all races since 1989.

FIVE-YEAR INFANT MORTALITY RATES AND FETAL MORTALITY RATIOS
Montana residents, 1979-1998



Source: MT Vital Statistics, 1998

Given the low population in Montana, statistics are most useful when looking at five years patterns since a small number of changes can produce extreme statistical changes. The graph illustrates the five-year average on each given year. The infant mortality rate has shown an overall decline over the past two decades. The five-year infant death rate decreased from 13.5 infant deaths per 1,000 live births in 1979 to 7.2 per 1,000 live births in 1998 (MT Vital Statistics, 1/2000). This compares to a national infant mortality rate of 7.2 infant deaths per 1,000 live births for infants of all races in 1997 (HRSA, 1999).

The top five causes of death for infants (1995-1998) for all races in Montana were related to premature birth, congenital anomalies, unspecified other causes, SIDS, and unintentional injuries.

Fetal mortality is defined as the number of fetuses that die after 20 weeks gestation and prior to a live birth. The fetal mortality rate shows an overall downward trend since 1990 in Montana. There were 7.0 fetal deaths in Montana per 1,000 live births in 1998. This ratio represents a total of 76 fetal deaths in 1998. The Montana five-year fetal mortality ratio in 1998 was 5.5 fetal deaths per 1,000 live births. This compares to a five-year rate of 8.6 fetal deaths per 1000 live births in 1979 (MT Vital Statistics, 1/2000). The year 2000 goal is 5.0 fetal deaths per 1,000 live births.

The Montana neonatal mortality rate (deaths in the first 27 days of life) for all races was 4.2 per 1,000 live births in 1998, compared to a national rate in 1997 of 4.8 deaths per 1,000 live births. The year 2000 goal for neonatal mortality in Montana is no more than 4.5 deaths per 1,000. The five-year rate of neonatal mortality in Montana was 4.0 deaths per 1,000 births in 1998. This compares to the state five-year rate of 9.1 deaths per 1,000 in 1979. Risk factors related to neonatal mortality include congenital anomalies, respiratory distress syndrome, short gestation, and maternal complications of pregnancy.

Postneonatal Mortality is defined as infant deaths that occur after the first month of life until the 12th month of life. Congenital anomalies and SIDS are the two major causes of postneonatal deaths in Montana. There has been little change in postneonatal deaths from 1979 to 1998. Advances in perinatal care, and medical technology have decreased the number of neonatal deaths, allowing more high-risk infants to survive into the postneonatal period.

Montana has developed Fetal, Infant, and Child Mortality Review (FICMR) teams in an effort to reduce infant and child deaths. There are 16 local mortality review teams and one state team currently. The purpose of these teams is to review deaths in order to understand the causes of infant and child deaths in the state so that prevention efforts can be focused in a community to reduce deaths related to the specific causes. According to FICMR data these 16 teams are reviewing approximately 80% of all fetal and infant deaths in the state.

Maternal Mortality: For the 1994-1998 time period, there were only two reported maternal deaths. There is concern about the accuracy of this figure related to the use of the correct definition of maternal mortality. Maternal mortality is supposed to be based on a mother's death one year after a birth of a child. A common mistake is the belief is that a "maternal death" occurs only during childbirth, or soon after childbirth. The rate of maternal mortality in Montana is generally thought to be higher than what is reported. Discussions are currently underway to consider adding a check box to Montana's death certificate to identify women who have had a child a year prior to their death. This will allow improved tracking and analysis of maternal mortality.

Low Birthweight: Infants born weighing less than 2,500 grams (5 pounds, 8.5 ounces), are considered low birthweight (LBW). Very low birthweight, (VLBW) is defined as an infant weighing less than 1,500 grams (3 pounds, 4.5 ounces) Low birth weights are associated with multiple potential health problems such as increased risk for infant mortality, chronic illnesses, developmental delays and learning problems. The percentage of low birthweight infants has remained relatively unchanged over the past two decades in Montana despite a steady decline in infant mortality rate. The percent of low birthweight infants was 5.1 in 1990 and 6 per cent in 1997. The 1995 national rate for low birth weight was 7.3 per cent (Healthy People 2010 Objectives). There is a greater risk for low birthweight among unmarried mothers and mothers with less than a high school education in Montana according to MT Kids Count Special Report #1. The MIAMI (Montana Initiative for the Abatement of Mortality in Infants) program is a public health program that targets high risk pregnant mothers to continue to reduce the number of low birth weight infants. This program will be described further under health services for pregnant women and infants. As mentioned previously, advances in perinatal care, and medical technology have also led to an increased number of low birth weight infants born weighing less than 1,500 grams who are surviving.

Disparity: There continues to be disparity between the Caucasian versus American Indian population related to rates of infant mortality. The Billings Service Area of Indian Health Services (IHS) includes all seven Montana reservations and the Wind River reservation in Wyoming. The five-year Indian infant mortality rate in the Billings service area was approximately 10.9 deaths per 1,000 live births in 1995. This compares to a Montana rate for all races in 1995 of 7.1 deaths per 1000 births.

The major causes of infant mortality in the American Indian population have begun to change over the past decade. A 1997 report by IHS noted 25.67% of infant deaths from 1990-1992 among American Indians were due to SIDS in the Billings service area. SIDS was the leading cause of infant death among American Indians in Montana and Wyoming. From 1994-1996 the rate of death from SIDS

among the same population decreased to 13.2% of infant deaths. The causes of infant death from 1994-96 in the Billings service area of IHS changed with the number one cause becoming congenital anomalies, 31.6%, followed by SIDS and “newborn affected by complications of the placenta, etc. 10.5 % . Staff from IHS speculate that the “Back To Sleep” campaign is one factor attributing to a decline in the number of reported SIDS deaths. Another factor is the education of health professionals on the use of the diagnosis of SIDS and the requirement of an autopsy prior to labeling a death due to SIDS.

There are differences in the birth rates between American Indians and Caucasians in Montana. The birth rate was 25.7 per 1000 population in the Billings service area from 1994-96. The Montana all races birth rate for the same period was less than 13 per 1000. The number of women beginning prenatal care in the first trimester is estimated to be lower among the American Indian population. In 1994-96 IHS statistics show that 66.3 % of American Indian women in the Billings service area received first trimester care. This compares to a rate of 81% of women of all races in Montana receiving first trimester prenatal care based on a five-year average from 1993-1997 (1999 Montana County Health Profiles).

Another health concern is the number of mothers who report smoking or drinking during pregnancy in the American Indian population. Statistics from IHS for the Billings service area show that 7.5% of mothers report drinking during pregnancy. This compares to a U.S. rate of 1.5%. The percent of American Indian mothers who reported smoking was over 30% in the Billings service area in 1994-96. There are no statistics for women of all races in Montana that self-report smoking during pregnancy. The program for high-risk mothers in Montana, (MIAMI) does collect information on smoking however. The rate of smoking among high-risk pregnant mothers in Montana of all races participating in the MIAMI program was even higher than the IHS statistic at 40%. This compares with a U.S. rate of approximately 15% during 1995 for all races. It appears that smoking is a concern across all races in Montana.

American Indian women in the state were more likely to have a high birthweight infant than Caucasian women. High birth weights can be associated with gestational diabetes. American Indian women are twice as likely to give birth with diabetes as women of all races according to the 1997 IHS Report. Diabetes as a pregnancy risk factor is also associated with pre-term birth (less than 36 weeks gestation). In the Billings service area the birth rate with a diabetic mother from 1994-96 was 31.7 per 1000 births per IHS report. Statistics from Montana Diabetes Surveillance: An Analysis of Birth and Death Records, (January, 1996), report the rate of maternal diabetes among Caucasians was 1.9 percent during the period 1988-1994. The American Indian rate for gestational diabetes during the same time period was reported at 3.1%. These numbers were derived from birth records where diabetes was checked as a risk factor. The overall birth rate with diabetic mother in the US in 1995 was 2.5 % . The Billings service area rate of 3.1 % is lower than the rate for American Indian women in all IHS areas, which was 4.5 % in 1994-96.

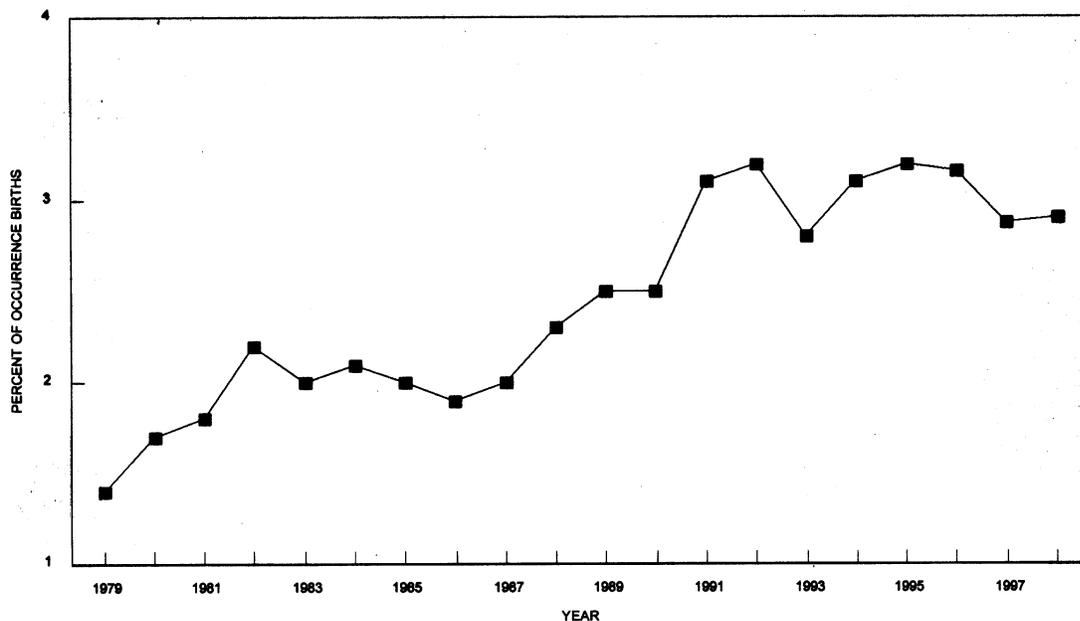
The current major issues of concern in the American Indian MCH population in Montana according to IHS staff and the Health Promotion and Disease Prevention Report include:

- Increasing the number of women receiving first trimester prenatal care
- Screening pregnant women for tobacco and substance abuse and providing follow-up
- Increasing well child visits for American Indian children
- Preventing obesity in Indian children

- Reducing deaths from cancer of the uterine cervix
- Increasing the number of women who have annual Pap screening
- Reducing breast cancer deaths
- Increasing the number of women age 50-69 who have annual mammogram screening and breast exam

Delivery: Most births in Montana occur in a hospital. In 1998 less than 3 percent of births occurred outside the hospital setting. There has been an increasing trend of deliveries outside of hospitals in Montana however since 1979. Direct entry midwives (DEM), were authorized to attend low risk pregnant women by the Montana State Legislature in 1989. The educational requirements for DEMs are outlined in the Montana Code Annotated and the Administrative Rules for Montana (37-27-320 (2)). DEMs are licensed under the Board of Alternative Medicine in the state and are subject to annual examinations. DEMs are required to report within 72 hours any incident that might have bearing on the mother's health to the Title V program director found within the Child, Adolescent, and Community Health Section of the Family and Community Health Bureau. The midwife must also report to the Board of Alternative Health Care regarding complications during the delivery. There is currently no over site system to know if reporting is complete or accurate. The following graph illustrates the rise in the number of births occurring outside of hospitals from 1979-1998.

**PERCENT OF BIRTHS OUTSIDE HOSPITALS
MONTANA OCCURRENCES, 1979-1998**

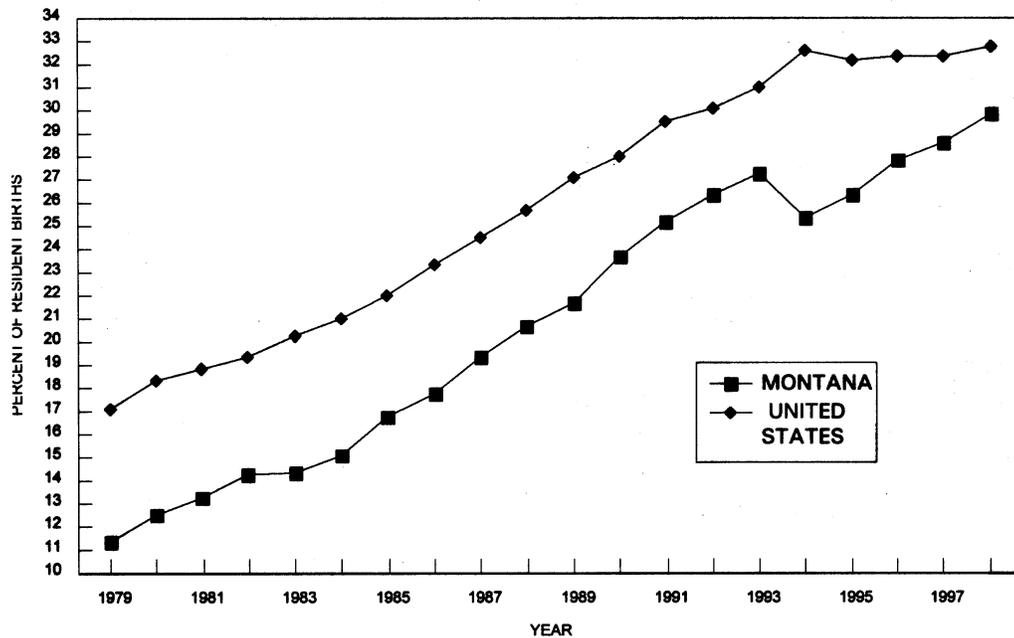


Source: MT Vital Statistics, 1998

Pregnancy Rate for Unmarried Women: An issue of concern is the pregnancy rate for unmarried women. This is a particular concern within the younger women of the state, between the ages of 15-24. The pregnancy rate among unmarried women has been increasing since the 1980s. In 1997, it reached a high of 27.9%. The national average reported in 1995 demonstrated that 32% of live births occurred to unwed mothers (MT Vital Statistics). Native American women were more likely to be

unmarried during pregnancy than their white counterparts. Children of unmarried mothers are at an increased risk of having adverse outcomes. Unmarried mothers as a group, are less likely to receive adequate prenatal care, more likely to participate in negative behaviors during pregnancy like smoking or drinking, and are more likely to live in poverty compared to their married counterparts. The following is a graph of the percent of resident births to unmarried women from 1979 to 1998.

**PERCENT OF BIRTHS TO UNMARRIED MOTHERS
MONTANA AND U.S. RESIDENTS, 1979-1998**



Source: MT Vital Statistics, 1997

Newborn Screening: Virtually all newborns in the state of Montana are screened for inborn errors of metabolism—PKU, hypothyroidism, and galactosemia. Screening for hemoglobinopathies is being considered and a pilot program has begun. The state does not universally screen newborns for cystic fibrosis. There is continued debate related to the cost versus benefit of cystic fibrosis screening.

Management of the state newborn screening program has been recently transferred to DPHHS Special Health Services (SHS) section, which will allow increased continuity of care for those newborns needing follow-up services which are available through the SHS section.

Under discussion currently is the suggestion to add a hearing screening checkbox on birth certificate forms. The addition of a checkbox may raise awareness of the need for hearing screening and improve accuracy of data gathered. A survey of Montana hospitals estimates that 60% of infants born in 1999 were screened for hearing before they left the hospital. A weakness of the service system is the current lack of coverage by state medicaid, or the children’s health insurance program to provide assistance with the cost of hearing aids once a need is identified.

SIDS: SIDS is the sudden death of an infant less than one year of age that remains unexplained after a thorough case investigation including a complete autopsy, examination of the death scene and review of the clinical history. SIDS continues to be an issue of concern within the state and was mentioned earlier under the disparity section. There were 13 SIDS deaths per 10,000 live births in 1997 (MT Vital Statistics, 1997). In 1998 there were 7 deaths attributed to SIDS in Montana and 10,791 live births. The national rate in 1995 was 8.0 per 10,000 live births (Healthy People 2010 Objectives). The Department of Public Health continues to provide education to the public about the tragedy of SIDS and on ways to prevent it—such as laying an infant on its back, removing any contact with sheepskin, and no smoking in the household. In both 1998 and 1999, DPHHS received small grants to provide education opportunities for the public on SIDS. A SIDS intervention guideline for Public Health Nurses was developed and is currently available through the Child and Adolescent Health Section of the Family and Community Health Bureau. The department is also in the beginning stages of trying to improve legislation that would mandate autopsies of infants who die from SIDS. There are still two counties within the state that do not mandate autopsies for deaths in which SIDS is suspected.

Breastfeeding: Breastfeeding is an issue championed among many organizations across the state. Breastfed infants usually have a healthier weight gain, and usually do much better in health related issues than their bottle-fed counterparts. WIC provides education and greatly encourages their new mothers to breastfeed. Montana's Child, which is a project of Healthy Mothers, Healthy Babies, also advocates for breastfeeding. The DPHHS monitors the number of mothers that breastfeed as part of national performance measures, and also as one of the state negotiated performance measures. The percent of mothers who breastfeed is derived from the WIC population who reported breastfeeding their infants at six months of age. In 1996, the rate was 35.1%. This increased to 37.7% in 1998, which is very close to the 2000 goal of 39%.

Prenatal Care: There is widespread agreement among MCH professionals that early and continuous prenatal care is positive and effective (Kotch, 1997). Tracking of prenatal care can be difficult secondary to women changing providers and the lack of a unified health data system across the State. The American College of Obstetricians and Gynecologists describe four functions of prenatal care: risk assessment, serial surveillance, health education, and psychosocial support. Montana utilizes the Kotelchuck Index to evaluate the adequacy of prenatal care participation. This index uses the number of visits a woman receives during her pregnancy, the gestation of the pregnancy at delivery, and the trimester in which care began to determine the adequacy of prenatal care participation.

The percentage of women who adequately participated in prenatal care improved from 71.6% in 1993-95 to 72 per cent in 1997, (Montana 1999 County Health Profiles). Montana has been striving to increase entry into early and continuous prenatal care for all pregnant women through public and private health care professional's efforts throughout the state.

Adequacy of prenatal care is one of the health status indicators utilized by the state to measure progress in providing access to prenatal care. Another indicator is the percent of women beginning care in the first trimester. The Healthy People 2000 goal for first trimester entry into prenatal care was 90%. The 1999 Montana County Health Profiles show that 81% of women received care in the first trimester based on the most current data year, which is 1997. Earlier entry into prenatal care helps medical staff to closely monitor the women's health behaviors, and educate the mother on the risks she may be placing her child in by smoking or drinking during pregnancy. As mentioned earlier, forty percent of MIAMI clients have reported smoking while pregnant. This is likely an underestimate due

to self-reporting methods. Montana currently monitors the percentage of mothers who report smoking and/or drinking during pregnancy in their performance measures. This number is derived from MIAMI data. MIAMI will be discussed further under the enabling services section of this report.

Health Status of Children and Adolescents

Child and Adolescent Mortality: The top five causes of death for children 1-14 (1995-1998) continues to be unintentional injuries, unspecified other causes, congenital anomalies, cancer, and homicide/suicide.

Unintentional Injury: A preventable cause of morbidity and mortality among children and adolescents is motor vehicle accidents (MVAs). In 1998, Montana had a death rate from MVAs of 22 per 100,000. Montana currently ranks 10th in the nation, with number one being the worst, for the death rate from MVAs. Thirty seven percent of deaths due to MVAs in 1998 were in the 15-34 year old age group (MT Vital Statistics).

According to Montana's 1997 Youth Behavior Risk Survey (YRBS), the state ranks higher than the US in several issues that contribute to higher rates of unintentional injuries. For example, 32% of Montana youth rarely or never wore a seatbelt when riding in a car. This rate however dropped to 23% on the 1999 YRBS. This compares to a national rate of 22%. On the 1997 YRBS, 47% of Montana youth reported riding in a car driven by someone who had been drinking alcohol in the past 30 days. This compares to a national rate of 39%. On the 1999 YRBS, 27% of Montana youth surveyed reported driving a car when they had been drinking alcohol. This compares to a national average of 15%.

Due to the rural nature of Montana, many younger people begin driving at an early age to assist with farm activities as well as to get to school and extra curricular activities. Montana roads can be treacherous under normal circumstances but become deadly when driven by inexperienced drivers. Efforts are underway in Montana to require a graduated driver's license.

Montana also has a high incidence of firearm injuries. Hunting is a popular State pass time, and even considered by some to be a right of passage for the young. The death rate due to firearms was 13 per 100,000 in 1998. Twenty three percent of firearm related deaths occurred in individuals between the ages of 1 and 24. In 1995, the national rate for firearm-related deaths, for all individuals, was 13.9 per 100,000 (MT Vital Statistics and Healthy People 2010 Objectives).

Poverty: The number of children living in poverty is a widely used indicator of child well being. Poverty is closely associated with undesirable outcomes in areas of health, education, emotional well being and delinquency. (Kids Count Data Book, 1999). More than half of children in Montana live in rural counties, which is not a problem in itself, but when combined with poverty it can lead to isolation and a lack of services. Isolation is a key issue for people living within rural or frontier counties. Families are separated by extremely large distances, thereby removing access not only to support systems, but also to medical services and other necessary entities. In 1996, the rate for children age 18 or younger living in poverty in Montana was 19% (Kids Count Data Book, 1999). This number is based on a family earning less than \$12,931 for a family of one adult and two children in 1997. The Montana Office of Rural Health notes that in 1999 Montana was 7th in the nation for the percent of school age children living in poverty. Public Health nurses noted on the pre-contract survey in 1999

that they feel poverty has increased in their counties, which causes an increase reliance on public health services. (See appendix O for the Pre-contact survey results).

The following is a table from the U.S. Census Bureau, March of 1998 that illustrates the growing issue of poverty among Montana children over time.

YEAR	% OF CHILDREN <19 AT OR BELOW 200% OF POVERTY	% OF CHILDREN <19 AT OR BELOW POVERTY WITHOUT HEALTH INSURANCE
1993-95	43.3	8.4
1994-96	48.1	7.9
1995-97	50.6	13.2

Uninsured Children: Estimates by state officials show there are 20,000 to 25,000 uninsured children in Montana. Of this it is estimated that 14,700 are at or under 150% of the federal poverty level. Of that number, they believe 3,000-4,000 children are eligible for Medicaid. The federal-state children’s health insurance program (CHIP) is prepared to cover approximately 10,000 children who are not eligible for Medicaid and whose family earns less than \$20,050 per year based on a family of four. Six thousand children have been enrolled in CHIP as of June 2000. CHIP will be further discussed under enabling services.

Child Abuse/Neglect: The exact number of children experiencing abuse or neglect in Montana is not known. There is a need for more effective reporting standards in order to determine baseline prevalence in Montana. Child Abuse and Neglect is a problem in Montana and there are several child abuse/neglect prevention organizations in the state. For example, the Montana Children’s Trust Fund, which is under the DPHHS for administrative purposes, funds activities to increase community capacity for innovative child abuse and neglect prevention, education, and support programs for parents, families, and abused or neglected children. This program will be further discussed under enabling programs for children and adolescents.

Another way in which Montana is trying to combat child abuse and neglect is through goals and benchmarks that were developed by the Governor’s Interagency Coordinating Council (ICC) on Prevention. Their first goal is to reduce child abuse and neglect by promoting child safety and healthy family functioning. They plan to accomplish this by reaching the following benchmarks:

- By the year 2005, double the number of child care providers who have credentials in early childhood care and education
- By the year 2005, maintain the success rate of children receiving in-home services at 95%
- By the year 2005, increase the number of at-risk children receiving in-home services by 15%
- By the year 2005, increase the law enforcement reporting rate for incidents of domestic abuse to 80% of those who seek shelter-care services

Dental Care: Lack of access to dental care is a priority concern for Montana youth. DPHHS and its partners continue to work together regarding dental care to improve access for the MCH population. A dental coalition was formed in 1999 with the goal of improving access to dental care among the MCH population. Four working groups were formed to develop short term and long term strategies to improve dental access in Montana. There are shortages of dentists in some areas of the state and some

dentist refuse to see Medicaid patients. On an analysis of calls received by Healthy Mothers, Healthy Babies, in 1998, dental access was the third highest area of need parents identified for their children. For a more complete view of this analysis, (see Appendix O). The Montana Council for Maternal Child Health surveyed approximately 40 core stakeholders in the fall of 1999. Dental access for children was listed as the second highest priority in the state, (see Appendix O). Appendix O also includes the summary of a survey of Montana dentists by Healthy Mothers/Healthy Babies in 1999.

To date, reporting on dental MCH performance measures has been limited to information from sentinel schools. Hopefully, with the advent of the state integrated data project, IDEA, data will be more readily available at both the county and state levels on this issue. The DPHHS is also scheduled to have an on-site visit from the Association of State and Territorial Dental Directors in 2000.

The DPHHS provides a fluoride mouth rinse program to school-aged children across the state. Because of the higher prevalence of well water usage, this is a necessary service to provide so that children receive the adequate amount of fluoride to help prevent dental decay.

Immunizations: Immunization clinics are coordinated at the local level by public health nurses. The state had a rate of 78.5% of children aged 2 or younger immunized in 1996, and that rate increased by 10%, to 88.4% in 1998. The Montana year 2000 goal is to have 90% of children immunized; this has been achieved.

Environment concerns: Montana environmental health concerns include exposure to lead. Lead can be ingested by children playing around a home where lead-based paint chips or dust are present. Most homes built before 1978 contain lead. Lead exposure also occurs when lead is released into the air from smelters. One of the state Superfund sites is located in East Helena where the Asarco smelter dominates the landscape. Blood lead levels in East Helena children in 1975 was an average of 28 ug/dl. This level fell to 3.83 ug/dl by 1997 due to increased environmental controls. This compares to a national average blood lead level of 2.8 ug/dl to 2.7 ug/dl during the same time period. A survey of East Helena children in 1999 demonstrated that lead levels may again be climbing as an average level of 5.7 ug/dl was found among 80 children tested. Testing will continue to see if these 1999 levels were an anomaly or the beginning of an upward trend. Lead screening will be addressed more in depth below.

Other environmental health concerns are related to the history of mining in the state. In 1999 a major health concern began to be highlighted in Libby, MT. Libby was home to a vermiculite mine for several decades but it closed in 1990. Asbestos dust from this mine has been connected with increased respiratory illness among residents. The state DPHHS is presently investigating the health risks related to the dust from this mine. The use of cyanide in mining also presents a potential health risk in Montana when ground water inadvertently becomes contaminated. Montana only recently banned the use of cyanide in mining operations.

In April of 1996 a Montana Rail Link train derailed 30 miles west of Missoula, MT along Interstate 90 and near the Clark's Fork River. The town of Alberton, MT was most affected by the spill of 64.8 tons of chlorine, 17,000 gallons of potassium cresylate, and 85 pounds of sodium chlorate. Five hundred residents were evacuated from the hot zone and 300 people were treated for symptoms of potential chlorine/chemical exposure in nearby hospitals. The long-term effects of high levels of chlorine exposure in humans are unknown. Chlorine exposure can be associated with eye irritation and long-term respiratory problems. Residents in the Alberton area have complained of memory loss, chronic

fatigue, and aching joints, which are ailments that are difficult to positively, link with chemical exposure. The EPA, federal Agency for Toxic Substance and Disease Registry, state DEQ, DPHHS, and local Missoula county health department are among the groups involved in addressing the health concerns of this spill. Studies and monitoring are ongoing.

Lead Screening: The Montana LEAD program has implemented blood lead testing in 39 of 56 counties and screening has also been implemented on some Reservations. During 1998, lead screening was performed on 2,600 children in WIC clinics. Statewide about 2% of children have had levels above 10 mcg/dl, which indicates a problem. Ten percent have also been found to have levels greater than 6 mcg/dl, which indicates that there is a possible problem. All of the children found with elevated blood levels were residing in areas designated as Superfund sites. Follow-up care is provided to all children with elevated blood levels. Environmental follow-up is provided for areas in which a child has tested positive for blood lead levels around 20 mcg/dl.

Most of the lead screening to date has focused on children 0-6 years old in the WIC program, but screening is available to all children less than 72 months of age when requested. Information shows that approximately three-fourths of the State's WIC population is enrolled in Medicaid. There are other high-risk medicaid children and non-medicaid children living in poverty who also need to be included in the lead screening process. The program is currently trying to recruit more physicians to screen children and increase the awareness of the issues involved with lead poisoning.

Teen Pregnancy and Adolescent Sexual Behaviors: Of concern for the adolescent population is the teen pregnancy rate. In 1995, teens represented 14.9% of all pregnancies, 12.7% of all births, 26% of abortions, and 16.4% of all fetal deaths (March of Dimes). For 1998, the birth rate for youth aged 15 to 17 was 19.4 per 1,000 live births (MT Vital Statistics). According to the 1999 Montana County Health Profiles, the teen fertility rate, which is a 5-year average from 1993-1997, was 41 per 1,000. Unfortunately, Montana has the dubious distinction of ranking fourth in the nation, with number one being the highest, for the percent of reported legal abortions obtained by teenagers (MT Primary Care Office).

The 1997 fertility rate for Caucasian females aged 15-17 was 14.7 per 1,000. For American Indian female's aged 15-17, the fertility rate was 75.0 per 1,000 (MT Vital Statistics). American Indian females show a higher risk for initiating late, or receiving no prenatal care, participating in negative health behaviors such as smoking or drinking during pregnancy, and are at a higher risk for having gestational diabetes, thus putting both mother and infant at risk. These issues influence the higher infant mortality rates seen in the American Indian population.

The table below shows Montana's youth compared to the nation as a whole on reported sexual behaviors. In 1997, 46% of Montana's adolescents reported being sexually active, but only 55% of these adolescents used a condom. During 1996, 46% of the reported cases of chlamydia occurred in 15 to 19 years olds. The table is from the 1997 Youth Risk Behavior Survey (YRBS), depicting sexual behaviors of Montana's youth.

Behavior	Percentage of Students Reporting Behavior					
	Grades 7-8		Grades 9-12		Native Am.	
	MT	US (1995)	MT	US (1995)	Res.	Urban
Ever had sexual intercourse	22	24	46	53	73	64
Had sexual intercourse with four or more people during their life	5	7	16	18	31	26
Used or whose partner used a condom during last sexual intercourse	58	58	55	54	46	42
No HIV/AIDS education	17	17	7	14	10	12

A plan to reduce teen pregnancy and sexually transmitted diseases (STDs) is addressed by the Governor's Interagency Coordinating Council (ICC) on Prevention's five benchmarks. Meetings currently held at the state are designed to format a plan that will provide a composite view of all the prevention efforts taking place in the state that relate to issues such as teen pregnancy and STDs. That list will then be given to various state agencies, in order to provide awareness of the prevention efforts and resources that other agencies are participating in and have around the state. Hopefully, this will enable better collaborative efforts between these various separate entities. One of their goals is to reduce teen pregnancy and STDs by promoting the concept that sexual activity, pregnancy, and child rearing are serious responsibilities. They plan to accomplish this by reaching the following benchmarks:

- By the year 2005, reduce the percent of 15-19 year olds who report ever having sexual intercourse to 43%
- By the year 2005, reduce the pregnancy rate for female 15-17 year olds to 27 per 1,000
- By the year 2005, reduce the birth rate for female 15-17 year olds to no more than 15 per 1,000

Related to this area is the issue of abstinence. The state applied for and received a grant from the federal government for abstinence education. It is a five year funded grant. Montana has designed their program as an education tool to provide adolescents with the skills to postpone sexual activity, and also to provide parents with better communication skills to help teach their children about abstinence. The purpose of the abstinence program is to reduce the number of teens who have engaged in sexual intercourse and to reduce the rate of pregnancies and sexually transmitted diseases. They hope to accomplish these goals by involving parents, public officials, educators, medical and health care providers, the religious community, community leaders, and the business community throughout the state. They are currently accepting requests for proposals (RFPs) from local communities that wish to provide abstinence only education. To date, the abstinence program has conducted two state wide campaigns which were positively evaluated and has ten local projects in place focusing on abstinence only education.

Adolescent Suicide: According to 1998 data, Montana had a suicide rate of approximately 16 per 100,000, which compares to a national rate of approximately 9.6 per 100,000 (MT Vital Statistics and Healthy People 2010 Objectives). A great majority of these suicides occurred among the young, male population. In Montana, suicide is the second leading cause of death among persons aged 15-19. Montana ranks third highest ranking in the nation for the death rate from suicide (Montana Youth Risk Behavior Survey, 1999). In 1998, there were seventeen youth age 10-19 that committed suicide in

Montana. Seven of these suicide deaths occurred in children age 10-14. The State Adolescent Health Coordinator notes that while teen suicides in the 15-19 year old age range have stabilized the numbers are increasing among 10-14 year old youth. According to the 1999 YRBS, 19% of Montana youth seriously considered suicide, with 16% making a plan to attempt suicide, and 7% actually attempting it. Currently the State Adolescent Health Coordinator along with the EMS Director and other collaborators are working towards developing a psychological autopsy process to look at environmental factors that may be playing a role in these young deaths. A steering committee was developed at DPHHS to combat the problem of teen suicide and began meeting in May 2000. The committee will develop a plan to help counties or cities in Montana define and build their own suicide prevention programs. This will be a challenge as there are 15 counties in the State that have no mental health program located within the county.

A survey was sent out by the Adolescent Coordinator with questions as to whether or not communities across the state had any prevention, intervention, or postvention resources to deal with suicide. Most respondents did not know of any resources in their community, and those that had resources had mainly intervention and postvention, rather than prevention. Much work needs to be done in this area if Montana is to see a decrease in its incidence of adolescent suicide.

Substance Abuse: In Montana, during 1997, 23% of child mortalities under the age of 15 involved an alcohol-related motor vehicle accident. This was greater than the nation's rate of 21% (Kids Count). According to the 1999 YRBS, 86% of Montana youth reported drinking alcohol in their lifetime compared to a national rate of 80%. Fifty-eight percent of Montana youth also had had at least one drink of alcohol in the past 30 days, compared to a national average of 52%. In 1997 27% of students surveyed reported driving after drinking alcohol during the past 30 days. This statistic dropped to 23% on the 1999 student survey.

On a survey given to elementary school teachers in 1999, 24.8% estimated that they had students who smoked. In Montana's 1996 dental needs assessment, 23% of adolescents used smokeless tobacco, double that of the national average. According to the 1997 YRBS, 25% of students smoked, which is identical to the national average. The YRBS also found that 33% of Montana males surveyed used chewing tobacco.

The 1997 YRBS also found that 34% of junior high students used alcohol before sex, and 30% of senior high students used alcohol before sex. Twenty-seven percent of Montana youth used marijuana during the past 30 days, compared to a national rate of 25%. Ten percent of Montana youth used any form of cocaine during their lifetime, compared to a national rate of 7%. Finally, 3% of Montana youth had ever injected any illegal drugs during their lives, compared to a national average of 2%.

Mental Health: Montana continues to struggle with having adequate mental health resources, especially for Medicaid clients. With the dissolution of the managed care mental health plan for Medicaid patients in 1999, this has become a serious issue. This issue spans across all the age groupings, but is of special importance with the state's youth considering the high rate of teen suicide. Montana ranks sixth in the nation for the percent of population lacking mental health services according to the Montana Office of Rural Health, 1999.

Violent Crime: Also of concern is the state's growing violent crime rate. It is the fifth fastest growing rate in the country. Gangs and gang-related activity have begun to appear in Montana. These are new issues for Montanans, but they can no longer be viewed as issues that occur only in urban areas of the

country. For a ten-year period between 1985 and 1995, the violent juvenile crime rate increased 139% (Kids Count). The following tables, from the Montana Board of Crime Control, record the percentage of crimes committed by sex and age of adolescent, for 1994-1997.

Female Crimes by Age	1994	1995	1996	1997
Less than 10	2.53%	2.14%	1.54%	1.22%
10-12	5.66%	7.89%	9.53%	7.31%
13-14	20.79%	26.31%	33.36%	26.30%
15	21.26%	21.65%	21.37%	27.70%
16	21.95%	23.12%	19.88%	22.17%
17	18.04%	18.90%	14.33%	15.80%
Male Crimes by Age	1994	1995	1996	1997
Less than 10	2.35%	3.23%	2.79%	1.82%
10-12	10.21%	11.39%	10.99%	9.35%
13-14	21.25%	25.25%	28.62%	24.17%
15	17.21%	18.47%	20.69%	20.53%
16	18.34%	20.12%	19.21%	23.80%
17	20.04%	21.54%	17.71%	20.35%

The following table, also from the Montana Board of Crime Control, is a comparison of adolescent offenses from 1994-1997. A key point of this table is seen when noting the increase from 1994 to 1997 of adolescents being charged with drug offenses.

OFFENSE	% REPORTED			
	1994	1995	1996	1997
Crimes against Persons	12.73%	13.20%	13.63%	14.66%
Crimes against Property	40.29%	40.27%	38.33%	36.68%
Crimes against Public Order	6.14%	7.31%	6.19%	6.31%
Crimes Against Public Admin.	4.89%	5.67%	6.08%	8.09%
Drug Offenses	4.91%	5.42%	6.85%	6.69%
Status Offenses	21.99%	20.64%	21.90%	22.01%
Other	9.05%	7.49%	7.02%	5.56%

Children with Special Health Care Needs

Disability Prevalence: Montana uses a broad definition of children with special health care needs to include children at high risk. Inclusion of “at risk” children has allowed services to be more inclusive. It is estimated that 18 % of children in the state have special health care needs. According to 1998 figures, 51,014 children in the state were considered to have special health care needs.

Congenital Anomalies: The following is a table of the top seven birth certificate reported congenital anomalies for 1995 and 1996. This is not an unduplicated count, as some children may have had more than one anomaly.

ANOMALIES	1995	1996
Heart Malformations	14	7
Other Circulatory/Respiratory Malformations	23	16
Other Urogenital Anomalies	20	11
Cleft Lip/Palate	11	25
Other Musculoskeletal or Integumental Anomalies	14	14
Down's Syndrome	10	11
Other Anomalies	82	53

Source: MT Vital Statistics, 1997

Special Health Services (SHS) and SHS Clinics: The SHS section of the Family and Community Health Bureau is the state Children with Special Health Care Needs (CSHCN) program. This section provides or supports several clinics across the state of Montana. These clinics include cleft/craniofacial, pediatric neurology, juvenile rheumatoid arthritis, metabolic, genetics, growth disorders, diabetes, and hemophilia clinics. In 1998, 57 specialty and subspecialty clinics were conducted serving 852 children in conjunction with private providers.

In addition to SHS there are services available to children with special health care needs through the federally sponsored Part C/Early Intervention program. The combination of programs work together to provide Montana infants and children with disabilities, and their families comprehensive and appropriate intervention services.

Additional information on programs and services for Children with Special Health Care Needs are presented under the Infrastructure Building Services section of this report.

Montana Medical Genetics Program: Children with special health care needs (CSHCN) are also served through the Montana Medical Genetics Program at Shodair Hospital. The program provides approximately 60 annual clinics in a year around the state. This program is the only source of comprehensive prenatal genetic diagnosis and management of genetic high-risk pregnancies in the state. Shodair Hospital in Helena provided the following genetic services in 1997: 539 field clinics, 110 fetal pathological examinations, 990 examinations of cytogenic specimens, and 3,185 alpha-fetoprotein analyses.

Montana Birth Outcomes Monitoring System: The Montana Birth Outcomes Monitoring System (MBOMS), is a relatively new system which will assist in early identification and surveillance of newborns and infants with targeted birth outcomes. Other goals of the MBOMS include decreasing the incidence of birth defects through population and client specific education, and improved services to affected newborns to promote healthy outcomes. MBOMS was initiated through the assistance of CDC and will greatly increase the infrastructure building capacity of the state, and allow more children to be placed in follow-up services if a screen is positive for any defects.

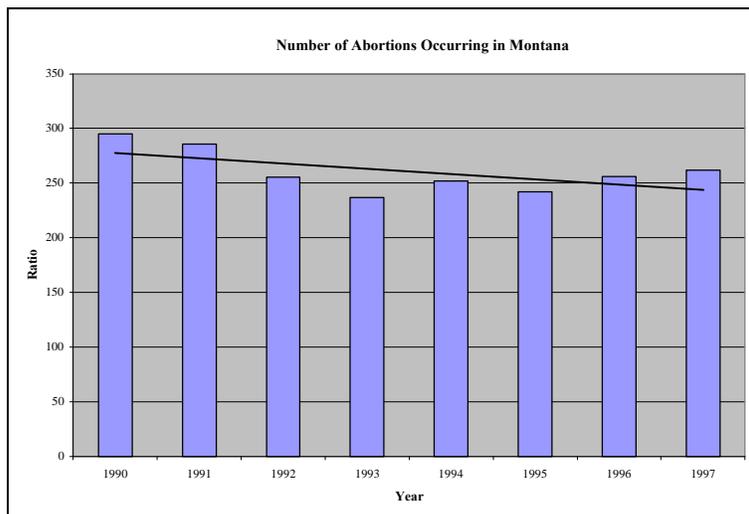
Status of Women of Childbearing Age and Families

Causes of Death: The top five causes of death for white females of all ages (1995-1998) continue to be circulatory system diseases, cancer, chronic obstructive pulmonary diseases, pneumonia and

influenza, and unintentional injuries. The top five causes of death for Native American females (1995-1998) are: circulatory system diseases, cancer, diabetes, unintentional injuries, and chronic obstructive pulmonary diseases, with chronic liver disease and cirrhosis very close behind.

Unintended Pregnancy: Unintended pregnancy is a cause for concern within this population. Infants from an unintended pregnancy are at an increased risk for low birthweight, poor growth and development, and abuse or neglect. Currently, the state medical officer is conducting a survey across the state on the “intendedness” of a pregnancy. It is estimated that in Montana more than half of all pregnancies are unintended—mistimed or unwanted, with that number being higher for adolescent pregnancies. In CY 1997 statewide family planning clinics prevented an estimated 18,680 unplanned pregnancies. This prevented an estimated 12,573 unplanned births, 2,679 abortions, and 3,412 miscarriages.

Montana monitors the rate of unintended pregnancy as one of the MCH Block Grant State negotiated performance measures. The rate of unintended pregnancy was 69% in 1997, 67% in 1998, and the 2000 objective is 63%. The rate of unintentional pregnancy is closely tied to the abortion rate. The following graph is the ratio of abortions that occurred in Montana from 1990 to 1997.



Source: MT Vital Statistics, 1997

Domestic Violence: Domestic violence is a significant issue in the state of Montana. There have been several things done within the past few years to help combat this problem. The Montana Coalition against Domestic and Sexual Violence (MCADSV) continues to assist women in the state in many ways. Recently, the Montana Domestic Violence Batterer’s Intervention Program (MDVBIP) created an advisory panel to create standards for batterer’s intervention programs. A survey was done by the DPHHS, regarding domestic violence within the state. Montana has begun to monitor the counties that consistently screen their patients for domestic violence as one of their state negotiated performance measures within the MCH Block Grant. The 1999 pre-contract survey showed that only 50% of counties are screening for domestic violence currently. For a clearer picture of domestic violence in the state, see the report which was developed by a graduate student intern who worked with the department in the summer of 1999 (Appendix P). This appendix provides a brief assessment of programs and resources in Montana related to domestic violence. An MPH intern student working within the Family and Community Health Bureau in the summer of 1999 completed it.

Substance Abuse: According to the Addictive and Mental Disorders Division, in a 1997 study, alcohol use was determined to be the most pervasive drug problem in Montana—even surpassing national rates. In their study, of 3,144 women sampled from the general population, approximately 21% of 18-24 year old women indicated that they currently have a substance use disorder. This result can then be viewed in correlation to MIAMI data on high-risk pregnant women that reveals higher rates of substance use and abuse during pregnancy. It is also noted that cigarette smoking among females in the state is also increasing, especially among the Native American population. On a survey given to elementary school teachers in 1999, it was estimated that 50% or more of school children are exposed to some type of smoking in their home.

Family Planning: There is a continued need for increased family planning services in Montana. It is estimated that of 46,570 women in need of subsidized family planning services in Montana, 35% (16,093) did not receive services in 1998. In Montana, family planning is one component of the Women’s Health Section of the Family and Community Health Bureau. This section administers Title X federal funding for the provision of family planning. The mission to improve the reproductive health of Montana people during their reproductive years compliments the mission of Bureau. Family planning services are directed towards achieving the following goals:

- Improve and maintain the emotional and physical health of men, women, and children, particularly through the detection and prevention of cancer and sexually transmitted diseases
- Reduce the incidence of abortion by preventing unplanned pregnancies
- Improve pregnancy outcomes by correction of health problems between pregnancies and by proper spacing and timing of pregnancy
- Assure that more children are “wellborn” by decreasing the incidence of prematurity and birth defects
- Decrease maternal and infant mortality and morbidity
- Assist couples who want to have children but cannot
- Prevent unplanned pregnancies (particularly in child abuse and poverty situations)
- Assist couples in having the number of children they desire so that every child is intended and loved

In 1998, family planning held 348 educational sessions across the state, and 10,038 people attended. Currently, the Women’s Health Section is working on a plan that would extend the time a woman is eligible for family planning services covered by Medicaid to six months after she delivers her child.

Sexually Transmitted Diseases (STD): In incidence of STDs is a public health concern. The following table shows the prevalence by year of the top four reportable STDs in the state from 1995-1998.

YEAR	AIDS	CHLAMYDIA	GONORRHEA	SYPHILIS
1995	37	1,220	69	19
1996	46	1,228	38	4
1997	47	1,208	67	5
1998	NA	1,414	NA	0

Source: MT Vital Statistics, 1997 and AIDS/HIV Bureau Data

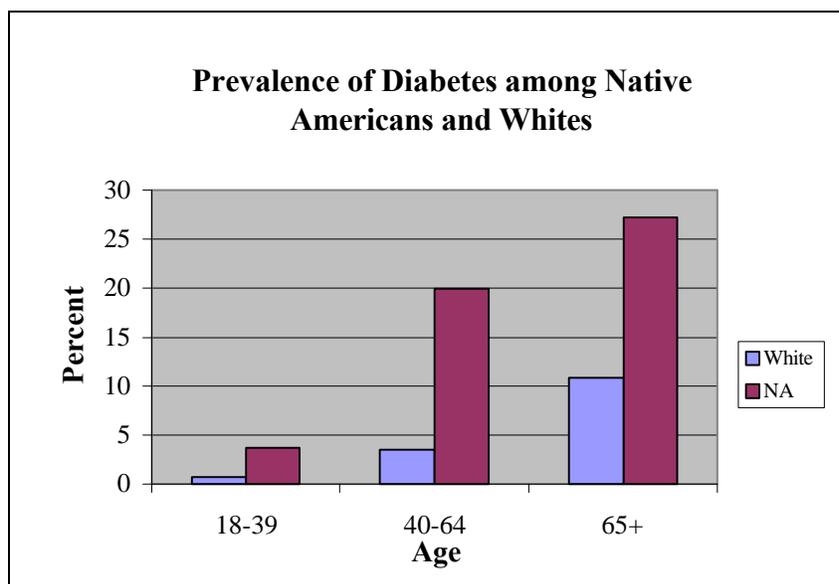
Of concern, is the fact that there is an increase in chlamydia and AIDS, but no established pattern for gonorrhea. It seems to come in cycles, which is always a difficulty to deal with for public health professionals who try to determine the environment that is related to these sorts of behaviors.

A high chlamydial rate can indicate risk factors for other STDs, and can serve as a surrogate marker to the number of individuals having sex without a condom. The following table compares the national rate of chlamydia versus the state rate, and also shows the different rates in the state health planning regions. When separated by region, disparities become visible. There are a higher percentage of minority populations in Region 1 and II.

Year	Laboratory-Confirmed Chlamydia Case Rates (per 100,000)						
	Nation	State	Region I	Region II	Region III	Region IV	Region V
1994	188	179	176	215	204	123	150
1995	189	152	137	237	160	120	113
1997	130	137	170	217	144	94	112
1998	NA	161	168	296	161	113	123

Source: AIDS/HIV Bureau Data

Disparities in Diabetes Incidence: American Indians in Montana experience a higher incidence of diabetes than do any of the other races within the state. The following graph is from data received from the 1997 Special Survey of the Behavioral Risk Factor Surveillance System (BRFSS), revealing the higher prevalence of the disease for those respondents residing on or near a reservation.



The prevalence of diabetes among Native American women residing on or near a reservation is 13.2%, compared to a rate of 4.3% for White women residing in the same area. This raises an important concern for American Indian women related to morbidity and mortality, especially in the childbearing years.

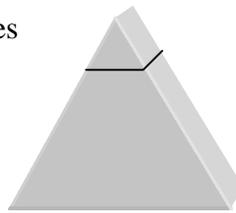
Other women’s health concerns in the state include increasing the awareness and prevention of breast and cervical cancer and the prevention of osteoporosis. The state family planning clinics provide breast and cervical cancer screening for any client receiving prescription contraceptives at the clinics as part of Title X requirements. Follow-up on abnormal pap smears is initiated by the clinics. Women age 50-64 years are addressed through a state breast and cervical cancer prevention program funded by CDC.

The Women’s Health Section of the Family and Community Health Bureau recently assessed the needs of providers on the provision of information on osteoporosis prevention. Based on results of this survey they developed an informational brochure available to family planning clinics.

HEALTH CARE SERVICES

The following section will describe public health services available in Montana and state priority concerns for each of the four core public health service areas.

3.1.2.2 Direct Health Care Services



The private sector medical community in Montana primarily provides direct health care services. State public health providers such as public health nurses also provide direct services that fill some of the gaps in health care to increase access to health care for all women and children in Montana. The following is a list of state priority concerns related to the availability of direct health care services in Montana.

- Lack of health care due to financial barriers
- Health care professional shortages
- Large physical distances to reach providers/specialists
- Lack of dental care access throughout the state
- Lack on access to mental health care

The following tables describe examples of direct health care services in Montana provided through public health programs that serve to fill gaps in direct care for each target population

Pregnant Women and Infants

Program	Target Group	Eligibility	Program Description	Provider
Well-Baby Checks	Infants	None	Medical professional exams to check proper development, etc.	PH Nurse
Prenatal Care	Pregnant women	None	Any direct service or procedure provided to a pregnant woman	PH Nurse

Children and Adolescents

Program	Target Group	Eligibility	Program Description	Provider
Well-Child Checks	Children 1-21	None	Medical professional exams to check proper development, etc.	PH Nurse
Migrant Children's Health Care	Migrant Children 1-21	Migrant Child	Program to provide migrant children with health care checks	Clinic Health Staff
Dental Care (Medicaid)	Children 1-21	Medicaid recipient	Program that provides dental care check-ups for children on Medicaid	Dentists

Children with Special Health Care Needs

Program	Target Group	Eligibility	Program Description	Provider
Part C/Early Intervention	CSCHN 0-3	Dev. Delay or, disability	Early intervention program providing support for parents with children eligible for the program; multiple services provided	Multiple: PT, OT, ST, Social Worker etc.
Cleft Palate Clinic	CSHCN	Medical	Clinic providing care, education, referral to other services for children with cleft palates	Multiple: MD, specialist, case mang.
Metabolic Outreach Clinics	CSHCN	Medical	Clinic providing care, education, and referral to other services for children with metabolic disorders	Multiple
Neurologic Disorders Clinics	CSHCN	Medical	Clinic providing care, education, referral to other services for children with neurologic disorders	Multiple
Juvenile Rheumatoid Arthritis Clinic	CSHCN	Medical	Clinic providing care, education, and referral to other services for children with juvenile rheumatoid arthritis	Multiple
Home-Based Clinical Care	CSHCN	Medical	Program that provides needed equipment (tube feeders, ventilators, etc.) for families	Multiple
Genetics Clinics	CSHCN	Medical	Clinic providing care, education, and referral to other services for children with genetics disorders	Multiple: Specialists

Women of Childbearing Age

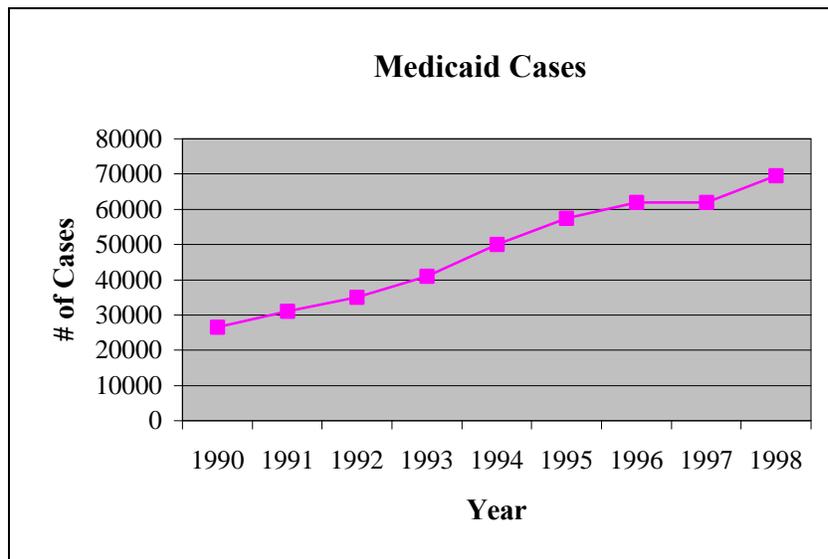
Program	Target Group	Eligibility	Program Description	Providers
Direct Family Planning Services	Women 15-44	None	Program that provides certain services (breast exams, pap smears, etc.) for women	Nurse, MD

FINANCIAL BARRIERS

Financial barriers to direct health care services have been a continued area of concern listed by public health nurses surveyed across the state. It is also an area of concern from the compilation of calls to the Healthy Mothers, Healthy Babies 1-800 number for assistance. In Montana an estimated 16.4 % of the population live at the poverty level according to the US Census Bureau 3-year average for 1996-98. The Census Bureau also estimates that 28% of children under age 5 in Montana live in poverty based on 1996 data. The Median Household income in Montana is only \$22,988 according to the 1990 census. Programs such as the Children Health Insurance Program (CHIP) is being initiated to increase the number of eligible children who enroll in Medicaid or CHIP to increase access to affordable health care for children.

Medicaid is the largest provider of health care coverage for children in the State of Montana. Medicaid covered 62,047 children in 1997 according to the Medicaid program report for the 2000-2001 legislature. Of the Medicaid recipients in 1997, 59.7 % were children. Children accounted for only 20.4 % of total Medicaid cost however in 1997. The majority of cost (73.7%) provided services to the blind and disabled, or aged. Low-income pregnant women are also eligible for Medicaid. The program limit is \$3,000 per pregnancy and the income limit is based on 133% of the federal poverty level.

Medicaid has seen an increase in their caseload over the past few years. In 1995, Medicaid had approximately 57,000 cases. As of February 1999, there were approximately 70,000 Medicaid cases.



Source: MT Statistical Report, February 1999

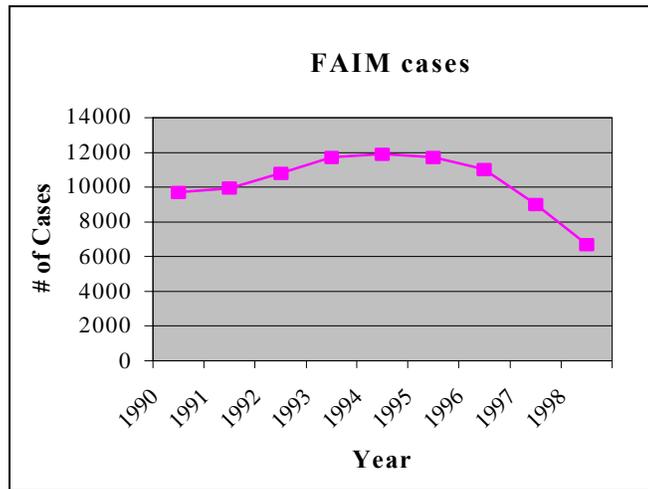
Medicaid eligibility varies by income. Children age 0-19 whose family income satisfies Temporary Assistance of Needy families (TANF) criteria are eligible for full Medicaid coverage. Family income must be below 40.5% of the Federal poverty level to meet TANF criteria. Families with an income at or below 133% of the federal poverty level are eligible for full Medicaid coverage for their children 0-5 years of age. The federal OBRA 89' legislation required all states to implement full or at a minimum, "phase in" coverage for children age 6-18 years whose families were at 100% of the federal poverty

line or below. Montana chose to “phase in” children age 6-13 years in 1997. By 2002 Montana will cover all children 18 years and under in families earning up to 100% of the federal poverty level.

Medicaid in Montana provides reimbursement for medical services rendered to Medicaid eligible American Indians who receive health care services through Indian Health Services (IHS) facilities or contracted providers. The reimbursement to IHS for Medicaid services has grown from 4 million in 1993 to 15.8 million in 1998 inclusive of all age groups.

Several changes occurred in Montana Medicaid over the past five years. The Families Achieving Independence in Montana (FAIM) program was implemented in 1995, which is Montana’s welfare reform program. FAIM resulted in reducing the number of individuals on welfare. FAIM however did not change service coverage for children, pregnant women, the elderly or disabled.

According to the Montana Statistical Report (February 1999 edition), FAIM has seen a significant decrease in its caseload. In 1995, FAIM had approximately 11,700 cases. As of February 1999, that fell to approximately 5,300 cases. The following is a graph of the FAIM caseload for the time period of 1990-1998.



Source: MT Statistical Report, February 1999

Also in 1995 the Medicaid HMO program was implemented for AFDC recipients in counties where HMO’s exist. As of May 1997 there were four participating HMO’s in the state. In 1996 Medicaid departmental reorganization was also implemented resulting in decentralization to divisions responsible to specific populations.

It should be noted also that under the federal Early Periodic Screening, Diagnosis, & Treatment (EPSDT) legislation, states are required to provide children with any medically necessary service regardless of whether that service is part of the state Medicaid package of approved services. In Montana EPSDT is administered under the Medicaid program.

The Children’s Health Insurance Program (CHIP) state plan was submitted in 1998. This program provides funds for premiums to purchase insurance for children 18 and under who meet financial eligibility and are not eligible for Medicaid. Outreach for the CHIP program is predicted to increase

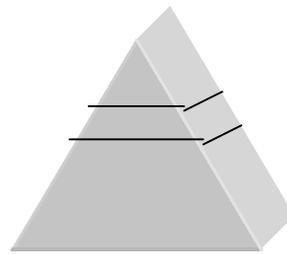
the number of children on Medicaid. This program will be discussed further under the Enabling Section that follows.

AVAILABILITY OF HEALTH CARE IN MONTANA

Distribution of health care providers varies greatly across the state. In December 1999 there were 10 counties that did not have any primary care physicians. In addition 12 counties had a ratio greater than 2000:1 of population per primary care physician (see map 1 in the map section of this report). There were 22 counties that were designated Medically Underserved in the same time period. Another 12 counties also had partial county designation (Appendix A).

Montana has a limited number of Pediatricians and OB/GYN's with most of these located in the counties of Flathead, Missoula, Lewis & Clark, Cascade, Gallatin and Yellowstone (see Appendix A). In December of 1999 there were 88 Pediatricians practicing in the state including sub-specialties and 88 OB/GYN's.

3.1.2.3 ENABLING HEALTH CARE SERVICES



Health care services that are classified as “enabling”, are services that increase access for women and children to health information and providers. Examples of enabling services in Montana are presented in the tables below.

Priority State concerns in this category are:

- Increasing the number of children that are covered by health insurance
- Continuing to provide and expand outreach to “at-risk” pregnant women
- Continuing to provide and expand services to “at-risk” children and families
- Pregnant Women and Infants

The following table is a list of the enabling programs and resources provided for pregnant women and infants.

Program	Target Group	Eligibility	Program Description	Provider
WIC	Pregnant women, infants, children	Medical/Nutritional Risk, Finan. limits	Nutritional Education, Food supplements, breast feeding education, lead screening, referrals to health care Providers, Federally funded	WIC Staff
MIAMI	Pregnant women	High risk pregnant woman	Program that addresses the barriers to the reduction of infant mortality (prenatal care, medical care, etc.)	PH Nurse, SW, Dietician
Follow Me	At risk infants 0-1	At risk infants for biological, develop., or environ. factors	Intensive home visiting and targeted case management program	PH Nurse, SW, Dietician
SIDS Follow-up	Infants 0-1	None	Follow-up program after a SIDS death-provides parental support, education	PH Nurse

Maternal and Infant Nutrition (WIC): WIC provides nutritional education, food supplements, and often serves as the catalyst to entry into other needed health care services. Montana currently has 107 clinics in operation across the state. These clinics provide WIC services to all 56 Montana counties and 7 reservations. They average a monthly caseload of approximately 21,500, which includes approximately 5,000 women, 4,300 infants, and 12,300 children. There were an estimated 35,600 potentially eligible women, infants and children statewide in SFY 1998 according to the WIC website: <http://wwwldphhs.state.mt.us/hpsd/pubheal/healsafe/nutritn/overview.htm>. Approximately 60 percent of those eligible for WIC were served by the program. Eligibility requirements include an income below 185% of the federal poverty level. WIC clients must also be determined by a health professional to be at medical or nutritional risk. Participation in WIC can lower Medicaid costs for mothers and newborns. WIC children are better immunized and more likely to have a regular source of health care.

WIC has also been very instrumental in the development of the IDEA project, which is a data integration project for state and county agencies. When this system is implemented it will hopefully begin to have an impact on the efficiency and coordination of public health services.

MIAMI: High-risk pregnant women are served through Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) program, which fosters increased access to health care services for at-risk mothers and infants. This program was initiated in 1986. MIAMI was designed to address barriers to the reduction of infant mortality, provide assurance that mothers and children will be able to access quality maternal and child health services, and reduce the incidence of low birth weight infants, infants born with chronic illnesses, birth defects, and severe disabilities resulting from inadequate prenatal care. MIAMI includes four key components:

- Local care coordination services for high-risk pregnant women
- Public education regarding the importance of early and continuous prenatal care, which leads to a healthy pregnancy outcomes
- Fetal, infant, and child mortality reviews (FICMR)
- Medicaid changes which assure access to services that improve the health of pregnant women, mothers, and infants

Through MIAMI the client receives home visiting by a public health nurse, social worker, and dietician. The program also provides education about the benefits of early prenatal care, and resources to improve access to medical care, to increase the likelihood of a successful term pregnancy.

MIAMI targets the 20% of the pregnant population most at risk for negative pregnancy outcomes. As of 1998, there were MIAMI programs in 32 counties and 4 reservations in Montana. These MIAMI programs provide annual care coordination for approximately 1,500 high-risk pregnant women.

Home Visiting: “Follow Me” is a specialized home visiting program for children with developmental, biological, or environmental risk factors. Follow Me currently provides home visiting for children ages 0-5, in 16 counties. The goal of the program is to enhance child health and development, promote parenting, and ensure early intervention service for identified “at risk” infants and children. The program is designed to follow children to and through systems of intervention for needed services, up until school entry. In 1996, 2,622 children were enrolled in the program. The number of children served increased to over 4,000 children in 1998. Expected outcome goals of the program include:

- Up-to-date immunization status
- A reduced incidence of substantiated child abuse and neglect
- Periodic developmental screening and assessment
- An identified medical home where they receive routine medical care
- Living in families where subsequent children are planned and spaced in at least two year intervals

An outcome-based evaluation plan for the Follow Me home visiting program was constructed in 1998 and resulted in a plan, which is being implemented at the State level.

Children and Adolescents

The following table is a list of the enabling programs and resources provided for children and adolescents.

Program	Target Group	Eligibility	Program Description	Provider
Follow Me	At risk children 0-5	At risk for biological, develop., or env. factors	Intensive home visiting and targeted case management program	PH Nurse, Social Worker, Dietician
CHIP	Children 1-18	150% FPL and not eligible for Medicaid	Children’s insurance program	Access to professional medical care
Caring Program	Children	Below 150-185% of poverty level	Program that provides health care coverage for children with financial barriers. Funded by donations and matching funds.	Access to professional medical care
MT Children’s Trust Fund	Children And parents	Open to submitted proposals	Funds proposals that function to prevent child abuse in communities across the state	Varies by proposal
Montana Promise	MT Youth	Open to submitted proposals	Provides seed money for projects that support the health and well being of youth in Montana	Varies by proposal

The Follow-Me program was described in the prior section under programs for women and infants.

Montana's Children's Health Insurance Plan (CHIP) is a low-cost, private health insurance plan that provides health insurance coverage to eligible Montana children through age 18 that are not eligible for Medicaid coverage. Financial eligibility is based on a family's adjusted gross income. CHIP is funded by the federal government, (\$11.7 million), state government (\$2.6 million) and parents share in the cost of the insurance through an annual enrollment fee and a co-payment for each visit.

A pilot program for CHIP was authorized by the 1997 Montana Legislature and enrolled approximately 1,000 children. The 1999 Montana Legislature appropriated money to expand CHIP. Approximately 10,000 Montana children are now authorized to receive health care benefits. As of June 1, 2000, 5,821 children have been enrolled with a steady increase of 600-800 children enrolling in CHIP per month. As of June 1, 2000 DPHHS eliminated an annual \$15 enrollment fee and the co-payment for American Indian children. Healthy Mothers, Healthy Babies, a recipient of the Robert Wood Johnson "Covering Kids" grant is a contractor working with the State CHIP office to identify and enroll uninsured children in Medicaid and the CHIP insurance plan.

The Caring Program provides funding for health care expenses for children that are not covered by insurance programs. This program is administered through Blue Cross Blue Shield of Montana and is funded through grassroots, private and public donations.

Two additional programs provide support to increase the health and well being of children across the state by funding individual proposals. These programs are the Montana Children's Trust Fund and the Promise programs. The Montana Children's Trust Fund provides grant money for projects that aid in the prevention of child abuse. Funds for this project come from a variety of sources including federal funds, state divorce filing fees, and income tax checkbox donations. For 1998-1999, the Fund was able to allocate money to ten very different projects across the state. The Missoula City/County Health Department was funded based on their program that provides parenting education and intensive home visiting to parents identified as having cognitive limitations. The Montana Women's Correctional Center was funded based on their program that provides parent education, intervention, and mentoring for female inmates to encourage positive parent-child bonds. These are just two examples of the programs that were funded this year. Other programs focused on issues such as teen parenting, forming multi-level partnerships among organizations, and single parenting. All programs funded by the Children's Trust Fund address ways to reduce child abuse and neglect in Montana communities.

Montana's Promise is a program that was developed from the Governor's Summit on Youth in the winter of 1997. The program's mission is to provide an additional 10,000 Montana youth with access to the five fundamental resources that can help them lead healthy, fulfilling, and productive lives: a caring adult, safe places, a healthy start, marketable skills, and opportunities to serve. It is in operation due to the efforts of businesses and individuals throughout the state who are committed to providing the five fundamental resources listed above to Montana's youth. As of January 2000, Promise had given out 25 seed grants, certified seven "Communities of Promise" with another 5 near certification. There were 35 communities with active Promise endeavors. The program had reached 7,315 youth at the beginning of 2000. Examples of funded programs are the Belgrade, MT program of reward and recognition for young people giving back to their community. A mentoring program in Gallatin County was funded for support of rural 8th grader's transitioning into the larger Gallatin County High

School. In Glasgow a program was funded for adult mentors working with youth on a greenhouse project to grow and sell native plants.

Children with Special Health Care Needs

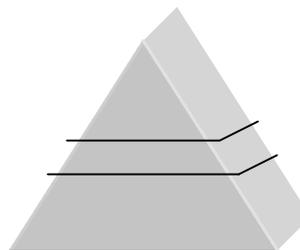
The following table is a list of the enabling programs and resources provided for CSHCN.

Program	Target Group	Eligibility	Program Description	Provider
Follow-up of Abnormal Newborn Screens	CSHCN	None	Follow-up program on abnormal newborn screens that facilitates links to other needed special services	Multiple
Follow Me	Children and families “at risk”	Identified risk factors	Follow Me is a public health nurse home visiting program that assist in identifying delays, and connects parents with needed services	Public Health Nurses
CHIP	CSHCN 1-18	150% FPL and not eligible for Medicaid	Children’s health insurance program	Multiple

Women of Childbearing Age

Family planning clinics provide enabling services to women of childbearing age in Montana by providing health education on issues such as sexually transmitted diseases, osteoporosis, and breast and cervical cancer prevention. Family planning clinics collect information on nutrition and lifestyle activities through intake forms and are able to direct clients to community resources for enhancing a healthy lifestyle. Family Planning clinics will be discussed further under Population Based Services.

3.1.2.4 POPULATION BASED SERVICES



Population Based Services are broad-based programs that aim to increase health screening and prevention of health problems. State Priority Issues related to population based services are:

- Increasing the availability of lead screening for children
- Increasing the number of immunized children
- Identification and surveillance of newborns and infants with congenital birth defects including FAS
- Decreasing the incidence of birth defects through education campaigns
- Increasing oral health among children
- Increasing the awareness of SIDS prevention and identification of cases
- Increasing the number of women screened for breast and cervical cancer

Decreasing unintentional injuries and death through improved safety awareness
 Decreasing teen pregnancy through education
 Decreasing the rate of adolescent suicide

Pregnant Women and Infants

The following table is a list of the population-based programs and resources available for pregnant women and infants in Montana.

Program	Target Group	Eligibility	Program Description	Provider
Pregnancy Risk Line	Pregnant women	None	Free hotline for pregnant women to call for information	Contract with providers
Well-Baby Screening	Infants	None	Medical professional screening exams to check the infant's development	PH Nurse at public screening clinics
WIC	Women, infants, and children	Percentage of poverty	Provides nutrition education, supplemental food, and referrals to other needed services	WIC staff
Statewide Immunization Efforts	Infants	None	Clinics to provide immunizations	Public health offices
MT's Child and Other Healthy Mothers, Healthy Babies' programs	Mothers and infants	None	Public education on topics such as breastfeeding, safety issues, and parenting; provides resources and link-ups to other services. 800 number for MCH questions.	HMHB staff
All Education Programs (pregnancy, FAS, prenatal, nutrition, shaken baby syndrome, SIDS, child abuse, etc.)	Pregnant women	None	Outreach programs to educate women on various issues	State staff disseminates information

Pregnancy Risk Line: This is a hotline service that is provided through a State contract with the University of Utah. Since 1986 the Pregnancy Risk Line (PRL), has provided women with a resource to call if they have any questions or concerns related to the effects of environmental exposures on pregnancy or breast-fed infants. The telephone service is available between 0830 and 1630 Monday through Friday. A data review for the PRL indicated that during January 1994 to June 1998, 70% of the calls received were from pregnant women, and 30% of the calls were from health care professionals. The Women's Health Section conducted a recent survey of OB/GYN and Family Practice physicians (n=359) to determine the awareness and use of the Pregnancy Risk Line. A summary of results can be found in Appendix Q.

Well-Baby Screening: Well-Baby screens of the infant population are performed by health professionals across the state of Montana. The state department strongly advocates for well-baby

screening. The Follow-Me home visiting program is one program that provides outreach to families with financial needs or with identified risks, in order to increase the number of infants who receive well-baby checks. Well-baby or child services are not mandated, but are recommended practices that the state encourages.

Whether or not an individual county spends MCH block grant dollars on well-baby screening is at the discretion of each county. Fiscal management decisions concerning local health departments vary for each county and the counties have the autonomy to spend their funds in the way they choose. Geographical distribution of public health services across the state varies related to county appropriation of funds.

WIC: WIC provides nutrition education, supplemental food, and usually serves as a catalyst to accessing other public health services. The state does not provide direct management of services in WIC. However, WIC works closely with other state MCH programs as they often serve the same clients. WIC is supported with 100% federal funds by the Department of Agriculture. No MCH block grant funds directly contribute to the program. Every county within the state has at least one WIC clinic, thus providing equality of geographical distribution. WIC serves as the lead agency for the lead screening program grant.

Statewide Immunization Efforts: Immunization efforts work much the same way as the well-baby screening from both a local and state perspective. Counties can choose to use MCH block grant funds to provide immunization programs. The state provides a data base system to track immunizations, and provides training and support.

Montana's Child: Montana's Child is project of Healthy Mothers, Healthy Babies (HMHB). This program was previously called "Baby your Baby" up until November 1996. The name change reflects a broader MCH scope covering pregnancy to age 18. Montana's Child is funded by public and private funds. It serves as a single point of contact for Montana families to learn more about maternal child health issues and related services. This program provides education as well as referral to services. Montana Child is accessible through a 1-800-telephone number. This 1-800 number is a state MCH contact number for public questions concerning issues related to pregnancy, child health and maternal health. This 1-800 number is answered by the HMHB office staff in Helena. Phone contact can provide referral to local services, disseminate information through follow-up mailings, and answer specific childcare questions. It is of interest to note what the majority of calls are about. Appendix O shows a recent summary of the types of calls received. These calls provide important public input into the needs of the state MCH population. Funding for the Montana Child program is provided through fund raising, grants and matching state medicaid funds.

There are other projects within HMHB with various public/ private funding schemes. These programs include the following list: *Covering Kids*, a program to increase children's health insurance coverage through advocating enrollment in state Medicaid and CHIP programs. Injury Prevention programs run by HMHB including; *Montana Safe Kids*, *Water Safety*, and *Bike Safety*. *DD PAC*, is a program to promote awareness of children with developmental disabilities and issues of concern in public service announcements. *Folic Acid Public Education*, is a program that collaborates with other agencies to help prevent congenital malformations. *Promoting Action for Teen Health Project*, is a program to promote teen health and teen pregnancy prevention. In an effort to increase awareness of the oral health issues, HMHB completed a survey on dental coverage for children in the state.

HMHB participates in the *Montana Children's Alliance*. This alliance of people from various private and government organizations meets every two years to write the Montana Children's Agenda for each state legislative session. The Children's Alliance was formed in 1987 and will be covered under the infrastructure building section. Appendix O contains publications from the *Children's Alliance*.

Education Programs: There are several state-run education programs in the state of Montana. The focus of some is to provide training of trainers to better educate the public on public health issues. For example, the MCH block grant funds support the spring meeting of public health nurses in the state, regional public health meetings, public health nurse orientations, and other meetings in which nurses are trained on subjects such as fetal alcohol syndrome, prenatal care, nutrition, and many other issues. The nurses then take their acquired knowledge back to their communities to educate the local community. The nurses are required to attend either the spring meeting or the annual public health association meeting in Montana, to continue their contracts.

The Family and Community Health Bureau staff directly provides educational inservices to the nurses, or may contract with someone who can provide the needed education. Unfortunately, the geographical distribution of educational services may vary. The state tries to provide meetings in the various regions of the state, but that does not guarantee that the nurses will be able to participate.

Children and Adolescents

The following table is a list of the population-based programs and resources for children and adolescents.

Program	Target Group	Eligibility	Program Description	Provider
Fluoride Mouth Rinse Program	Children 5-18	None	Fluoride mouth rinse is provided to all children in serviced schools to help prevent tooth decay	Schools where available
Well-Child Screening	Children 1-18	None	Medical professional screening exam to check child's development	Private and PH clinics
WIC	Women, infants, and children	Percentage of poverty	Provides nutrition education, supplemental food, and referrals to other needed services	WIC clinics
Statewide Immunization Efforts	Children 1-21	None	Clinics to provide immunizations	PH clinics
Lead Screening	Children 1-6	None	All children, especially those at high-risk should have their blood lead levels checked	WIC clinics and private clinics
Adolescent Suicide Prevention Efforts	Children 10-19	None	Psychological autopsy being developed; looks at prevention to postvention resources in a community	
School Nurse/Screening	Children 5-18	None	Screening for hearing, vision, dental, and scoliosis	School Nurses

Injury Prevention Efforts	Children 1-21	None	Results of FICMR efforts—prevention efforts to reduce unintentional injuries	PSAs
Nutrition Education	Children 5-18	None	School-wide education on the importance of good nutrition	Schools
Substance Abuse Education	Children 5-18	None	School-wide education on substance abuse	Schools, DARE
Abstinence Education	Children 10-19	None	Education program to reduce teen pregnancy, STDs, by teaching abstinence from sexual intercourse	State Abstinence Education Program
Montana Behavior Initiative	Children 5-18	None	Program within certain schools that focuses on the reduction of violence within communities	

Fluoride Mouth Rinse Program: The fluoride mouth rinse program is provided to all county schools when requested. It is a free oral health prevention program for students, paid for by MCH block grant dollars. A school nurse or local public health nurse administers the fluoride rinse to students. The state does not provide direct management of this program in the schools. The state’s primary role in this program is to dispense the resources and provide advice and recommendations when needed. Most schools across the state have the program, but some rural counties are currently not participating.

Well-Child Screening: Well-Child screens are carried out in the same manner that well-baby screens are done as discussed in the section above. The state strongly advocates for the inclusion of well-child checks into the health practices of all Montanans. The Follow-Me program provides outreach to families, which may otherwise not receive this service.

WIC: For a more detailed look at this program, read the above section in the pregnant women and infants portion on population-based services.

Statewide Immunization: This program was also covered earlier in the document in the pregnant women and infants section of population-based services.

Lead Screening: The lead screening program is managed by the WIC office. The state DPHHS and WIC collaborate on program management. This program is primarily funded through a grant that was recently received to improve lead screening of children. These funds are used in conjunction with other grant funding to provide education and information to localities that have a higher incidence of lead exposure—such as Superfund sites and mining towns. Recently Medicaid agreed to reimburse providers for blood draws providing a reimbursement of \$3.00 per capillary and venous draw. There is an effort to increase the number of children screened in the state. The lead-screening program was available in 39 of the 56 counties in 1999. The director of the program is encouraging more physician involvement to increase the number of children screened in Montana.

Adolescent Suicide Prevention Efforts: The state has recognized the growing problem of adolescent suicide and has been active in finding ways of addressing this important concern. The adolescent

coordinator for the state, along with the EMS director have conducted a survey to determine exactly what type of prevention efforts are currently taking place within the state. The state is currently looking for grant funding that can help supplement the work they would like to do. They hope to set up suicide prevention education programs throughout the state, especially for the counties that had a higher suicide rate in the last ten years. These education efforts would not only cover the issue of suicide directly, but underlying issues such as substance abuse, violence, and family issues.

School Health Screening: School Health Nurses are funded primarily by school districts in Montana. In 1999 there were only 43 school nurses in Montana full or part-time, and one school-based health center. The state DPHHS surveyed schools in Montana in 2000 to further assess the needs of school nurse programs. The survey found that 76% of school nurses were employed by a school district. The average number of hours worked per week was 24.4 hours. The National Association of School Nurses recommends a nurse to student ratio of 1:750. Montana nurses noted ratios as high as 1:5108. Needs identified by the survey of school nurses included:

- Continuing education for school nurses
- Decrease the ratio of nurse to students
- State legislation that mandates school health programs for all children

Since not all schools have nurses some districts contract with county public health nurses to provide school screening. Conflicts develop when a nurse contracted to provide screening is also expected to see children with acute illness within the schools. The DPHHS is currently working on policies and standards for public health nurses working in schools. Most schools do provide health screening for children, with smaller counties contracting with larger counties to provide services.

Availability of school nurses is an important issue due to a number of factors. These factors include the rise in the number of children requiring asthma medication at school, children with special needs requiring medical assistance, uninsured children lacking financial access to medical care, adolescent suicide rates, and the rural nature of the state that limits health care access. School nurses provide the school with the ability to screen children for mental and physical health issues and refer them to the appropriate level of care and resources.

Injury Prevention Efforts: The state EMS director recently received a grant to set up more injury prevention education throughout the state. This program is an offshoot of recommendations made by FICMR teams. Seatbelts and child restraints are an important issue in the state. There is currently collaboration between the state DPHHS, the governor, the media, and the police departments within the state on this issue.

Nutrition Education: WIC provides nutrition education to all of its clients, but some schools also provide a great deal of nutrition education to school age children. Nutrition education is not mandated, and therefore there are disparities found concerning the availability nutrition education in all schools. There are no MCH block grant dollars that contribute to this issue. The availability of nutrition education for children in Montana is currently governed by school district's or county's priorities. There is a need for increased DPHHS collaboration with agencies and organizations to improve education on nutrition issues. Obesity among children has begun to rise in the US and childhood obesity is an identified MCH concern by the Indian Health Services. Childhood obesity leads to increased incidence of diabetes among children.

Substance Abuse Education: Substance abuse education for children and adolescents takes place largely at the local level via schools, police department programs, and through PSAs. Substance use and abuse is very much an issue of concern within the state of Montana, and more prevention education is needed. The issue of drug abuse can be closely associated with other issues such as domestic violence, unintentional injuries, and suicide. Collaboration is needed to increase efforts between groups to prevent substance abuse. MCH block grants dollars are not currently directly involved in substance abuse programs.

Abstinence Education: There are two types of abstinence education, abstinence-based, and abstinence-only. Both promote abstinence as a means of birth control. However abstinence-only education does not allow the discussion of other methods of birth control. Abstinence-only education is funded through a federal grant that was recently received by the state. The Women's Section of the DPHHS manages the administration of grant funds to abstinence-only programs. Schools determine whether or not students receive abstinence-based or abstinence-only education. Abstinence education versus family planning for teens remains a controversial area.

Abstinence education, as defined by the federal MCH Bureau, means an educational or motivational program that follows the following criteria:

Has the exclusive purpose of teaching the social, psychological, and health gains to be realized by abstaining from sexual activity

Teaches abstinence from sexual activity outside marriage as the expected standard for all school age children

Teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems

Teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity

Teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects

Teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society

Teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances

Teaches the importance of attaining self-sufficiency before engaging in sexual activity

Montana Behavior Initiative: This is a program of the Office of Public Instruction (OPI). The Montana Behavior Initiative focuses on decreasing violence within schools, thus decreasing violence within communities. Education is focused on an individual level for students having issues related to violence. The school as a whole bases its prevention education on the very first precursor that can lead to an ultimate act of violence. The state DPHHS does not provide any funds to this program, and does not have input in program management. Not all schools have this violence prevention program, but it is possible for all to participate in it. To be a part of the program, the faculty and staff of the school must participate in a training workshop that provides them with the skills and knowledge to deal with possibly violent situations. The Montana Behavior Initiative seeks to provide proactive prevention, by providing appropriate education to school staff.

Children with Special Health Care Needs

The following table is a list of the population-based programs and resources related to children with special health care needs (CSHCN). There are only two programs listed in this area. Because of the special nature of this population, more programs and resources naturally fall into the direct services level of the MCH pyramid.

Program	Target Group	Eligibility	Program Description	Provider
Newborn Screening	All newborns	None	Universal screening of all newborns for inborn errors of metabolism	Hospitals
Hearing Screening	Newborns	None	Screening for hearing deficiencies	Hospitals

Newborn and Hearing Screening: Administration of the newborn and hearing screening programs was recently moved into the SHS section of the DPHHS. Combining the administration of these programs should lead to improved surveillance and follow-up of children with identified needs. Another goal of combining administration of these programs is to obtain a more accurate count of the number of children in Montana with special health care needs.

If a child is screened and a need is identified, SHS will act as a facilitator to link children and families with the program that will best meet their needs. Appropriate programs may include Part H/Early Intervention, SHS, or another agency. Direct management of a child's care will go to the most appropriate program, which will collaborate with the child's family and physician. For a more detailed look at how SHS and Part H/Early Intervention collaborate see the Infrastructure Building section to follow.

All newborns are screened for inborn errors of metabolism before they leave the hospital. In addition, approximately 30% of all newborns are screened for hearing problems at this time. There is variation in the distribution of hearing screening services across the state. Small rural hospitals are having more difficulty than the larger hospitals in implementing hearing screening because of the cost of the screening equipment. Hearing screening are not currently mandated, but the state does recommend it for all newborns.

Newborn screening is funded in part by MCH block grant funds, but that alone is proving to be inadequate. Currently the Special Health Section is surveying other states to determine how they fund their newborn screening programs. There is currently no funding for the provision of hearing screening. The state has proposed a check-box for hearing screening on the birth certificates.

Women of Childbearing Age

The following table is a list of the population-based programs and resources for women of childbearing age.

Program	Target Group	Eligibility	Program Description	Provider
Family Planning Services	Women 15-44	None	Program that provides education, certain services, etc. to improve the reproductive health of Montana. Title X funds.	Family Planning clinics
WIC	Women, infants, and children	Percentage of poverty	Program that provides nutrition education, supplemental food, and referrals to other needed services. Dept. of Agriculture funding.	WIC Clinic
Adult Immunization Program	Women and men	None	Program to provide and educate adults about the importance of immunizations	PH Clinics
Domestic Violence/Sexual Assault Prevention Programs	Women and families	None	Programs to help prevent domestic violence and sexual assault by providing shelter, education, etc. about the issue	Multiple
STD Prevention Efforts	Women 15-44, and men	None	Programs to help prevent STDs by providing education, etc.	Clinics, PSAs
Unintentional Pregnancy Prevention Efforts	Women 15-44	None	Programs to educate and prevent the incidence of unintentional pregnancies	Family Planning clinics
Substance Abuse Education	Women 15-44	None	Programs that provide education and promote activities which reduce substance abuse	Multiple
Other Education Programs	Women 15-44	None	Education programs on issues such as osteoporosis prevention and folic acid use	Multiple

Family Planning Services: Family planning is provided through federal Title X funds, and managed through the Women’s Health section of the Family and Community Health Bureau. Family planning frequently collaborates with other programs within the Family and Community Health Bureau due to the fact that they have similar goals of improving the reproductive health of all Montanans. Family planning clinics are not in every county within the state, but educational services are available throughout the state.

WIC: WIC was previously described in the section above in the pregnant women and infants portion of population-based services.

Adult Immunization Program: Montana does not have good data on the number of adults that need immunizations. Some counties utilize MCH block grant funds to provide immunizations for adult clients, whereas others do not. The Immunization section of the DPHHS provides support to these programs.

Domestic Violence/Sexual Assault Prevention Programs: Much of the prevention activity takes place outside the State D{HHS programs. Most of the activities occur through the efforts of advocacy groups. Public health nurses at the county level are becoming more comfortable with asking and making referrals when they encounter domestic violence situations. The state does help fund a hotline with the Montana Coalition Against Domestic and Sexual Violence (MCADSV) that serves the entire state, but otherwise programs are reliant on other funding.

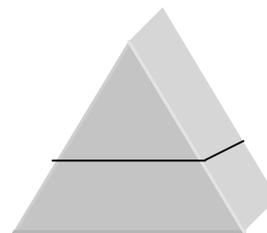
STD Prevention Efforts: Education efforts for the prevention of sexually transmitted diseases (STDs) takes place primarily within the family planning program. There is collaboration between health care providers and other organizations within the state such as the HIV/AIDS program to increase awareness of STDs and prevent their spread.

Unintentional Pregnancy Prevention Efforts: The majority of education on unintended pregnancy prevention takes place within family planning clinics. Unintended pregnancy has become an increasing problem in the state especially for younger women aged 15-24. Montana ranks 4th nationwide for the percent of reported legal abortions obtained by teenagers. This is an area where increased MCH block grant dollars may be needed as well as increased collaboration between organizations.

Substance Abuse Education: This is also an area that is of great concern in the state, especially when realizing how it affects other priority areas in the state. Not a lot of intensive education programs take place within the state related to substance abuse. This again goes back to the issue of reprioritizing needs and possibly collaboration between separate entities, thus providing more funds that can go into education to help prevent this issue from being such a major force within Montana.

Other Education Programs: Family planning clinics in Montana provide education on women's health issues such as osteoporosis prevention and folic acid use for women of childbearing age. There are also smaller education programs sponsored by separate grants, and are usually found only within certain areas of the state. A RFP process usually accompanies the grant allowing communities that apply for these funds the ability to cover education costs. Counties can also collaborate with other counties to provide education services to a larger portion of the population.

3.1.2.5 INFRASTRUCTURE BUILDING SERVICES



Infrastructure Building Services provide support for all of the above types of services. Included in this category are needs assessments, program development, program evaluation, policy development, standards development, training, research, activities that promote linkages between providers and agencies, and the development of information management systems. Priority needs in this service area include:

Increase coordination of services with IHS

Support development of integrated data system to improve the efficiency of data collection and program reporting for local PH providers

Provide training and support for local needs assessment process
 Advocate for the use of tobacco settlement funds into preventative health programs
 Continue to identify emerging needs such as asthma prevalence, obesity and environmental concerns for children
 Improve program evaluation processes and increase consumer feedback for continued quality improvement of programs.

Pregnant Women and Infants

The following table outlines programs that assist in infrastructure building in Montana for coordination of services for pregnant women and infants.

Program	Target Group	Eligibility	Program Description	Providers
Follow Me	Program	Target Group	Public Health Home visiting program. Coordinators provide linkages with providers	PH Nurses
MIAMI	Pregnant women	Risk Factors	Program provides links between families and providers of high-risk obstetric care and pediatricians.	PH Nurses
FICMR	Infants, children	None	Program to review infant and child deaths to assist in coordinating efforts to prevent further deaths	Local and state teams.
MBOMS	Infants	None	Program will develop an integrated database to improve surveillance and connect community services.	Special Health Services will coordinate program

There are three large hospitals in the state that are “Level III” centers for perinatal care and these facilities have developed linkages with providers in outlying areas for provision of care to high-risk pregnant women. There are three neonatologists and two perinatologists in the state. They are all actively involved in outreach and one perinatologist has a fixed wing airplane to fly to an area of need. MIAMI and Follow-Me coordinators have strong linkages with the providers of high-risk obstetric care, dentists and pediatricians in their respective health care service delivery areas.

It is the high-risk pregnant women who do not access prenatal care in a timely manner in rural areas who need improved coordination of services. Home visiting of pregnant women does not exist in all counties in the state. Prenatal and Lamaze classes, while often available, may not be affordable or accessible to all women in Montana. It is estimated by the Family and Community Health Bureau that the MIAMI program services are available to approximately 86% of high-risk pregnant women in Montana. There is a need for public health nurses and home visiting in all counties. Currently all counties do not have MIAMI or Follow-Me funding. There are 31 MIAMI projects with four on

reservations, and 16 Follow-Me projects. Some rural areas lack professionals who would make up the targeted case management team to provide comprehensive services through MIAMI or Follow-me. There are shortages of registered dietitians, social workers, and BSNs in parts of the state.

The MIAMI projects on Indian reservations have each developed unique models of service within their respective communities. One program works with Head Start mothers to promote healthy parenting throughout pregnancy and beyond. Another project provides transportation to prenatal care 40 miles away. Coordination of health care providers on and off the reservation is required. A major concern is the access to prenatal care by American Indian women living off reservations.

The urban Indian health care and migrant health care centers do not reach state-wide to provide direct health care or home visiting services to all American Indians or migrants who need care. Consultation from the Region VIII Minority Health Consultant has resulted in recommendations to develop more culturally competent systems of care through improved communication between the state and tribes. A small OMH grant was awarded to the state to facilitate communication between the state and tribes. Also a proposal to create a Minority Health Coordinator position has been developed within the Family and Community Health Bureau to address the need for improved communication and coordination of services for minorities. That proposal is one of many legislative proposals for the 2001 session.

Fetal Infant and Child Mortality Review (FICMR), teams have been formed in the state to improve preventative efforts and reduce deaths related to the known causes. A protocol manual was developed in 1997 and was distributed to all the MIAMI communities later that year. There are currently 16 FICMR teams across the state. There has been collaboration between tribes and counties with three local FICMR teams. There was a need identified to diversify the state FICMR team and include representation from Indian Child Welfare, and Tribal legal and social services. These team members are being recruited in the year 2000.

Montana Birth Outcome Monitoring System (MBOMS) is funded through assistance from CDC. Efforts will focus on bringing many different data sources together into a central location. Data will be utilized for surveillance, policy development, and service planning.

Children and Adolescents

The following table is a list of the infrastructure building programs and resources provided for children and adolescents.

Program	Target Group	Program Description	Providers
FICMR	Statewide	Program to review infant's and children's deaths, provide recommendations to prevent future incidents	Local teams
Healthy Childcare Montana	Day Care Center Staff	Public Health Nurses are trained statewide to act as health consultants for day care providers	PH nurses
Montana Children's Alliance	Legislators	Promotes well being of children by identifying and educating Montanans about the services considered to be vital to Montana's children. Recommendations to the state legislature on children's issues.	Alliance of non-profit and gov. agencies
Family and Community Health Advisory Council	State Government	Advises the state Family and Community Health Bureau on matters impacting the health and well being of women, children and children with special health care needs in Montana.	Appointed members who represent of range stakeholders
Family and Community Health Bureau	Local Health Departments	Develops standards of care, provides data analysis, needs assessment, training, program evaluation and planning for various programs for children and adolescents. Distributes MCH Block Grant monies to counties via contracts with county public health offices	State staff

FICMR was described earlier and is a statewide system to review fetal, infant, and child deaths to increase understanding of the causes of death and prevent further deaths.

Quality childcare is not affordable for many low-income working families and many childcare facilities are of poor to mediocre quality and staffed by untrained workers. The Healthy Child Care Montana program promotes efforts to increase the quality of childcare by providing consultation.

Montana Children's Alliance was initiated in 1987 and develops a Children's Agenda every two years that specifies recommendations to the state legislature concerning the needs of children in the state. The purpose of the alliance is to promote the wellbeing of children by identifying needs and increasing awareness about services considered vital to Montana's children and families. Members of the Alliance include representative from state agencies, county agencies, professional organizations, non-profit organizations, and health care providers.

The Family and Community Health Advisory Council was formed in 1999 to assist in the interpretation of current national, regional, state and local information relating to the health of mothers and children in Montana. The council's goals include assisting the state in identifying problems related to the delivery of services, access to services, or quality of services available to mothers and children in Montana. The council acts as advocates for the services provided by the Bureau and makes recommendations to improve services to families and children in Montana.

State maternal child health services are administered within the Family and Community Health Bureau (FCHB) of the Montana Department of Public Health and Human Services. There are four service sections in the FCHB, which include: Child, Adolescent and Community Health (CACH), Special

Health Services (SHS), WIC/Nutrition, and Women's Health. There is also an administrative unit, which is responsible for the maternal child health block grant and management of contracts. The Bureau conducts statewide MetNet conferences for county public health personnel each spring and organizes regional meetings with counties during the summer and fall. Public input is requested at regional meetings through the addition of focus groups that began in 1998. While public participation has been limited it is hoped that it will increase, as more people become aware of this forum.

The FCHB has an approximate budget of \$17.2 million, which includes Title V, WIC, Title X, Preventative Health Block Grant, CDC, CISS, SSDI and state general funds. Bureau staff continually work to create responsive and dynamic programs that adhere to funding source requirements and the needs of Montanans. Approximately 88 % of the total Bureau budget is expended at the local level. The Bureau works closely with other agencies to coordinate services. In 1999 they worked with the CHIP office and Medicaid to promote access to improved health and dental services for children. Bureau staff participate on the Joint Committee for Healthy Kids to address health needs in the schools. Staff members work with programs such as Mothers Against Drunk Drivers (MADD), on FAS/FAE prevention and are involved in coordinating efforts with other agencies to prevent substance abuse, suicide and unintentional injury prevention. The State medical director works closely with American Association of Pediatricians (AAP), American College of Obstetricians and Gynecologists (ACOG), and the American Association of Family Practitioners, (AAFP) to coordinate state efforts with health care providers.

Some of the activities initiated recently at the FCHB include strategic planning for the development of a state suicide prevention plan, a state-wide dental summit and development of strategies to improve dental care access for children, surveys of schools and day cares to assess the prevalence of asthma in Montana's children, and a survey of school health programs to assess the need for more school nursing programs.

Each section of the Bureau is continually involved in the assessment of public health programs' effectiveness through data analysis, and through summarizing feedback from the local level provided by public health nurses on yearly pre-contract surveys. Continuous quality improvement of programs is conducted by public health nurses, state program directors, and through participant surveys at the local level. On the 1999 pre-contract survey it was found that 24 counties have not begun to include customer satisfaction surveys as was requested as a contract requirement. This is an area where improvement can be made.

Montana does not currently receive Title IV grants for comprehensive HIV care to pediatric, adolescent and women with HIV. As of August 1999 there were only four pediatric AIDS cases in the state reported since 1985. Montana currently has only Ryan White Title II and Title III funded programs for HIV/AIDS. The DPHHS, Communicable Disease Prevention and Control Bureau STD/HIV Section administer Title II funds. Title II Programs in Montana include AIDS Drug Assistance Program (ADAP), Health Insurance Continuation Program (ICP), and HIV Care Consortia. The Deering Community Health Clinic in Billings administers the Title III Program. Title III provides grants to public and private non-profit clinics for early intervention services for individuals seeking HIV counseling.

Children with Special Health Care Needs

The following table is a list of the infrastructure building programs and resources provided for CSHCN.

Program	Program Description	Provider
Regional Clinic Coordination	Project to regionalize the special health care clinics, to enhance efficiency of care	Special Health Services
MT Birth Outcomes Monitoring System	Program that tracks targeted birth outcomes, provides surveillance of newborns with targeted outcomes and connects service providers to improve services for children with congenital birth defects.	SHS section of DPHHS with CDC funding

Regional Clinics: Special Health Services (SHS) is the section under the Family and Community Health Bureau, which administers funding for children with special health care needs, (CSHCN) programs under the MCH Block grant. This section was initially involved primarily in direct care services for CSHCN but has begun a transition towards providing coordination and infrastructure building activities over the past five years. Special Health Services contracts with four regional coordinators in the state to set up three types of clinics for children that are held twice a year. These clinics are Cleft Palate Clinics, Metabolic Disorder Clinics, and the newest type of clinic is a Neural Tube Defect Clinic, which began in January 2000. The state provides training for the regional coordinators on their role of coordinating care within their communities. SHS also began developing a data base system that will track children attending clinics and assist regional coordinators in clinic management. This data base system is being tested in FY 2000.

In an effort to increase the infrastructure at the state level, the SHS division is developing standards of care for regional clinics to improve the quality of care provided. Standards for the metabolic clinic were drafted this year. Planning has begun for development of standards for the cleft palate clinics and neural tube clinics. Special Health Services plans to use chart review to monitor the quality of care once standards are in place and all direct care is coordinated at the local level.

Montana Birth Outcomes Monitoring: MBOMS is a project under the SHS section to improve tracking and follow-up for infants with birth defects. The CDC assists with funding for this project to improve surveillance and coordination of services for children with special health needs in the state.

Collaboration of Services: Services for children with special health care needs in Montana may be provided through several agencies and providers. Collaboration and coordination of services are an important component of infrastructure building. Other agencies that may be involved include the federal Part C/Early Intervention program, SSI, and community-based services. The following section will describe the functions of related agencies and how these agencies collaborate with each other and with local providers of health care.

Part H/Early Intervention: This is a federally funded program with the mission of assuring that all Montana infants and toddlers with disabilities, and their families have the right to comprehensive, appropriate intervention services--developed with the family as the lead members of the team, and responsive to the family's needs and dreams for their child. The focus of this program is to enable families to become effective lifelong advocates for their children who have developmental disabilities

or delays. The following services are available to children who are eligible for assistance through the Infant and Toddler Program:

- Early identification, screening and assessment (including medical services for diagnostic evaluation purposes)
- Special instruction
- Parent and family education, training and counseling services
- Speech pathology and audiology services
- Physical therapy and occupational therapy
- Psychological services
- Support coordination and social work services
- Health services (necessary for the child to benefit from early intervention services) and nursing services
- Nutrition services
- Vision services
- Assistive technology devices and services
- Transportation and related costs

The Developmental Disabilities Program, of the Department of Health and Human Services administers the Part C/Early Intervention program. There are currently seven regionally-based agencies across the state, to provide services to families. The federal government mandates that all children that would be considered eligible for this program are included in the program; therefore, there are no income requirements for these services. Eligibility for the program is determined by the child having:

- An established condition which is very likely to result in a developmental delay—even if the delay does not currently exist, or
- A significant delay of 50% in one developmental area or 25% in two or more of the following areas:
 - Communication development
 - Physical development, including vision or hearing
 - Social or emotional development
 - Adaptive development
 - Cognitive development

The majority of the Part C/Early Intervention program covers children from birth to age three, and then if needed, continues to cover appropriate services. Part C usually serves as the link between families and schools, by helping with the transition into school-based services, such as special education.

Part C and SHS Collaboration: Part C and SHS work together in several ways. The following is a list of ways in which the two agencies combine efforts.

- Provide mutual referrals across agencies (SHS, Follow Me, and Part C) for children/families who may need, or be eligible for services provided by the different groups
- Provide a joint Individualized Family Service Plan (IFSP) and Nursing Care Plan (NCP)—which becomes one document to guide services to the child/family, with roles and responsibilities defined
- Routine discussion and identification at IFSP meetings about the child's/family's need for medical services which might be provided by public health nurses

Emphasis in discussions with families on the concept that children need a medical home (usually a primary care physician, with the assistance of public health staff) where all of their medical service needs can be tracked and met

Mutual invitations to training events of interest to both Family Support Specialists (Part C) and Public Health Nurses (SHS)

Telephone, e-mail, or on-site technical assistance/training at the request of either public health or Part C agencies or staff

Ongoing (negotiated every three years) formal interagency agreement on coordination of services and responsibilities of each state agency involved in early intervention services, including the Health Policy and Services Division, SHS, Part C, and the Office of Public Instruction

The director of SHS is a member of the Part C advisory council.

SHS and Collaboration with State agencies and Community Systems: Staff from SHS formally meet each year with state SSI staff. Informally, there is ongoing communication between SHS and SSI divisions throughout the year regarding funding and coordination of care.

In 1999 a Special Health Services Advisory Council was formed to improve collaboration, and access input from parents, pediatricians, public health nurses, Indian Health Services, Part C, dental providers and others with a related interest. This council is a subcommittee of the Family and Community Health Bureau Advisory Council. The SHS Advisory Council will meet every 6 months.

The SHS section coordinates efforts with Montana Healthy Mothers Healthy Babies and the state March of Dimes to promote folic acid education throughout the state. Related to providers, there is a strong relationship between SHS and St. Vincent's Hospital in Billings, and Community Hospital in Missoula where outreach clinics are held yearly to evaluate children.

Special Health Services provides training for county public health nurses in the state concerning home visiting for CSHCN. Special Health Services funding support public health nurses in providing home visiting services. Special Health Services also assist parents in obtaining evaluations or testing to determine a diagnosis for a child when financial aid is required and encourages coordination of care through a local pediatrician. They have recently made a request of the training center of the American Association of Pediatricians to provide training for pediatricians in Montana on the definition and use of a medical home.

(For further information on interagency agreements See form 13, Service system Constructs for Children with Special Health Care Needs in the Electronic Reporting Forms Section)

All Population Groups

The following table is a list of the infrastructure building programs and resources provided for all the population groups.

Program	Target Group	Eligibility	Program Mission	Funding Sources
Staff Training and Education	Public Health Staff	Staff member	Provide staff education and training to better enable staff to provide quality public health services.	State
IDEA Project	All	None	Enhance integration and efficiency of the management of public health data across the state.	State
Healthy Communities	All	Coalitions	Encourage collaboration among stakeholders and empower communities to envision and plan for a healthy community through efforts of local coalitions.	State DPHHS and local fund raising
Community Incentive Program (CIP)	All	RFP or MOA	To develop a comprehensive and coordinated risk –focused prevention delivery system. To build capacity and infrastructure within communities.	Federal State incentive grant
Interagency Coordinating Council	All	RFP	Develop a comprehensive and coordinated prevention delivery system in the state designed to strengthen health, well being a safety of children, families and communities.	Federal Vista grant, ICC member agencies support PRC
Integrated Funding Project	All	Pilot	Improve PH management efficiency by integrating the allocation of funds for multiple state programs to the local level.	
Turning Point Initiative	All	None	Community improvement project to better enable communities to become healthy	Turning Point Initiative Grant RWJ Foundation

IDEA Project: The state has been working to develop an integrated public health data system that would increase the efficiency of data gathering and improve collaboration between counties and state public health agencies. A contract was given to Seaquest to develop this program initially but they have defaulted on the contract. As of April 2000, preparations have begun to convert to an Oracle design. Pilot testing of data conversion is scheduled to begin in August of 2000. Pilot test sites are scheduled to begin in Missoula, Butte, and Shelby by the end of 2000.

Healthy Communities: This program is a state-facilitated program to encourage collaboration among stakeholders in the health of Montana’s communities. The mission is to empower communities to create their own vision of a healthier community, determine community needs and assets, and develop strategies to achieve their vision. The state level coalition is funded by DPHHS. Local coalitions are responsible for their own funding with some state assistance with allocation. There is a national Healthier Communities coalition that sponsors teleconferences and other national conferences. Montana is one of 29 states participating. Training is provided to communities through METNETs. There are 23 local level coalitions.

Community Incentive Program: This program's mission is to develop a comprehensive and coordinated statewide risk-focused prevention delivery system designed to strengthen the healthy development, well-being and safety of Montana's children, families, individuals and communities. Funding is provided through a federal state incentive grant. After 3 years the program is required to leverage other funds to continue. Of the grant money received, 85% goes to local communities. Communities decide how funds will be received and distributed. Key players besides the communities include the Interagency Coordinating Council, SAMSHA- Substance Abuse and Mental Health Services Administration, CAPT- Center for the Application of Prevention Technology and CSAP- Center for Substance Abuse Prevention. The target group is local coalitions that wish to access funds to develop an infrastructure to prevent teen ATOD use.

Interagency Coordinating Council: The mission of this council is to develop policies and practices within state government that will effectively elevate the importance of prevention. The goal is to develop a comprehensive and coordinated prevention delivery system designed to strengthen the health and well being of Montanans. Funding comes from a federal VISTA grant to the Prevention Resource Center (PRC). ICC member agencies contribute \$5,000 each to support the operations of the PRC. The ICC funded a 3-year demonstration project in 1996. The PRC's VISTA project has placed 19 VISTA's in 12 communities. Training is provided quarterly to train VISTA's in prevention principles and best practices; coalition building, volunteer training and other topics to for building a sound prevention infrastructure. A website has been established for county trend data on 42 social indicators associated with prevention. ICC members include: the Attorney General, the Superintendent of Public Schools, Directors from Labor and Industry, Public Health and Correction; Chair of the Montana Trust Fund, The state Coordinator of Indian Affairs and two persons appointed by the Governor.

Integrated Funding Project: Currently there are over 12 categories of state public health funds for local health departments. Each category has it's own specific reporting requirements. The goal of the Integrated Funding Project is to consolidate funds to counties and simplify reporting requirements. The Project is scheduled to begin in four pilot sites in July 2001.

Turning Point: The mission of Turning Point to increase our public health system's ability to assess, monitor and respond to the changing health-related needs of Montana communities. A goal is to improve collaboration among the government, communities, organizations, education, labor, and business. Turning Point is funded at the state level by a Robert Wood Johnson grant and DPHHS in-kind. At the local level funding is received from the W.K. Kellogg Foundation. Key players in the program include the Public Health Improvement Task Force. This task force consists of representatives from local health departments, managed care, cooperative extension, university faculty, hospitals, local government, public health association, DPHHS, Dept. of Environmental Quality, Indian Health Service, and the State Legislature. Technical support is provided through the national Turning Point offices at the University of Washington and the National Association of City and County Health Officials.

There are four local Turning Point sites: Gallatin Health Alliance, Cornerstone Project in Lake, Flathead and Sanders counties, Sheridan county, and the Fort Peck Health Coalition. Each site develops their own public health improvement activities using local ideas and solutions.

3.2 Health Status Indicators

Collecting the needed data to report on health status indicators for the first time was extremely difficult and time consuming. However, the process resulted in forging some interesting relationships with other programs as they attempted to help facilitate the process. The Montana Vital Record Bureau was extraordinarily helpful and responsive as was the Census and Economic Information Bureau of the Department of Commerce, Office of Public Instruction, Juvenile Justice and the State Library. Some blanks remain, however, but not for lack of effort. As previously mentioned, the concept of “indicators” seemed to appeal to local county health professionals, particularly if they were able to track indicators of specific interest to their communities. This interest will be encouraged by way of county contracts in 2001. Health status indicators are displayed in ERP section 5.5 and 5.6.

The process of collecting the needed data to respond to the health status indicators as well as the performance and outcome measures has highlighted Montana’s need for good, reliable, consistent data. Much of what we needed was not available, some was too available in that there were numbers and values from all sorts of sources, none of which agreed. There were sophisticated data systems that were unable to produce the required reports and some systems that simply did not perform at all. During the summer of 2000, graduate students from Emory University are helping define trends and targets. Roger Rochat is providing epidemiology consultation. But, more attention on a routine basis must be focused on the need for ongoing, routine collection of data. Systems need to be evaluated and there must be assurance that they will be able to provide what is needed. And finally, the integrated public health data system needs to be supported and completed and implemented.

3.2.1 Summary Of Montana Priority MCH Needs:

Increase access to health care for children (CHIP and School Health Programs)

Decrease unintended pregnancy

Increase dental care access for children

Increase prevention programs for school age children (substance abuse, tobacco use, suicide prevention, teen pregnancy prevention, fire arm safety, non-violent conflict resolution)

Decrease disparities between the health of American Indians and all Montanans (infant mortality, rates of cervical CA, and diabetes)

Increase the efficiency of reporting data and the integration of public health data statewide. Increase input from epidemiological analysis

Decrease the risks for poor health, developmental delays and child abuse through support and expansion of public health programs that provide outreach to parents and children “at risk” (MIAMI, Follow-Me and parenting education programs)

Decrease the number of infants born with a high risk for poor health through support and education of “at risk” pregnant mothers through programs such as MIAMI

Increase access to mental health services, substance abuse prevention and suicide prevention programs

Increase the training and support of public health nurses and work to strengthen public health infrastructure.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

Budget forms are included in ERP as forms 2, 3, 4 and Justification of the budget follows the budget forms in the following narrative:

Form 2

The proposed budget for FFY 2001 includes the following:

1A Primary and Preventive Services for Children \$806,575

This budget item includes the budget for the Child, Adolescent and Community Health Section of \$267,664 plus 49% or \$538,911 of MCHBG expended by counties for children in 1999.

1B Children with special health care needs \$833,371

Budget includes the SHS budget of \$821,371 plus 1.1% or \$12,000 of MCHBG expended by counties for children with special health care needs in 1999. Counties reported using 10% of MCHBG for this area in 1997 and 2% in 1998. The variability continues to be attributed to changes in counties understanding of the definition of CSHCN. In order to assure compliance with the 30% rule, adequate resources continue to be placed in the SHS section.

1C Title V Administrative Costs \$163,296

Budget includes the estimated state cost allocation of \$103,296, plus 5.5% or \$60,000 of local contract costs reported as administrative costs.

2 Unobligated balance \$0

Montana continues to budget and expend to the level of the annual award.

3 Total State Funds \$1,389,673

Budget includes the MIAMI and MIAMI for reservations general funds (\$561,997), general funds for support of the Prenatal Program (\$29,238) the Public Health Home

Visiting (Follow Me) General funds (\$77,991), funds for the Missoula FAIM project (\$10,000), funds for the Montana Medical Genetics Program (\$683,115), and general funds designated for the family planning program (\$27,332).

4 1989 Maintenance of Effort Amount \$485,480

5 Local MCH Funds \$2,604,648

The budgeted amount was based on the amount of match reported by counties for 1999.

6 Program Income \$0

Program income is not yet consistently reported, but the requirement to report is being emphasized. State staff do not generate income through Medicaid or other billing.

7. Federal-State Block Grant Partnership \$6,537,960

8. Other Federal Funds \$17,389,116

8a	SPRANS	\$0	
8b	SSDI	\$95,000	
8c	CISS	\$72,500	Administered by Health Systems Bureau
8d	Abstinence Education	\$186,439	Third year of a five year award
8e	Healthy Start	\$150,000	Mortality and Morbidity Review
8f	EMSC	\$103,744	Helps support suicide prevention plan development and carseat safety efforts.
8g	WIC	\$12,667,168	Includes clients services, retailer contracts and administrative costs.
8h	AIDS	\$0	
8i	CDC	\$612,375	Includes Lead \$250,000, Montana Birth Outcome Monitoring System \$112,375 and Integrated Data for Evaluation and Assessment \$250,000
8j	Education	\$0	
8k	Title X FP	\$1,196,935	
	PHBG (FP)	\$183,898	
	PHBG (Dental)	\$9,973	

Form 4 Expenditures by Target Population

Variations in local funding continue to impact the expenditures as compared to the budgeted amounts. Local counties reported approximately \$800,000 in excess of the budgeted amount, with the excess primarily in the infants, children and “other” categories. Large expenditures in school health services were noted, with some counties reporting the majority of their funds expended in school health services.

Form 5 Expenditures by Level of the Pyramid

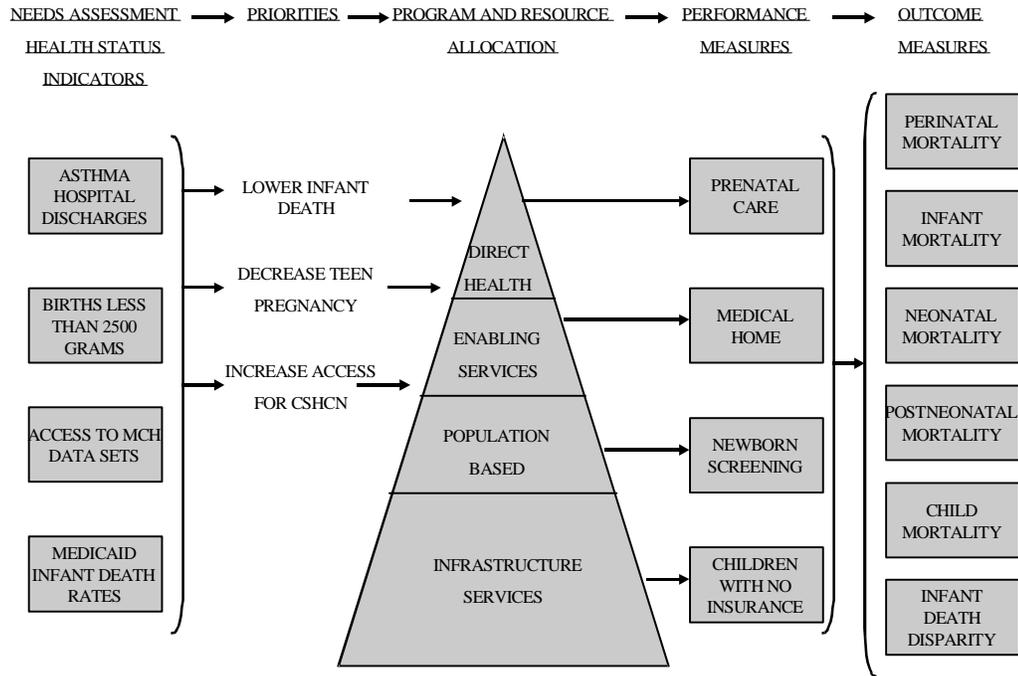
Local reports continue to attribute large percents of county expenditures in the direct services. FCHB staff will continue to work with local staff to assure that they recognize the necessity of infrastructure and core public health services, and report accordingly.

3.3.2 Other Requirements

Sources of other Federal MCH dollars, State matching funds (including non-federal dollars that meet at least the legislatively-required minimum match for Title V), and other funds used by the agency to provide the Title V program are described in the budget justification section. Montana’s maintenance of effort from 1989 is \$485,489.

3.4 Performance Measures

Figure 3
**TITLE V BLOCK GRANT
 PERFORMANCE MEASUREMENT SYSTEM**



3.4.1 National “Core” Five Year Performance Measures

3.4.1.1 Five Year Performance Objectives

Figure 4
PERFORMANCE MEASURES SUMMARY SHEET

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home”		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2 State Negotiated Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
Percent of unintended pregnancy.	X					X	
Percent of women reporting alcohol use in pregnancy				X			X
Quality standards for the health care of the MCH population have been established by state staff and their local/community partners.				X		X	
Percent of infants who are breastfed at six months.		X					X
Percent of counties establishing fetal infant child mortality review committees.				X	X		
Percent of facilities using standardized domestic violence screening tool as part of care assessment and planning.				X		X	
Percent of two year old children screened for lead.			X				X
Percent of Medicaid eligible children who receive dental services as part of their comprehensive services.				X		X	
Percent of pregnant women who report cigarette smoking.				X			X
Rate of firearm deaths among youth aged 5-19.				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
 IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2.2 Discussion of State Performance Measures

The reason for selection of each state performance measure is described below. All levels of the pyramid were incorporated to better enable communities to receive more adequate services.

DIRECT HEALTH CARE

Performance Measure # 1: Percent of unintended pregnancy (Process)

This performance measure was chosen because of legislative interest in the area, the perceived cost benefit to the public and its strong link to title X goals. Montana identified unintended pregnancy as one of its priority areas both in the Montana Health Agenda and as a state performance measure due to the cyclical nature of negative health outcomes associated with having a child

that is not intended, including, but not limited to morbidity and mortality rates (Outcome measure #1 and #7).

ENABLING SERVICES

Performance Measure #4: Percent of mothers who breastfeed their infants at six months (Risk Factor)

This performance measure is a WIC goal and allows for improved health services. Montana has identified appropriate post partum care, including support of breastfeeding, as one of its priority areas. Breastfed infants are shown to have healthier outcomes than those who are not breastfed (Outcome measures #1, #5, and #7).

POPULATION BASED SERVICES

Performance Measure #7: Percent of two year old children tested for lead (Risk Factor)

This performance measure is a program initiative for Montana. Lead can have systemic and potentially lethal effects on children. With mining, smelting and the possibility of young families living in and remodeling older homes, the risk for exposure to lead is high in Montana. Montana has recognized this and identified it as one of its priority needs. (Outcome measure #6).

INTRASTRUCTURE BUILDING

Performance Measure #2: Percent of women reporting alcohol use in pregnancy (Risk Factor).

This performance measure relates to improving pregnancy outcomes, a priority area in the Montana Health Agenda. The costs associated with alcohol use during pregnancy are enormous for the affected individual, his family and society in general. Drinking during pregnancy is a risk factor for many negative birth outcomes (Outcome measures #1, #5 and #7).

Performance Measure #3: Quality standards for health care of the MCH populations have been established by state staff and their local/community partners (Process)

This performance measure is a bureau initiative to improve standards of care throughout every level of service for all MCH

populations. This performance measure has the potential to transcend every priority issue because of its widespread emphasis. It also has the potential to have an impact on each national and state outcome measure. (Outcome measures #1 through #7).

Performance Measure #5: Percent of counties establishing fetal/infant/child mortality review teams.

This measure is a local contract requirement designed to improve the health and well being of infants and children. It also relates to Montana's priority areas which seek to develop the capacity of communities to review and analyze fetal, infant and child deaths in order to identify and implement preventive measures. It also relates to all outcome measures in terms of its broad scope (Outcome measures #1 through #7).

Performance Measure #6: Percent of facilities using standardized domestic violence screening tool as part of care assessment and planning. (Process)

This performance measure was chosen due to the increasing awareness of the scope of this issue in Montana. Because of its pervasive negative implications for women's and children's health, Montana has made this a priority for community awareness and action. Women who feel or who are threatened or experience direct violence cannot be expected to have health birth outcomes or to provide healthy environments for their children. Children exposed to violence are at risk for an array of negative outcomes throughout their lives (Outcome measures #1, #2, #6, #7).

Performance Measure #8: Percent of Medicaid eligible children who receive dental services as part of their comprehensive services (Process)

This performance measure was chosen in order to establish baseline data to assist in addressing dental access needs. Montana has stated that one of its priority areas is to remove barriers related to disparity of care by providing Medicaid clients with the most comprehensive care available to them.

Performance Measure #9: Percent of pregnant women who report cigarette smoking (Risk Factor).

The percent of women who report smoking in Montana is an ongoing issue. From MIAMI data, it is known that there is a

much higher incidence of pregnant women who smoke than actually report doing so. This performance measure also relates to improving prenatal care and pregnancy outcomes which are priorities in Montana and appear as Montana Health Agenda items as well. This performance measure also impacts the outcome measures for fetal and infant mortality (Outcome measures #1-#5 and #7).

Performance Measure #10: Rate of firearm deaths among youth age 5-19 (Risk Factor).

This performance measure was also chosen to establish baseline data in order to take more efficient and appropriate action on the issue of firearm deaths in Montana young people. It is related to the performance measure establishing mortality review teams and their potential to identify preventive measures. Montana is “gun country”; owning a gun and hunting are perceived as rights of passage by many Montanans. Reasonable and thoughtful access to, safe storage and safe handling of firearms are issues to that need to be addressed by all public health providers. This performance measure has strong links to suicide incidence since the vast proportion of youth suicides are with firearms.

3.4.2.3 Five Year Performance Objectives

See ERP form 11 as well as the specific discussion in Section 2.4 and 2.5

3.4.2.4 Review of State Performance Measures

See specific discussion of performance measures in Section 2.4.

3.4.3 Outcome Measures

State Outcome Measure #7: Native American infant mortality rate.

The largest minority group in Montana is the Native American Indians. Racial disparity and infant mortality in Montana is much more clearly identified, followed and analyzed by tracking Native American infant mortality than any other racial group.

IV. REQUIREMENTS FOR THE ANNUAL PLAN [SECTION 505 (a) (2)(A)]

4.1 Program Activities Related to Performance Measures

In Section 2.4, each federal and state performance measure and outcome measure was discussed in detail in terms of what was accomplished during 1999, what was ongoing during 2000 and what is planned for 2001. That discussion will not be repeated in this section; the reader is referred to Sections 2.4 and 2.5.

In general, the FCHB plans to continue to integrate performance measure activities into all phases of bureau planning. Further integration into the strategic plan with the guidance of the FCHB Advisory Council will take place. Updating the Montana Health Plan will include specific performance measures. Identifying specific bureau goals for legislative activities will include performance measures. Regional meetings with local health department staff will continue to include discussions of performance measures, health status indicators and will continue to encourage local departments to address these issues, some of which will be included as contractual requirements.

The Bureau may decide to change or eliminate two negotiated performance measures after getting feedback from the bureau sections, counties and the Advisory Council. Those performance measures were identified in the earlier discussion.

The Bureau plans to implement recommendations from the Epidemiology and trending study going on in the summer of 2000.

4.2 Other Program Activities

Other program activities are described by pyramid and population category in Section 2.4 and 2.5.

4.3 Public Input

Public input during 1999 was sought in several ways. The Family and Community Health Bureau Advisory Council provided a variety of comments from the members representing numerous advocacy organizations for mothers and children. The requirement of a consumer satisfaction survey in the county contracts added a new mechanism for public comment as did the public forums held in conjunction with the annual regional meetings. The counties respond to the Bureau in a satisfaction survey of their own, providing the Bureau with needed feedback. All meetings, seminars and conferences are evaluated. A Web based questionnaire is still being considered allowing users to respond to a survey on line. And, finally, public input in Montana goes on all the time. The public does not hesitate to call and let us know what they are thinking. Even the Governor has his private phone

line listed in order to encourage the citizens of Montana to let him (and us) know how we are doing and what is needed.

4.4 Technical Assistance

Technical assistance needs in Montana in FFY 2001 include staff and/or resources to help:

1. Develop and implement the suicide prevention plan
2. Develop a re-allocation formula
3. Investigate mechanisms to access hospital and insurance record information for data use
4. Develop a waiver to extend the length of time clients are eligible for family planning services
5. Investigate FAS/FAE prevention efforts in rural/frontier settings
6. Implementation of a dental access plan.

Other TA opportunities may arise during the FY. Staff is encouraged to contact counterparts in neighboring and/or similar states, and use contacts gained from national meetings to access information and networking. Resources from a trip in 1999 (as part of the AMCHP New MCH Director Mentor Program) have continued to be valuable and have been used repeatedly over the last year.

V. SUPPORTING DOCUMENTS

5.1 Glossary

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Adolescents - Older children - young adults through the 18th year (up to the 19th birthday).

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. [Title V Sec. 501(b)(3)]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year's MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. [Title V Sec. 501(b)(4)]

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - (For budgetary purposes) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. **(For planning and systems development)** Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms

such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses

certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Goal - General statement of purpose.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining

the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local Funding (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Birth Weight - Birth weight of 1,000 through 2,499 grams (5.5 pounds) or gestation of 28 to 37 completed weeks.

Low Income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. *[Title V, Sec. 501 (b)(2)]*

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

- 1) What is essential in terms of the provision of health services;
- 2) What is available, and
- 3) What is missing.

Newborn (Neonate) - Through the first 27 days of life.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and

other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block Grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the State), *Other* Federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by State MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," "Population Based Services," "Enabling Services," and "Direct Medical Services."

Very Low Birth Weight - Birth weight of <1,000 grams (3.5 pounds) or gestation less than 28 completed weeks.

Woman of Childbearing Years - Female 15 through the 44th year of age.

ACRONYMS AND ABBREVIATIONS

AFDC	Aid to Families With Dependent Children
ARMS	Administrative Rules of Montana
BYB	Baby Your Baby
CACFP	Child and Adult Care Food Program
CDC	Centers for Disease Control and Prevention
CNM	Certified Nurse Midwife
CSHCN	Children With Special Health Care Needs
DEM	Direct Entry (lay) Midwife
DHES	(Montana) Department of Health and Environmental Sciences
DPHHS	(Montana) Department of Public Health and Human Services
ECB2	Every Child By Two
EI	Early Intervention
EPSDT	Early, Periodic Screening, Diagnosis and Treatment
FAIM	Families Achieving Independence in Montana (welfare reform)
FAS/E	Fetal Alcohol Syndrome/Fetal Alcohol Effect
FCHB	Family and Community Health Bureau
FICMR	Fetal, Infant and Child Mortality Review
FIMR	Fetal/Infant Mortality Review
FPS	Family Planning Section, FCH Bureau, DPHHS
GF	State General Funds
HMHB	Healthy Mothers, Healthy Babies, the Montana Coalition
HMO	Health Maintenance Organization
IDEA	Individuals with Disabilities Education Act; also Integrated Data for Evaluation and Assessment
MACo	Montana Association of Counties
MCA	Montana Code(s) Annotated (state statutes)
MCA	Montana Children's Alliance
MCHB	Maternal and Child Health Bureau, Department of Health and Human Services
MIAMI	Montana's Initiative for the Abatement of Mortality in Infants
OPI	Office of Public Instruction (State Education Agency)
PCA	Primary Care Association
PCCA	Primary Care Cooperative Agreement
PIHS	Perinatal and Infant Health Section, DPHHS, FCHB (formerly Perinatal Program)
PLUK	Parents, Let's Unite for Kids
RFP	Request for Proposals

SHS	Special Health Services Section, FCHB (formerly Children's Special Health Services)
SIDS	Sudden Infant Death Syndrome
SSA	Social Security Administration
SSDI	State Systems Development Initiative Grant from MCHB
SSI	Supplemental Security Income
STD	Sexually Transmitted Disease(s)
UM	Center for Population Research, University of Montana
USDA	U.S. Department of Agriculture
VBAC	Vaginal Birth after Cesarean Section
WIC	Women, Infants and Children Supplemental Food Program

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under

one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National

Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled “Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions” in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee’s policy of maintaining a drug-free workplace,
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
 - (1) Abide by the terms of the statement; and

- (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
- (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
- (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are

constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting documents

Please see separate document, Appendices.

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All Other Forms

5.9 National "Core" Performance Measure Detail Sheets

5.10 State "Negotiated" Performance Measure Detail Sheets

5.11 Outcome Measure Detail Sheets