

# STATE TITLE V BLOCK GRANT NARRATIVE

STATE: MT

APPLICATION YEAR: 2005

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## **I. General Requirements**

[A. Letter of Transmittal](#)

[B. Face Sheet](#)

[C. Assurances and Certifications](#)

[D. Table of Contents](#)

[E. Public Input](#)

## **II. Needs Assessment**

### **III. State Overview**

[A. Overview](#)

[B. Agency Capacity](#)

[C. Organizational Structure](#)

[D. Other MCH Capacity](#)

[E. State Agency Coordination](#)

[F. Health Systems Capacity Indicators](#)

### **IV. Priorities, Performance and Program Activities**

[A. Background and Overview](#)

[B. State Priorities](#)

[C. National Performance Measures](#)

[D. State Performance Measures](#)

[E. Other Program Activities](#)

[F. Technical Assistance](#)

### **V. Budget Narrative**

[A. Expenditures](#)

[B. Budget](#)

### **VI. Reporting Forms-General Information**

### **VII. Performance and Outcome Measure Detail Sheets**

### **VIII. Glossary**

### **IX. Technical Notes**

### **X. Appendices and State Supporting documents**

## **I. GENERAL REQUIREMENTS**

### **A. LETTER OF TRANSMITTAL**

The Letter of Transmittal is to be provided as an attachment to this section.

### **B. FACE SHEET**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. ASSURANCES AND CERTIFICATIONS**

The appropriate Assurances and Certifications--non-construction program, debarment and suspension, drug free work place, lobbying, program fraud, and tobacco smoke--are maintained on file in Montana's MCH program central office and are available upon request.

### **D. TABLE OF CONTENTS**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

### **E. PUBLIC INPUT**

Public input is solicited in the form of public meetings in conjunction with regional visits, from local public health departments through pre-contract surveys and from the Family and Community Health Bureau Advisory Council, representing partners and consumers. Counties are required to include consumer surveys in their contract responsibilities.

*//2004/*Public input was obtained from pre-contract survey, which solicits issues and concerns from all contract counties (accounting for 54 of Montana's 56 counties). Contractual requirements include that contractors conduct periodic needs assessments, and the input from those assessment are reported on the pre-contract surveys. Public meetings, which had been scheduled beginning in conjunction with regional MCH meetings in 1999, were not held in 2002 due to poor attendance.

Public input is also obtained from the Family and Community Health Bureau (FCHB) Advisory Council, who represent various MCH partners and constituents. The FCHB reviews the pre-contract survey summary at the June meeting each year, and provide direct input from the constituency they represent. Advisory Council members are invited to participate in the video link to the block grant, and several participated in 2002. Copies of the block grant are made available to Advisory Council members, and availability of the text and data from the block grant is provided through the FCHB Facts newsletter in the fall.*//2004/*

*//2005/ No change from 2004 //2005//*

## **II. NEEDS ASSESSMENT**

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

### III. STATE OVERVIEW

#### A. OVERVIEW

Montana's geography, population size and distribution, nature of her minority groups, political jurisdictions, and economic characteristics have a profound effect on: the health of her citizens; how direct and public health services are provided; and on the enormity of health disparities in the state. These factors affect both the State's health priorities and initiatives, and the process for determining those priorities.

**GEOGRAPHY:** Montana is the fourth largest state in the United States, encompassing 147,046 square miles. The vastness of the state can be illustrated by the fact 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. That same in-state distance is equivalent to the distance between Chicago and Washington, D.C. Western Montana is mountainous, heavily forested, dotted with 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 of the state is within the Great Plains; the land is semi-arid to arid and access to water is often a concern. Annual precipitation in Montana averages less than 15 inches. Forest and range fires both in the state and upwind routinely affect local air quality and can exacerbate asthma and other respiratory conditions.

Vast distances, isolation of small communities, individual ranches and farms, as well as severe winter weather can 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. Public transportation is limited, with many areas in the state totally void of air, rail or even bus transportation. The Insurance Institute for Highway Safety published a study of traffic safety laws in all 50 states in their January 2001 journal. The laws they rated were seat belt, young driver licensing, DUI, child restraints, motorcycle helmet use and red light camera laws. Montana was rated dead last with poor ratings for DUI, helmet use, young-driver training and red light cameras. The state had a marginal rating for child restraint and seat belt laws. /2004/In 2000, traffic deaths per vehicle miles in Montana cause the state to be ranked 2nd highest in the nation for fatalities while vehicle miles driven/capita is ranked 17th and seat belt use is ranked 15th. (Congressional Quarterly's State Fact Finder, 2002) //2004// **/2005/Montana is 4th in the nation in total land area. In 2002 Montana ranked 9th in land owned by the federal government. In 2002, Montana ranked 42nd in visitors to state parks. In 2001 Montana was 29th in hunters with firearms. The state ranked 37th in percent of the population not physically active.**

**POPULATION CHARACTERISTICS /2004/ Despite the size of the state, its U.S. Census 2002 population estimate is only 909,453, less than the population of Rhode Island. //2004// Population density is 6.2 per square mile. The median age in Montana in 2000 was 37.5 years, nearly four years older than the median age a decade ago and higher than the national average of 35.3 years. Montanans at least 85 years old have increased by nearly 44% over the last ten years, while those under 10 years dropped by 6.5%. Sixty-four 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 smaller communities and on farms and ranches. Montana is predominately white -- approximately 91% of the 2000 population is white, compared to 75% in the nation./2005/Montana has 0.3% of the total population of the United States; it is 44th in rank order. It is projected that Montana will have an 18% change in population from 2001 through 2015, 7th in % of change in that interval. Projected population in 2025 is 1,121,000, again 44th in rank order. In 2001 Montana was 13th in the nation in population 65 and over and 26th in population 17 and under. In 2000, Montana ranked second in the nation in 8th grade math proficiency, and first in the nation in 8th grade science proficiency. In 2002, Montana was 4th in the nation for ACT scores. In 2000, Montana ranked 11th, at 89.6%, in population with high school diplomas and 10th in the nation at 91.1% in high school completion rate. In Montana in 2002, 23.6% of the population were college graduates. In 2000-2001, ranked 32nd in pupil-teacher ratio (at 14.6). From 1999-2000, Montana**

**ranked 42nd for children with disabilities enrolled in public school (19,039). From 2001-2002, Montana ranked 47th in teacher salaries (\$34,379). In 2002, Montana was 29th in state aid to pupils in daily attendance. In 2000 Montana ranked 24th in state and local funding for higher education. On 2001, Montana ranked 31st in total crime rate, 28th in violent crimes, 28th in murder and rapt and 9th in juvenile crime index. In 2001, Montana ranked 2nd in traffic deaths per 100 million vehicle miles.**

**In 2001, Montana ranked 31st in percent of births to unwed mothers, 19th in recipients of TANF, 16th for recipients of food stamps, and 34th in SSI recipients. In 2000 Montana ranked 9th in kids in foster care. In 2002, Montana ranked 34th in the condition of children based on Anne E Casey indicators (such as income, education, health).**

**IN 2001, Montana ranked 28th at 56% of households with computers and 34th with access to the Internet, and 44th in high tech jobs.//2005//**

Minorities: Eleven tribes of American Indians make up the largest minority population in Montana, representing approximately 6.2% of the total population. The average age of the American Indian population is younger than the population as a whole, and the American Indians account for approximately 12% of the births in the state, resulting in continued increases in the percentage of the population.

#### RESERVATION 1990 POPULATION 2000 POPULATION

Blackfeet	8,549	10,100
Crow	6,370	6,894
Flathead	21,259	26,172
Fort Belknap	2,508	2,959
Fort Peck	10,595	10,321
Northern Cheyenne	3,925	4,470
Rocky Boy's	1,954	2,676

The Hutterite population, a religious group similar to the Amish, makes up another minority segment of the population of 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. The Hutterites live on approximately 30 to 35 self-contained and rather isolated, agricultural colonies scattered across Montana. German is the primary language. Children usually attend colony schools. 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. A pilot project was initiated in Wheatland County in 2001, using Maternal Child Health Block Grant funding to support efforts to a) conduct oral screenings, b) conduct hypertension screenings, c) evaluate need for depression screening, and d) provide education regarding farm injury including CPR training outreach to several colonies in the area. /2004/ The pilot project revealed that in general colony children have good access to dental services, but do need education on how and when to brush. Efforts continue to raise awareness of, and to screen for, both hypertension and depression. Receptiveness to educational efforts and screening varies significantly across individual colonies and its leadership. //2004//

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 in the state since 1990. This represented 4.2% of the increase in population over that time span. According to the 2000 Census, Montana ranks 40th in the nation for percentage of Hispanic people in the population. The state ranks 50th in the nation for African-American people with less than 1% of Montana's population.

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. 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.

White 90.6% Asian .5%  
American Indian 6.2% Black .1%  
Hispanic 2.0% Other .7%

***//2005/In 2002, Montana ranked 42nd in visitors to state parks. In 2001 Montana was 29th in hunters with firearms. The state ranked 37th in percent of the population not physically active.//2005//***

ECONOMIC CHARACTERISTICS: Montana's economic history is one of extraction of natural resources, beginning with the early fur trade. The majority of the land is used for agricultural purposes. The state also produces oil, gas, lumber and coal. Limited 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. /2004/Mining, the timber industry, oil refining and the railroads have left a legacy of environmental pollution. In 1999, Montana ranked 6th in the nation for toxic chemical release and currently contains 15 Federal Super Fund sites, including the mile deep, heavy-metal flooded Berkeley Pit in Butte. As of February 2003, Montana also has 46 State Superfund sites with high or maximum priority in 23 counties (including 3 reservations) covering landfills, mines, railroad facilities, lumber mills, solvent sites, oil refineries, and gas plants. One of the nation's largest vermiculite mines is located in Libby, Montana. Although the mine and milling operation shut down in 1990, a medical screening program conducted by the Agency for Toxic Substances and Diseases Registry (ATSDR) and the State of Montana DPHHS has disclosed that several hundred people were exposed to asbestos contaminating the vermiculite and have evidence of asbestos related diseases. High levels of asbestos contamination have been found at the Libby High School, Libby Middle School, and several Elementary Schools as well as at many residences and businesses in the community. Medical testing and retesting continues in Libby and the Environmental Protective Agency has undertaken an extensive project of asbestos removal and remediation of the properties in the town. //2004//

/2004/The 2001 Montana State Legislature passed a resolution requiring that an interim feasibility study be conducted to explore implementing an environmental health tracking system in Montana. The Montana Chronic Disease Registry Study Task Force was established and the study was done in conjunction with the Montana University System. In 2003, the Legislature approved proceeding with development of an environmental health tracking system with support from a 5-year, \$2.5million grant from the CDC. The grant will allow Montana to: standardize all databases and information systems that address hazards, exposures, and disease; enhance the state's capacity in environmental epidemiology by improving the capability to analyze data; implement a demonstration project addressing air quality and asthma. //2004//***//2005/The Montana Department of Public Health and Human Services is funded to develop capacity and plan for an Environmental Public Health Tracking (EPHT) system. Funding is received through a 3-year cooperative agreement with the Centers for Disease Control and Prevention as one of 22 pilot states. The EPHT vision is to better protect communities from adverse health effects through the integration of public health and environmental information. Tracking is the ongoing collection, integration, analysis and interpretation of data. The environmental public health tracking system will improve surveillance of chronic diseases, birth defects, and developmental delays and link this health data with existing data on environmental hazards and exposure to better inform health concerns. Current funding is provided through September 2005.//2005//***

Montana's workforce is well-educated. 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 is comprised of two universities, four colleges and five colleges of technology. 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 strongest growth in jobs has been in the professional, technical, sales and service sectors. With the ageing of Montana's population, 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; and, although only 8.2 percent of Montana residents earn their living from farming, forestry and fishing, this rate is four times the national average.

Tourism is becoming a major industry -- non-state residents spent \$1.6 billion in the state in 1999. However, tourism jobs are typically in the service sector, which pays relatively low wages for the majority of jobs.

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 50th 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.

//2004/Federal funds account for a large proportion of Montana's revenue: in 1999, federal spending represented 84 cents of every dollar of state revenues spent making Montana 5th in the nation for this federal investment; in 2001, the federal share of Montana's welfare and Medicaid costs was 73%, or 4th highest in the nation. Resources supporting state level efforts for MCH and CSHCN are overwhelmingly federal -- less than 5% of funding for the FCHB or the CSHS sections are from the state general fund. Montana depends on its local partners to make up the required match for the MCHBG. //2004//

POVERTY: Montana also continues to be home to a large percent of people in poverty, with 15.5% (compared to 13.3% nationally) estimated to be below poverty, including 21.3% of children (compared to 19.9% nationally) below poverty. (U.S. Census Bureau State and County Quick Facts, Appendix 03-B) All but two reservations are found in eastern Montana and the majority has limited natural resources, high unemployment and disproportionate poverty.

A recent survey of homeless people (conducted in spring of 2000 by CIVIC Consulting sponsored by the Montana Continuum of Care Coalition and DPHHS) of shelters, food banks and other public assistance venues in ten Montana communities identified 1,331 people as homeless, with nearly 20 percent of them under age 18. Twenty-one percent of the individuals surveyed said they had family members -- 41% of the total homeless population reported coming from families including 126 people reported as age 6 or under and 100 between age 7 and 18. Communities consider the number of homeless to be much greater, but no one knows how much greater. There are rural areas in Montana, especially in the eastern part of the state, that are impossible to survey. The survey indicates the major causes of homelessness are severe mental illness, chronic substance abuse and domestic violence. Other reasons listed include job loss, eviction and release from an institution. Mental illness, job loss/no skills and substance abuse were the top three contributing factors. When asked to identify all items or services that were needed, respondents listed their top five needs as food and clothing (474), medical care (472), place to live (457), job training/skills (389) and mental health care-medication (382).

In a 2002 newspaper article (Helena "Independent Record"), it was pointed out that the Polaris School District (in south central Montana) is one of three districts in the country with 100% of its school age children living in poverty. Nine other districts were among the nation's 100 worst: Glacier County ranked 35th, Roosevelt County ranked 67th and Big Horn County was 88th. All three counties are dominated by Indian Reservations. The same article stated that 20 % of Montanans earn no more than \$6.20 per hour.

In November 2000, the Helena "Independent Record" provided the following information on Hunger in Montana: "153,000 people live in poverty in Montana; 60,000 are children under the age of 18?In an average month, 62,328 Montanans used food stamps. Of those, 29,656 were children. 10.2 percent of Montana households are termed 'food insecure' while 3 percent are 'food insecure with hunger'." In the ten counties that geographically contain the bulk of the seven reservations, reservation households represent 70% of the total households in the county receiving food stamps in calendar year 2001. (Human and Community Services Division data, July, 2002)

The national unemployment rate during calendar year 2001 was 4.8%. Montana's rate was slightly lower at 4.6%. However, the 12.6% unemployment rate on the reservations was 274% higher than the state rate that year. /2004/ Year after year, data on poverty in Montana continue to demonstrate the disparity of impact on the population as a whole compared with the seven Indian Reservations. The reservation with the most abundant resources at its disposal still has 52% higher unemployment than the state's overall rate in 2002.

### Annual Average Unemployment Rates on Montana's Reservations

#### Reservation 1999 2000 2001 2002

Blackfeet	21.3%	20.0%	17.4%	15.6%
Crow	14.9%	21.8%	25.1%	21.8%
Flathead	5.9%	5.8%	8.0%	7.0%
Fort Belknap	23.7%	19.4%	16.4%	18.1%
Fort Peck	11.4%	10.9%	8.6%	8.7%
Northern Cheyenne	19.0%	21.0%	21.3%	19.2%
Rocky Boy's	30.0%	27.3%	22.5%	21.8%
Reservations Total	11.6%	12.0%	12.6%	11.3%

Montana 5.2% 5.0% 4.6% 4.6%

(Source: Montana Department of Labor and Industry, Research and Analysis Bureau, June, 2003) //2004//

In a 2002 grant application for local school program funding, one reservation noted that 70% of the adult population is unemployed, more than 56% of the families live below the poverty level, more than 55% of the families live in broken homes, the school drop out rate is 53% and more than 60% of the children test below the 40th NCE on standardized achievement tests. Substance abuse, juvenile delinquency and gangs are major social problems on this and other reservations. "The lack of opportunities is just overwhelming. There are no jobs on the reservations." (Montana Intergovernmental Human Resources Bureau) Neil Rosette, of RJS & Associates, estimates the average unemployment rate on reservations in 2000 was 67.4%.  
**//2005/In 2002 Montana ranked 23rd in cost of living; cost of living index for Montana in 2002 was 97.5. Unemployment rate was 3.9, 44th in rank order. Montana ranked 9th in the country for tourism spending in 2000. In 2002 Montana ranked 35 in the percent of change in housing prices. The percent of change was 25.20. In 2002, Montana ranked 31st in bankruptcy filings by individuals and businesses. Montana's index of economic momentum in 2002 was 0.74, 8th in the nation. In 2002 Montana ranked 31st in the nation for income from gambling. From 1997 through 2001, Montana ranked 31st in home ownership. In 2003, Montana's unemployment rate was 4.7. In 2002, 13.7% of Montana's population was in poverty with 18.4 % of children living in poverty.//2005//**

POLITICAL JURISDICTIONS: The state has 56 counties ranging in area from 719 square miles to 5,529 square miles; 46 counties are considered frontier, 8 are considered rural and only 2 are considered urban. /2004/ Fifty-four counties have county health departments, While these 54 counties contract with the DPHHS to provide MCH and other health services, the local health departments are

county entities under the control of local Boards of Health and the staff are county employees. //2004// There are seven Indian reservations with separate nation status for 11 Indian tribes occupying 8.4 million acres. /2004/ The separate nation status of each of the seven reservations in Montana, and the federal role in public health on the reservations, pose jurisdictional challenges affecting coordination of county and tribal health services for clients in common between the two service delivery systems. For example, a periodic update interface was designed between the I.H.S. data system and the county-used Public Health Data System in which the State's central immunization registry is located. The periodic data "dump" would update both databases for clients in common between the two systems, most frequently prior to the beginning of each school year. Four of the seven tribes have tribal health clinics staffed by the Indian Health Service. The other three tribal health clinics belong to the three "compact" tribes that staff their own clinics. Although the I.H.S. data system is used at all seven tribal health clinics, patient health data that is not entered into the system for I.H.S. staff services may not be shared with the State without separate agreements with the three compact tribes that staff their own clinics. One such agreement was nearly reached when a change in tribal leadership brought the agreement to a halt. Further, the I.H.S. national office decided in 2001 to design their own specifications for all state registry interfaces with their data system and the Montana effort was superseded. The federal interface is still in alpha testing. //2004//***2005/Montana ranked 4th in the nation in number of eligible voters registered and 7th in the percent of population who voted in November 2002 (50% voted). In 2001 Montana ranked 8th in impact of the federal government per capita and 5th in federal spending on grants per capita. In 2000 Montana 26th in state and local tax revenues and 45th per capita in tax burden. In 2000 Montana ranked 5th in property taxes. In 2001 the state ranked 46th in sale taxes, 28th in individual income taxes, 18th in highest person income taxes and 19th in corporate income taxes.***//2005//

**ACCESS TO HEALTH CARE:** Nine counties have no private medical services at all. There are 54 local county public health departments. Health care for the tribal residents of Montana is provided by a network of services including: off-reservation hospitals, clinics and practitioners; county health departments; Indian Health Service systems; and tribal health services located on the seven reservations. It is commonly estimated that approximately half the Indian population does not live on the reservations 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.

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 that 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 that serves their military personnel and 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.

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.

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, Libby/Lincoln County, and Livingston/Park County. Chinook/Blaine County and Ashland/Rosebud County have recently received notice of CHC funding. 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.

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, Hysham/Treasure County, and Beaverhead and Madison Counties. In 1999, these centers served 12,400 migrant workers.

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. All the service units, with the exception of the Rocky Boy's 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.

HMO penetration in Montana continues to be very limited. The Montana Medicaid HMO that had operated in Billings and Great Falls for four years was discontinued effective July 1, 2000. The Department and the HMO mutually decided that, with enrollment lower than expected and with increasing federal regulations, it was no longer feasible to continue to offer this Medicaid option.

County health departments are central to provision of public health services in Montana. Of the 56 counties in Montana, 54 of them provide some sort of public health services. Immunization and WIC services are provided in all counties, sometimes by arrangements with neighboring counties. Public health departments range in size from a large system including primary care services for the underserved 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, depending on contracted efforts to address public health and MCH service needs. Sanitarian services are available in all counties. The pool of trained public health nurses is very small and recruitment continues to be a problem. The loss of just one nurse significantly affects 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 for MCH dollars, this is the only funding available to carry out core public health functions.

Accessibility to primary care givers is inconsistent. The larger population centers have adequate numbers of primary care providers and accessible specialty care for those with public or private health insurance. /2004/However, all or part of 44 counties are designed by HRSA as Medically Underserved Areas (MAU) and 4 counties are also designated as having Medically Underserved Populations (MUP) for their low-income residents. The Bureau of Business and Economic Research of the University of Montana is studying the incidence of uninsured status in Montana and on June 25, 2003,

reported the following for the Montana population under age 65: 43% of urban residents are uninsured and 57% of rural residents; 31 to 45% of American Indian residents are uninsured, while 18-22% of Whites and all others lack health insurance. (Only .5% of residents 65 years of age and older lack health insurance.) It is often working families that lack health insurance -- 45% of the uninsured have incomes two times above the poverty level, 75% are employed, 92% have a high school education or higher. Most of the businesses in Montana are small businesses, and many cannot afford health insurance premiums for themselves/their families or their employees. Agricultural families are often disqualified from public programs because of their high assets, even with low income, and have no ability to pool for reduced premiums. //2004//

/2004/ Access to dental care for Montanans without dental insurance is difficult. Because of the reimbursement rate for Medicaid recipients, many dentists refuse to accept Medicaid clients, making the workloads of those who do overwhelmed by the need. The Montana Foundation of Dentistry for the Handicapped is co-sponsored by the Montana Dental Association. This group provides free comprehensive dental care to people who are permanently disabled, medically compromised or elderly and who cannot afford dental care. As of June 2003, a waiting list of 70 people is reported. Six Montana Community Health Centers (Billings, Butte, Great Falls, Helena, Missoula and Libby) include some dental services wide ranging variation of coverage -- one provider three days a month has 3,000 on the waiting list in Missoula. One of the repeated themes in the qualitative data from Montana's point-in-time PRAMS was lack of access to dental care for Medicaid participants during their pregnancies. Dental clinics are offered in thirteen locations on the seven reservations through the Indian Health Service. //2004//

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 nation 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 an 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. All maternal deaths are reviewed. There were two pregnancy-associated or pregnancy-related maternal deaths reported in provisional data for 2001. There were two maternal deaths in Montana in 2000 and both were autopsied. As yet, maternal death review has not been incorporated into the fetal, infant and child death review process. It remains under consideration.

The violent crime rate in Montana 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's murder rate is 27th in the nation. 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. 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 they 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) 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 caseloads 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. According to preliminary figures from the Health and Human Services' Centers for Disease Control and Prevention, released June 26, 2001, "Mortality for several leading causes of death declined in 1999". This national trend included falling rates for heart disease and cancer, which continue to account for over half of the deaths in the US each year. In addition, "suicide, homicide, and firearm mortality dropped an estimated 6 percent between 1998 and 1999." There were reported increases in other leading causes of death, "including septicemia (6.6 percent); hypertension (5 percent); chronic lower respiratory diseases (4 percent), and diabetes (3.3 percent)." CDC's State Health Profile for Montana (Year 2000), notes childhood health concerns to include birth defects, vaccination coverage, infant mortality, prenatal care and teen pregnancy. /2004/ Montana has developed a birth defects registry that now contains data for 2000, 2001, and 2002. An increased rate of Down's Syndrome appears to be developing in the data. A CDC investigation is going to be performed in the late summer of 2003 on the increased incidence of gastroschisis in the Billings area. //2004// Proportionately more infant deaths are attributed to birth defects and Sudden Infant Death Syndrome in Montana than nationally -- these are interesting statistics, due to the lack of confirmation of birth defects and to the inconsistencies of SIDS reporting still identified by the state FICMR team. Considerably less than the national average percent of deaths are attributed to low birthweight/respiratory distress syndrome. Again, Montana's small numbers may have contributed to the variability.

/2004/In November 2002, the Fetal Infant Child Mortality Review (FICMR) program authorized by the Montana State Legislature in 1997 published its first report using 1997-2000 data. There were 865 fetal, infant and child deaths in Montana during that time period. Just under half of these deaths (427) were reviewed by the 27 local FICMR teams covering 48% of the counties. These reviews do not

represent a statistical sample, but rather the variability of the current local review process. Nevertheless, the program determined that 42% of the reviewed deaths that contained prevention findings were preventable. The primary causes of infant deaths were congenital anomalies, prematurity and SIDS (68% found in the tummy position). Primary causes for death in children 1-17 were unintentional injuries such as motor vehicle accidents, natural causes and suicide. The motor vehicle death rate for American Indians was 2.27 times the Caucasian rate. //2004//

Montana's vaccination coverage is noted as at or better than national averages for Measles-containing vaccine, DTP, Polio and HIB, and slightly less than the national average for Hepatitis B and Varicella.

Montana's small numbers result in variable statistics. According to the 2000 Montana Vital Statistics Report "Montana's rates for cerebrovascular disease, pneumonia and influenza and diabetes showed inconsistent relationships with the U.S. rates" ( p. 63) Montana also appeared to have a high incidence of deaths attributed to chronic lower respiratory diseases, including bronchitis, emphysema, and asthma. The report also noted that Montana's incidence of deaths due to accidents (motor vehicle and non-motor vehicle) and suicide continues to be higher than the national averages. The report does note that a switch from ICD 9 to ICD 10 coding has likely resulted in some inconsistencies and variability, which may have affected reports. However, Montana's consistently high incidence of deaths due to accidents and suicide cannot be rationalized or explained by data. According to the CDC report, Montana had one of the highest death rates (age adjusted) in the nation, exceeded only by Arkansas, Mississippi and Alabama. Montana also had the most deaths per 100 million miles traveled, and the third highest incidence of suicide.

Montana, as does most of the nation, faces a health care worker shortage. During the reporting year 2001 and into 2002, a task force was created and appointed by the Governor to "To accurately assess the shortage of health care workers, and to develop recommendations and strategies to effectively address the issue." An excerpt from recent minutes summarizes the situation in Montana:

"According to the U.S. Department of Health and Human Services' recently published State Health Workforce Profiles, in Montana, some health care occupations - Licensed Practical/ Vocational Nurses (LPNs), nurse practitioners, certified nurse midwives, dentists, dental hygienists, dental assistants, pharmacists, psychologists, social workers, home health aides - are keeping pace with national average ratios of workers per 100,000 population. Other important occupations lag behind: With 181 physicians per 100,000 population, Montana is below the national average ratio of 198 physicians per 100,000.

Montana has 764 licensed registered nurses (RNs) per 100,000 population, less than the national average of 798 per 100,000.

With 41 pharmacy technicians and aides per 100,000 population, Montana ranks 49th among the 50 states.

Montana has 6.5 psychiatrists per 100,000 population, well below the national average of 11.1 per 100,000.

With 19 occupational therapists per 100,000 population, Montana is below the national average of 24 per 100,000.

Montana has 25 respiratory therapists per 100,000 population compared to the national average of 31 per 100,000.

With 92 clinical lab technicians and technologists per 100,000 population, Montana is well below the national average of 105 per 100,000 population.

Montana ranks 40th in the nation in dieticians and nutritionists, with 14 per 100,000.

***/2005/ In 2001, Montana ranked 21st in immunization rate. In 2000, Montana ranked 39th in infant mortality at 6.1/1000 live births. In 2002, Montana was rated 24th in state health rank by the United Health group (based on a composite of indicators such as unemployment, health practices such as smoking and availability of health services and outcomes such as death rates, etc). IN 2001, Montana was 19th in the percent of non-elderly without health insurance (15.9%). Montana ranked 39th for adult smokers and 42 in percent of the population considered obese. In 2002, Montana was 39th in number of physicians/100,000 population with 207 physicians for every 100,000 population.***

***In 2000, Montana ranked 35th in Medicaid recipients and 25th in state and local funding spent***

**on health and hospitals. Montana ranked 34th in per capita spending on Medicaid recipients, 7th in average Medicaid spending per child, and 19th in Medicaid spending on aged recipients. Montana ranked 6th in the nation for hospital expenses per inpatient day at \$2,573.**

***In 2002, Montana ranked 43rd in percent of the population in HMOs.//2005//***

This snapshot does not tell the whole story. Montana needs nearly 1,000 more health care workers right now just to catch up to the national averages! And, as Montana's population continues to age, demand for all occupations - including those that are now adequately staffed - will rise dramatically while the health care workforce diminishes. The impact will be felt more dramatically in Montana than in most other states because of our older-than-average population: by 2020, Montana's population is projected to increase 15 percent, while the population over age 65 is projected to grow by 85 percent, compared to national growth projection of eighteen percent and fifty three percent respectively." (Minutes of the Governor's Blue Ribbon Task Force On Health Care Workforce Shortage meeting on Thursday, May 30, 2002, Page 3.)

## **B. AGENCY CAPACITY**

***/2005/ The Pubic Health and Safety Division (PHSD) within the Department of Public Health and Human Services (DPHHS) is responsible for most public health programs, including the Maternal Child Health (MCH) and Children's Special Health Care Needs (CSHCN) programs. The MCH and CSHCN services as described in Title V of the Social Security Act are managed in two Bureaus in two divisions within the DPHHS. The Family and Community Health Bureau (FCHB) is the primary MCH agency, responsible for development of the MCHBG report and plan, budget monitoring, and implementation of the plan. The Health Care Resources Bureau includes the Children's' Special Health Services program, which is the unit responsible for services to children with special health care needs and their families and is located in the Child and ADult Health Resources Division.***

***Efforts to integrate and coordinate services to the MCH target population of pregnant women and infants, children, including those with special health care needs and adolescents, childbearing women and the families of all target populations have been ongoing over the last decade. Staff at the state level work closely together to decrease administrative burden and streamline reporting requirements for local contractors/partners. Over half of Montana's local health departments are "one man shops", with a public health nurse, and possibly an administrative assistant responsible for implementation of numerous state programs. Since 1999, all counties have a standard MCH contract, requiring them to provide services to the MCH population. A spring public health meeting was initiated in 1999, combining meetings of WIC, public health nursing, home visiting programs, and immunization programs. This decreased travel time and meeting planning costs./2004/The Spring Public Health Meeting in May 2003 had 293 participants -- one of the largest public health gatherings in state history//2004/The spring public health meeting in May 2004 had 325 participants.//2005//***

***/2005/The FCHB administers the following federally funded programs: the Special Supplemental Nutrition Program for Women, Infants and Children (WIC; the Title X Family Planning Program; the State System Development Initiative project which supports MCH service reporting through the Public Health Data System (PHDS); the Universal Newborn Hearing Screening program; the Healthy Child Care Program; the Birth Defects Registry; the Coordinated School Health Program; and the Pregnancy Risk Assessment Monitoring Survey (PRAMS). The FCHB administers the contracted clinical genetic services program, and Montana's Initiative for the Abatement of Mortality in Infants or MIAMI, (now renamed Public Health Home Visiting), which are funded by state general fund. //2005//***

***/2005/The Children's Special Health Services (CSHS) section in the Health Care Resources***

**Bureau administers 30% of the MCHBG. Services are provided to Montana children with special health care needs and their families by the CSHS program staff and their contractors. Services include case identification and referral, consultation and technical assistance, clinical programs and staffing, regional clinic coordination in two locations, and direct payment of 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. In Montana, CSHCN program eligibility is based on diagnosis/condition and financial eligibility. CSHS has worked with various stakeholders regarding the need for systems to reflect common values for the benefit of all CSHCNs, while also promoting access to community-based systems of care and decreasing competition among programs for dwindling resources. CSHS works with State agencies and private business to insure access to community based care. This includes partnering with private organizations to provide case management services to CSHCN where public health resources are not available. Coordination of services with Medicaid, dental, durable medical, home and community based waivers and the transportation programs may result in improved outcomes for CSHCNs. Collaboration with the medical centers in Billings and Missoula have resulted in family-centered pediatric specialty clinics, insuring that specialists are available to families locally, reducing or eliminating the burden of out of state travel for medical care. CSHS has also begun to research the capacity of local county health departments to participate in targeted case management for CSHCN. CSHS has begun to promote the need to provide community-based care for CSHCN, regardless of their diagnosis or disability. Bringing new partners to the table, such as Early Intervention (Part C), and the Montana School for the Deaf and Blind has provided CSHS the ability to stress the need to promote the core values in providing care to all CSHCN. This activity has increased the capacity of the program by decreasing the duplication among these providers. Continual collaborative efforts will further streamline the system for families. The ability to support and provide case management for CSHCN has expanded due to the increase in the number of private firms that have shown an interest in the activity. Additionally, emphasis on provider education has brought some public health departments back to providing this service. The beginning of cross system coordination is occurring to assist families in choosing the appropriate case manager for their child's situation.//2005//**

**/2005/CSHS continues to foster relationships with non-profit organizations dedicated to children's issues. Parents Lets Unite for Kids (PLUK) is a longstanding advocate for parents and families, and the host organization for Montana's Family Voices chapter. Work with PLUK has centered on collaboration to improve access to community-based, family-centered services for CSHCN. One such endeavor is the CMS Family-to-Family Health Care Information and Education Center grant. This grant promotes and formalizes family-to-family support in communities for CSHCN in Montana. A medical home demonstration project titled "Optimal care coordination for CSHCN" focuses on assessing the abilities of the medical home to effectively provide care coordination by fostering relationships with families and the providers of community-based systems. CSHS will also develop a professional standard for case managers of CSHCN and a series of educational forums to be delivered throughout state. CSHS works to empower families to coordinate services for their children in an attempt to avoid service duplication. CSHS receives both approvals and denials of SSI benefits for children. Children who are not eligible for SSI are directed to the local public health department, a specialty clinic or a private case manager to assist with accessing appropriate services. Individuals who are SSI disabled and receiving Montana Medicaid benefits have access to a full array of rehabilitative services. Efforts with SSI have led to the development of an electronic data link to the CSHS program to receive the SSI referrals. CSHS is working toward increasing the program's capacity re education for families of SSDI children and works with Medicaid to insure appropriate service delivery. CSHS is also working to coordinate with other service systems by linking clinical processes to prior authorization functions within SCHIP and Medicaid.//2005//**

**/2005/WIC has been developing a restructuring plan for WIC service delivery for the state.**

**Limited resources and increasing demands on local staff necessitated a careful review of the existing structure. Local staff are actively participating in the restructuring process, which began with a facilitated meeting in September of 2002 and has continued into the present. The statewide committee recommended that local agencies have a minimum of 200 participants and those with less than this amount align with a neighboring local agency. The goals of restructuring are: to provide high quality nutrition services; to maximize available (delining) resources; to ensure more stable funding/funding available for other needs, such as training/education of staff, creation/purchase of nutrition education materials); and to achieve economy of scale for programs (Montana's funding is not expected to increase).//2005//**

**//2005/The Family Planning program contracts with 15 local agencies to provide family planning services in 38 locations. All 15 family planning programs are designated STD programs and all programs have enrolled medical service providers that provide comprehensive breast and cervical screening services to an identified target population. One location is an administrative site for the Montana Breast and Cervical Prevention Program. Four family planning sites are funded as HIV prevention sites./2004/Family Planning staff and contractors have been working on a strategic plan for family planning services in Montana//2004// A strategic plan workshop with contractors and staff was conducted and a plan developed.//2005//**

**//2005/In 1989, the Montana Legislature enacted legislation establishing the Montana Initiative for the Abatement of Mortality in Infants (MIAMI)and supporting it with general funds. The goals of the legislation compliment the charges in Title V of the Social Security Act, which are to 1) assure 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, 2) reduce the incidence of infant mortality and the number of low birth weight babies and 3) to prevent of the incidence of children born with chronic illnesses, birth defects or severe disabilities as a result of inadequate prenatal care. MIAMI funding was contracted to 22 counties (providing services to 33 counties) and 6 of the 7 reservations in the state to provide home visiting services for high-risk pregnant women and their young children. The program provides services to approximately 1,400 high-risk pregnant women and their families each year, accounting for about 13% of the pregnant population in the state. MIAMI (now called Public Health Home Visiting) has been revised to focus on the most vulnerable and needy high risk pregnant women and the distribution of funds has been changed as well. A formal Request for Proposal (RFP)process was conducted in 2004 to solicit proposals from county and tribal health departments in response to the specific service requirements of the program. Twenty contracts will be awarded to the successful applicants. MIAMI funding was not included in the Governor's Budget Plan as presented to the 2003 legislature. \$550,000 of the base \$589,000 for MIAMI was restored by the legislature very late in the session, due to the efforts of local public health providers, their clients and advocates The next legislative session begins early in January, 2005. The final status of the MIAMI funding will not be finalized until early April 2005 when the Legislature adjourns. It is anticipated that the local support of this critical program for high risk pregnant women will be as strong as it was during the last session. //2005//**

**//2005/Montana's Fetal, Infant and Child Mortality Review originated with the MIAMI program in 1989 with focus on fetal and infant deaths. Child deaths were added to the review process in 1996. Contract funding from HRSA supported state and local team efforts into 2002 -- the Maternal Child Health block grant has absorbed the cost of the state staff supporting the program, and local teams have become self supporting, relying on volunteer time and resources. In 2003, 28 teams were reviewing almost 90% of the deaths for 43 of the 56 counties and 5 of the 7 Indian Reservations. Montana's first Fetal Infant Child Mortality Review Report was published in spring of 2003 and was presented to the Governor in a briefing by representatives from around the state. The 2003 legislature passed legislation verifying and clarifying the ability of counties and tribes to partner on reviews. Due to this expanded capability for FICMR reviews, there are now 27 consolidated community level teams reviewing deaths for 53 counties and all 7 reservations. Montana now has the capability to review about 90% of all fetal, infant and child deaths. These teams assess prematurity issues leading to the**

**death of an infant, and initiate change or make recommendations as appropriate.//2005//**

**/2005/Montana's oral health program has worked closely with the Primary Care Office and Primary Care Association over the last several years to focus education and cooperation regarding the importance of oral health and the serious access issues that exist in our state. The dental program also coordinates school-based efforts to enable schools to conduct dental screening and fluoride rinse programs. School children receive dental screens and participate in the fluoride rinse program. The Oral Health program also works in conjunction with the WIC, Head Start, Healthy Child Care Montana and the Child, Adult Care Food Program to develop appropriate services for the pre-school population. Training materials for public health and dental professionals were supplied to dental screeners and data recorders on a case-by-case basis to assure standardization and utilization of the Basic Screening Survey (BSS) surveillance instrument developed by the Association of State and Territorial Dental Directors (ASTDD).//2005//**

**/2005/In partnership with the Office of Public Instruction, Montana has been developing a coordinated school health program using the CDC DASH guidance since 2000. Local county health nurses, funded by MCHBG dollars, have traditionally provided school nursing services in many counties. Services included recommended screening of vision, hearing and scoliosis, but little guidance or support to school staff providing health and safety services and education was available due to lack of staff time. CDC DASH funding allowed for hiring of a full time Comprehensive School Health Coordinator responsible for coordination of the public health components of the state's Comprehensive School Health Program. This position coordinates a bi-monthly joint meeting with OPI, called the Joint Committee for Healthy Kids. The Comprehensive School Health grant was approved but not funded by CDC in April of 2003. Division management discussed the importance of the ongoing role, and funding sources were investigated. Funding support was tentatively identified which would allow the state to retain the permanent position approved by the legislature. Various sources were used to retain at least half a position dedicated to coordinated school health. However, the 1/2 school health position was lost in early 2004.//2005//**

**/2005/The Healthy Child Care Montana project has been a contract activity with a local health department, to help develop resources and services, which may improve the health and safety in childcare settings. State and local staff have worked to mainstream the efforts to coordinate public health and childcare provider efforts. The transitioning of the federal funding toward the ECCS development will capitalize on the partnerships developed. Contract staff continues to provide consultation and support to local health departments and resource and referral networks. Contract staff developed resources as part of local obesity efforts, which may be shared with other communities. Contract staff assisted in the development of local bioterrorism response guidelines for child care providers, and will partner with state agency staff to provide BT training to child care providers and schools as resources allow.//2005//**

**/2005/Asthma has been identified as a major health concern in Montana, and efforts to improve tracking and case management have resulted in several funding streams. Montana applied for a grant to assess the asthma incidence and develop appropriate treatment strategies in fall of 2001 - the grant was positively reviewed, but was not funded. A Relief from Asthma Program (RAP) for Medicaid children with asthma in partnership with Montana Medicaid was begun in March 2002. The program was piloted in seven sites, and training was conducted for public health staff to provide the case management services. Reimbursement for services was through the targeted case management program for children with special health care needs. In 2002, a student intern from Emory University conducted a retrospective surveillance project of charts of patient's receiving services from three CHCs in the state. The project revealed that pediatric asthma prevalence in these health centers is similar to the national average, and Native American children had a higher rate of asthma than the Caucasian population in this study. A guide "Asthma and Child Care, What You Need to Know" was developed and mailed to registered day care providers in 2002. In 2003, the RAP program continued to serve**

**Medicaid children in seven counties around the state. Medicaid implemented a chronic disease case management program, Nurse First, and the RAP program has been superceded by this initiative. There are four nurses available to cover the entire state for direct client contact and the rest of the Nurse First program is provided telephonically. The Bureau maintains a childhood asthma educational outreach to public health nurses and the general public.//2005//**

**/2005/The state SIDS rate has been above the national rate for all years in this decade. 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. In 2002, SIDS deaths occurring in childcare settings were recognized as a new area for concern. A guide entitled "Sudden Infant Death Syndrome: A Guide for Child Care Providers" was developed and approximately 1800 copies were distributed through the twelve Resource and Referral Networks to registered child care providers. In 2003, recognizing that shortened hospital stays for new moms and their infants may be hindering the provision of "new parent" information, letters were sent to every Montana hospital asking them to examine their policy on infant sleep position in their nurseries and to model "Back to Sleep" as a teaching tool, and a press release on "Safe Sleep Recommendations for Infants" was launched statewide. This program continues to provide information and resources, including safe cribs, for families across the state, aided by a grant from Safeway for crib purchase. With a grant from the CJ Foundation for SIDS, the program developed and disseminated Native American SIDS risk reduction materials noting that prematurity and low birth weight are SIDS risk factors.//2005//**

**/2005/The Fetal Alcohol Prevention program began in 2001, funded by Congressional set-aside funding focusing on South Dakota, North Dakota, Minnesota and Montana. The project funded \$3 million dollars per year to develop a three component effort which included 1) the creation of a Four State FAS Consortium, charged with program development, implementation and evaluation, 2) assessment which included gathering of consistent data with which to accurately assess the incidence and impact of FAS in the region and 3) intervention projects, focused on the prevention of fetal alcohol syndrome and fetal alcohol effect. Montana's intervention was built upon the MIAMI project, adding intensive home visiting and case management for pregnant women at risk of having a child with FAS/FAE. The project enabled the state to partner with Dr. Phillip May, a researcher from the University of New Mexico to bring a team to provide FAS evaluation clinics in the state. The team included dysmorphologists, an educational diagnostician, a neurologist, and trained interviewers to work with biologic mothers. The first of six three-day FAS Diagnostic clinics were held in 2002 in Great Falls and at the Blackfeet Reservation. In the third year of the FAS project, continued Congressional earmarked funding is questionable. Strategies to incorporate the FAS prevention efforts into the MIAMI program were considered. The FAS Advisory Council sought alternative funding to support efforts. NCAST training was provided to local FAS prevention team members to improve their ability to identify and intervene on maternal use However, Four State Consortium FAS funding was not earmarked at the federal level. Montana is now considered a non-active member contingent upon funding. //2005//**

Adolescent Health Efforts to develop strong adolescent health services continue with emphasis on the two top causes of morbidity and mortality in Montana: unintentional injury and suicide. Adolescent issues are coordinated out of the CACH Section by the Adolescent Health Coordinator. Suicide prevention efforts are directed by priorities set in the Montana Suicide Prevention Plan, which was finalized in 2001. The improvement of youth mental health resources and addictions treatment for adolescents is another focal point. A recent co-operative project regarding unintentional childhood injury is a feasibility study cross-linking data from ambulance, hospital emergency rooms, Medicaid payment, and traffic accident data. Preliminary results should be available by the end of the year. Adolescent health needs are also addressed through collaboration with the Montana Abstinence Program, Women & Men's Health Section, the Immunization Program, Infectious Disease Program,

***/2005/In 1985, the Montana legislature authorized the creation of a voluntary statewide genetics program, funded by a tax on individual insurance policies. The program provides for newborn heelstick screening follow up, and genetic services and education for the people of Montana. FCHB provides the newborn screening program follow up, referring children identified with metabolic disorders to the CSHCN and genetics programs for intervention and evaluation. In 2004, a formal request for proposal (RFP) process was undertaken to award a new contract for clinical genetic services for Montana after more than a decade of annual renewal of the existing contract. A new contract has been awarded to the previous contractor and services and reporting requirements have become more clearly focused./2005//***

***/2005/Montana's birth defects registry, the Montana Birth Outcome Monitoring System (MBOMS), was initiated with CDC funding in 2000. The population based registry identifies and refers children in need of services to the CSHCN and other appropriate services. Initially, the program was a passive case ascertainment system, focusing on four major anomalies - congenital hypothyroidism and cleft-craniofacial, cardiac, and neural tube defects. CDC recommended active case ascertainment, which was added in 2001. The program was funded for an additional three years of CDC funding in 2002. Also in 2002, a student intern from Emory University spent the summer in Montana analyzing the MBOMS data. With the help of staff from CDC, a high incidence of Down's Syndrome was identified and subsequently evaluated. The birth defects coordinator in the FCHB works closely with CSHCN program to assure case identification and follow up. In 2003, the birth defects coordinator, working with staff in Denver, identified what appeared to be a high incidence of gastroschisis in the south central part of the state. Following internal review, CDC was notified, and determined that an investigation was warranted. A letter was sent to CDC in June of 2003, and an EIS officer investigated the incidence in August in cooperation with Montana's birth defects registry staff. The final report is anticipated to be complete and released this summer./2005//***

***/2005/Montana's heelstick newborn screening program was based in the Montana Public Health Laboratory until 1995, when newborn screening follow up was transferred to the FCHB. A team of experts reviewed Montana's newborn screening program in the summer of 2000, providing staff with a list of recommendations and resources. As a result of that consultation, a newborn screening committee was formed, and has addressed many of the recommendations. The program continues to be a partnership between medical providers and hospitals, the public health laboratory, parents, the FCHB and the CSHCN program. Montana's screens include four department-required blood tests for PKU, galactosemia, congenital hypothyroidism, and hemoglobinopathies. Due to fiscal constraints and resistance to any increase in existing lab charges, additional lab tests have not added for a number of years. In 2004, the monitoring of newborn heelstick and hearing screening will be combined with maintenance of the birth defects registry to ensure continuity of contact with the local birthing facilities and physicians, to stress the importance of early detection and intervention of treatable conditions in newborns, and to continue the smooth referral of confirmed cases of abnormality to CSHCH, the medical home and the Montana School for the Deaf and Blind./2005//***

***/2005/The Integrated Data for Evaluation and Assessment (IDEA) Project was designed in 1998 to provide improved support for the delivery of maternal and child health-related services at the state's local public health departments and to improve local and state capability for evaluation of program effectiveness. The Public Health Data System (PHDS) was developed for use at local health departments to support their client case management and reporting capability. PHDS has been designed to support four of the public health programs provided at the local level -- client case management and tracking, an initiative to serve women with high risk pregnancies, family planning and immunizations. The immunization component will include: population of the immunization registry with birth record data; immunization data from the Indian Health Service and participating tribal health departments; and linkage with***

***private providers of immunizations. Interface of the PHDS with the Indian Health Service data system in use in Montana's tribal health department stalled when the IHS decided to establish its own national immunization registry interface protocol for use by all states. It has been in beta testing for more than two years. PHDS has been rolled out to 83% of the local public health departments.//2005//***

Statutory Authority for Maternal and Child Health Services Authority for maternal and child health activities within the Department are found in the Montana Codes Annotated ((MCA), 50-1-202. General powers and duties of the state include administration of federal health programs delegated to the states; rule development for programs protecting the health of mothers and children (including programs for nutrition, family planning services, improved pregnancy outcomes, and Title X and Title V); accept and expend federal funds available for public health services, and use local health department personnel to assist in the administration of laws relating to public health.

Rules implementing the above authority are found in Title 16, Chapter 24, and 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./2004/The rules governing the

CSHCN program and the NBS program were revised in 2003. Since the rule changes did not adversely affect clients and providers, CSHS adopted the rules for use on October 1, 2002. However, they are currently in the Department's legal office undergoing preparations to be officially filed with the Secretary of State. An external review committee in 2000 initiated NBS program rule changes in response to recommendations from a review of the Newborn Screening Program. A committee including perinatal and neonatal clinicians and staff from the Laboratory Bureau, the Healthy Resources Bureau and the Family and Community H

## **C. 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. The department mission is "improving and protecting the health well-being and self reliance of all Montanans." In the 1995 reorganization of state agencies, human services programs were combined with health services to create a comprehensive "mega agency". During that same reorganization, the environmental component of public health was separated and those functions now are carried out by the Department of Environmental Quality. Organizational charts of the Montana Department of Public Health and Human Services, the Health Policy and Services Division, the Family and Community Health Bureau and the Health Resources Bureau are included in following pages.

The Director of the Department since 2001 is Gail Gray, former assistant superintendent of education for the state. Dr. Gray leads a department which is the second largest in the state, following the Department of Transportation. The Department has a staff of approximately 3,000, located across the state. DPHHS is organized into ten divisions:

- Addictive and Mental Disorders
- Child and Family Services
- Child Support Enforcement
- Disability Services
- Fiscal Services
- Health Policy and Services

Human & Community Services  
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 (HPSD). The mission of HPSD is to "Improve and protect the health and safety of Montanans." Maggie Bullock has been the administrator of the division since 2001. The programs and staff (approximately 180) are organized into five bureaus and one administrative support unit:

Communicable Disease Control and Prevention Bureau  
Health Resources Bureau  
Health Systems Bureau  
Family and Community Health Bureau  
Medicaid Services Bureau  
Public Health and Environmental Laboratory Bureau  
Financial, Operations, and Support Services Unit

Maternal and child health services as described in the Title V of the Social Security Act are the responsibilities of the Family and Community Health Bureau (FCHB) and the Health Resources Bureau (HRB). The Family and Community Health Bureau has a staff of 30 and a total budget of approximately \$21 million. The bureau is organized into four sections, which are:

Child, Adolescent and Community Health (CACH)  
Maternal Child Health Data Monitoring  
WIC/Nutrition  
Women's and Men's Health

The Health Care Resources Bureau (HCRB) has 18 staff members and an annual budget of approximately \$16 million. The bureau is organized in two sections: Children's Special Health Services (CSHS) and the Children's Health Insurance Plan (CHIP).

HCRB provides services to children in three ways: direct services to children, indirect services to children, and administrative services.

Direct services to children include metabolic clinics and case management services, regional clinics, nutrition services, neonatal follow-up, newborn screening follow-up, medical home program, transition services, case management, care coordination, clinic coordination, systems of care development, dental services, vision services, hearing aids, medical services, enrollment, and medical reviews.

Indirect services to children include: outreach, cultural competence, plan relations, provider relations, advocate liaison, enrollee education/newsletter, quality assurance/improvement, customer service, family support and referral, health care integration for access, coordination and referral, policy development and review, complaint processes, web page development and maintenance, and data systems development and coordination.

Administrative services include: office and facilities management, personnel management, labor-management relations, state/federal coordination, CHIP State Plan, MCH Block Grant submission, administrative rules, file and chart systems, research, professional development, surveys, technical assistance, contracts, waivers, payroll, new employee orientation, communication, budget and fiscal, performance measurement, grant writing, safety and security, program evaluation, legislative support, congressional requests, public relations, and purchasing and inventory.

The FCHB manages approximately 300 contracts with local providers for MCH services including primary and preventive services for women, infants and children, family planning services, tribal

programs and WIC. Approximately 90% of the total bureau budget is expended at the local level.

Provision of timely information to contractors and partners is managed in several ways. The division has a website which includes information and resources for all bureaus and sections. The website continues to be a "work in progress". In addition, the FCHB publishes a newsletter titled "FCHB Facts" bi-monthly, and the HRB publishes a "CHIPChat" quarterly. In addition to the Spring Public Health meeting which was discussed in the Agency Capacity section, the WIC and MCHDM section conduct regional meetings annually, taking information regarding block grant reporting and needs assessment and WIC program requirements and system changes to communities across the state. State program staff also routinely participate in and present at pertinent meetings around the state, including the Montana Public Health Association, the Montana Perinatal Association, the Montana Academy of Pediatricians, the Montana Nurses Association and other professional organizations.

Staff in the Women's and Men's Health Section are the designated links to 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.

/2004/As a result of 2003 legislative action, a new division will be created within the department effective July 1, 2003. The Child and Adults Health Resources Division, will be overseen by Deputy Director John Chappius until a division administrator is recruited.

The new division will be organized into three bureaus:

Medicaid Services Bureau - Jeff Buska, Bureau Chief

Health Care Resources Bureau - Mary Noel Bureau Chief

Children's Mental Health Bureau -- Bureau chief position presently advertised.

The division will bring together health resources for children, including CHIP, Children's Special Health Services, and the Children's Mental Health Program. Linkages with other program focusing on children, including Part C and Developmental Disability programs for Children are under investigation. In addition to the children's services, the division will house the primary care and hospital portions of Medicaid, which were previously part of the HPSD. The final structure of the new division will be completed in SFY 04.

The Health Policy and Services Division, which will be renamed as the Public Health and Safety Division, will be a smaller division, focusing on public health services and programming. The division will be led by Maggie Bullock, and be organized into four bureaus, including:

Communicable Disease and Prevention Bureau; Terry Krantz, Bureau Chief

Family and Community Health Bureau; JoAnn Dotson, Bureau Chief

Health Systems Bureau; Jane Smilie, Acting Bureau Chief

Laboratory Services Bureau; Paul Lamphier, Bureau Chief

Both divisions will receive operations support from the Financial, Operations, and Support Services Unit, supervised by Dale McBride. Reorganization of that unit is anticipated.//2004//

***/2005/ Reorganization of the Public Health and Safety Division continues. The newly reorganized division has six bureaus:***

***Financial Operations & Support Services Bureau, Dale McBride, Bureau Chief***

***Communicable Disease Control and Prevention Bureau; Terry Krantz, Bureau Chief***

***Family and Community Health Bureau; JoAnn Dotson, Bureau Chief***

***Public Health System Improvement & Preparedness Bureau; Jane Smilie, Bureau Chief***

***Laboratory Services Bureau; Paul Lamphier, Bureau Chief***

***Chronic Disease Prevention & Health Promotion Bureau; Todd Harwell, Bureau Chief***

***The creation of the new bureaus were in order to clarify the public health improvement role and distinguish between communicable and chronic disease prevention efforts. The state and***

***the public health community will face many changes in the coming year. Governor Judy Martz elected not to run again, assuring that we will have a new Governor elected in November. The director of the Department of Public Health and Human Services, Gail Gray, also announced her intent to leave in January, when a new appointee will likely be appointed. Governors do have the perogative of appointing existing directors, however, Dr. Gray will leave the state to join her family, so we are assured a new director. And during the first week of July 04, Public Health and Safety Division Administrator Maggie Bullock announced her retirement effective the end of August 2004.***

***The FCHB had several staff leave, allowing for restructuring and organization of some roles. The Newborn Screening and Hearing Screening role was combined with the Birth Defects Monitoring, freeing a position to focus on epidemiology and analysis. In addition, the school health funding and 1/2 position was lost, resulting in the Adolescent Health position to also take on that responsibility. The Fetal Alcohol Syndrome Prevention position was expanded to allow for support of the Public Health Home Visiting programs and substance abuse prevention. New staff hired this year, include:***

***Rosina Everitte, MCH Data Monitoring, Epidemiology/Statistician  
Erin Lavender, Child Adolescent & Comm Health (CACH), Early Childhood Comp Systems  
Sandra Van Campen, CACH, Public Health Home Visiting and Substance Abuse  
Prevention //2005//***

#### **D. OTHER MCH CAPACITY**

As noted earlier, the FCHB Bureau has a staff of 30 and the HRB a staff of 18. The CSHS staff and four FCHB staff (the dental health, adolescent health, child health coordinators and the person responsible for maintenance and monitoring of the local MCHBG contracts) are the 10 staff paid fully with MCHBG. All other FCHB state staff are supported all or in part by other funding, including federal funding (WIC, Title X, Pregnancy Risk Assessment Monitoring, Birth Defects Registry, Newborn Hearing Screening, SSDI and FAS) and general fund (voluntary genetics). HRB staff outside of the CSHS program are supported by a combination of federal CHIP and state match.

In addition to program staff, administrative costs are allocated to all programs in the state agency to support fiscal, operations and legal services. Cost allocation is budgeted based on an analysis of services costs anticipated -- for SFY 03 and 04, that estimate is for approximately 4.5% of the total budget. In addition, state law allows local health departments to use up to 10% of their funds for administrative purposes. Local agencies have been reported approximately 6% of their expenses as administrative costs.

The purpose and structure of the Family and Community Health Bureau Advisory Council was discussed briefly earlier in this report. The Council includes a parent of a child with special health care needs, who is also a Head Start teacher. A list of the memberships is attached. The CSHCN Advisory Group also has two members who are parents of children with special health care needs. The Newborn Hearing Screening Advisory Groups also includes parents of children with hearing loss and adults with hearing loss.

As stated earlier in this application, much of the capacity to address the health needs of the MCH population exists at the local level. MCHBG is distributed to 54 of the 56 counties through MCH Contracts. Those amounts are based on an allocation formula that considers target population and poverty levels. The amount of funding obviously impacts the amount of time and subsequent work, which may be "purchased" with the dollars -- some of the smallest counties receive only \$1,000. The funding does require that a designated individual be available to monitor MCH needs. According to the Montana 2002 County Health Profiles, there were approximately 120 public health nurses, 81 registered sanitarians, 14 registered dieticians and 27 health educator FTEs in public health settings

across the state. The MCHBG helps support a portion of those positions, and in cases, provides the "anchor" or designated funding for public health in the county.

Also noted earlier in this application, the IDEA project Public Health Data System is a system developed for local health departments to use for case management and project reporting. SSDI funding helped in the initial development phases. The system is supported with approximately \$25,000 annually -- to date that amount has been matched or exceeded by various other sources, including Preventive Health Block Grant, Immunizations and Title X. While still a work in progress, the concept of common reporting software is crucial to accurate assessment and documentation of public health services.

The Health Resources Bureau maintains a Family Health Line Since January 2001, the Department of Public Health and Human Services' Family Health Line (1-877-KidsNow) has been the toll-free line with which Montanans can access information about health care programs for children and other health issues sponsored and promoted by the Department. Most of the calls received on the Family Health Line are related to CHIP (the Children's Health Insurance Plan), but approximately one-fourth of the nearly 16,000 phone calls received each year has a referral component, in which the caller is referred to programs, both public and private, including those administered under Montana's Maternal and Child Health Block Grant.

The contract for the Pregnancy Riskline in Utah was discontinued in December of 2001. The National March of Dimes Toll Free line now provides consumer and provider call in services, with back up teratogenic counseling and assessment available. Montana continues to support the concept of a nationally supported toll free line, similar to the Poison Control Line system created approximately 25 years ago.

Brief Bios for the Bureau Chiefs and Section Managers for the MCH and CSHS Areas are included below

Sib Clack is supervisor of the Maternal and Child Health Data Monitoring Section and has a Master's degree in Psychology from Columbia University in New York. She has worked in Montana State government in management and budget analysis, system development, and higher education for over 20 years. She has been in public health for the past six years and has shepherded the development of the integrated Public Health Data System for case management and tracking of immunizations, MCH interventions for high-risk pregnant women and children, and family planning. Ms. Clack is working with other programs to create referral linkages and tracking between newborn metabolic and hearing screening, the birth defects registry, CSHCN, IDEA Part C, the Office of Public Instruction, and the Montana School for the Deaf and Blind to assure an appropriate continuum of service delivery for high risk children and their families.

Jo Ann Walsh Dotson RN MSN, is Chief of the FCHB. Ms. Dotson is a pediatric nurse, with a Bachelor of Science in Nursing from Baylor University and a Master of Science in Nursing from University of Texas. Ms. Dotson practiced in specialty inpatient and public health settings in three states prior to moving to Montana. She was an assistant professor of nursing at Montana State University eight years, and has been at the state health department for 12 years, in various positions including nurse consultant, primary care officer and section supervisor for the Health Assessment and Resource Development section in the Health Systems Bureau. She has been the bureau chief for five years. She is presently a doctoral student at Oregon Health & Sciences University, recently completing her second year of course work. Ms. Dotson completed a three-year fellowship with the Robert Wood Johnson Executive Nurse Fellows Program in 2002. Ms. Dotson serves on a number of advisory councils in and out of state government, including the Montana Council on Developmental Disabilities, the board of directors for Montana's March of Dimes and is the Region VIII Councilor for the Association of Maternal Child Health Programs.

Chris Fogelman, RD MPH, is the manager of the Nutrition Section, which includes the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). Ms. Fogelman is a

Registered Dietitian, with a Bachelor of Science in Home Economics with an Emphasis in Dietetics from Mount Marty College in Yankton, SD, traineeship at McKennan Hospital in Sioux Falls, SD and a Master of Public Health in Public Health Nutrition and Maternal Child Health from the University of Hawaii in Honolulu, HI. She has worked in the field of public health nutrition focusing on maternal-child nutrition for over twenty years. Ms. Fogelman has been in her present position for approximately 20 months and with the WIC Program for twelve years. Ms. Fogelman currently serves as a board-member-at-large for the Montana Dietetic Association and as a member of the Rocky Mountain Development Council Head Start Health Advisory Council.

Deborah Henderson, RN is manager of the child, Adolescent and Community Health Section. Ms. Henderson is a registered nurse, with a BSN from Jamestown College, Jamestown, ND. Ms. Henderson worked as a public health nurse for counties and IHS As well as a pediatric and nursery nurse before moving to Montana and took a job at the state health department in 1991. She has been in her current position for four years. Ms. Henderson has recently been accepted into the MCH PHI certificate program and will attend classes this summer in Salt Lake City.

Mary Noel, Chief of the Health Care Resources Bureau, is a graduate of Carroll College, Helena, Montana, with degrees in Political Science, Communication, and Public Relations. She has more than 25 years' experience in program and project management, including 10 years in the field of HIV/AIDS. Her prior experience also includes long-term care and the private sector. She is approaching her fifth anniversary with the State of Montana, where she came to help develop Montana's Children's Health Insurance Plan. Mary is a member of the National Alliance of State SCHIP Directors, the Montana Public Health Association, and the Association of Maternal and Child Health Programs.

Suzanne Nybo, MS, is Section Supervisor for the Women's and Men's Health Section. Ms. Nybo has a graduate degree in Psychology/Applied Science in Social Science from Montana State University. She administers and supervises a state reproductive/preventive health care program and is the Director of the federal Title X Family Planning Program and Co-Women's Health State Coordinator. Ms. Nybo has worked in reproductive and public health for 28 years and received numerous state and national awards for her leadership in reproductive health care. Ms. Nybo currently serves on the Public Health Improvement Task Force, on the safety net subcommittee of the State Health Plan advisory committee, and as the Bureau's Management Representative on the Employee Labor Management Committee. She and section team received the 2002 Governor's Team Award for Excellence in Performance.

Barbara Smith, BA, BBA is Program Manager for Children's Special Health Services. Ms. Smith has a Bachelors of Arts in Health Services Administration and a Bachelor of Arts in Business Administration from Eastern Washington University in Cheney. Prior to accepting this position in February of 2003, Ms. Smith administered community-based Medicaid programs, which was nationally recognized for innovative program development and quality assurance modes. In her role, she serves on the Family Support Services Advisory Council and the State of Montana Employee Benefits Council.

*//2005/ No changes //2005//*

## **E. STATE AGENCY COORDINATION**

Perhaps the sole benefit of the small size of the public health service community in Montana is that coordination of services becomes a relatively easy process. The fact that few people wear many hats at both the state and local levels and in the private and not-for-profit communities usually results in more thorough coordination of the available services. Everyone knows everyone and many clients are served in common. People work diligently to meet local client needs as efficiently and effectively as scarce resources allow. Local input is sought at the state level, usually in the form of advisory councils or committees composed of parents, client advocacy groups, local health providers, and legislators.

In 1999 the Family and Community Health Bureau Advisory Council formalized its creation with

election of officers and generation of bylaws. The Advisory Committee continues to be instrumental in the development and on-going assessment of the Strategic Plan for the Family and Community Health Bureau, consults with program staff on the PRAMS project, the SSDI grant, intra- and inter-departmental coordination efforts, the birth defects registry educational program, the WIC program, women's and men's health initiatives, and community and adolescent health concerns. Mary Noel, the bureau chief of the Health Systems Bureau participates as a staff member on the FCHB AC. The FCHBAC members provided effective advocacy for MCH programs during the 2003 State Legislature and played key roles in preserving the state's general fund support of the locally fielded, high-risk pregnancy intervention program, MIAMI.

The Universal Newborn Hearing Screening Task Force continues to advise the state program on the implementation of this screening program. The Newborn Screening Advisory Committee also provides invaluable advise to the Division (including the Public Health Laboratory, the newborn screening monitoring program, and the birth defects registry).

The WIC section supports a local WIC directors group and also facilitates statewide exchange of information for nutritionists through their annual meetings. In 2003, a "restructuring" effort was undertaken by group representing a partnerships of local and state WIC staff and local health department administrators. The group is redesigning WIC service contracting and coordination, with regionalization incorporated into the design. The contracts reflecting the redesign will begin in October 2004.

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 gubernatorial Abstinence Advisory Council charged with monitoring and advising the Department on implementation of the Title V Abstinence Program Grant.

The Children's Special Health Services section of the Health Care Resources Bureau contracts with in- and out-of-state consultants. The State CHIP program in contained in the HCRB and collaboration with Medicaid is an integral part of operations. The CSHS section receives input and guidance from an advisory group consisting primarily of medical providers, but also including parent participants and advisors. Jo Ann Dotson, the Bureau chief of the Family and Community Health Bureau participates as a staff member on the CSHS Advisory Group. ***/2005/ CSHS coordinates services and activities directly with providers through the Montana Chapter of American Academy of Pediatrics, an advisory committee, public payers such as SCHIP, state employee benefits plan and Medicaid, the Family Voices chapter housed at Parents Lets Unite for Kids (PLUK), the Insurance Commissioners Office and others. CSHS continues to expand their ability to coordinate services with other partners who work with CSHCN. In Montana much of this activity occurs at the local level through service providers. CSHS chooses to work toward coordination at a state level. //2005//***

The staff members of the Family and Community Health Bureau (FCHB) are active participants on many intra- and inter-departmental committees. They are also represented on statewide and national planning organizations. Bureau staff members 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. Refer to the attachment for a listing of some of the roles FCHB and HRB staff take in state agency coordination.

*/2004/*The development of detailed system requirements, user acceptance testing, and testing of enhancements as well as provision of on-going local support for users of the Public Health Data System have required extensive time commitments from program staff of the Immunization program in one Bureau, and from staff of CACH, Women's and Men's Health and MCH Data Monitoring sections in another Bureau beginning in late 1997 and continuing over the past six years. */2004/* As of June, 2003, PHDS has been rolled out to more than half of the 47 counties that have requested the

integrated data system and plans are to roll out to the remainder by late fall of 2003. (Only 7 counties have not requested PHDS, all of which are small and some of which do not yet have the required internet connectivity to support the central database transmission to and from Helena.) The local public health departments that comprise the User Group of the PHDS act as the advisory group for the ongoing maintenance and enhancement of the system.//2004//**2005/83% of the local public health departments are currently using the PHDS. System enhancements continue to be made to meet needs of both larger and smaller health department users of the system.//2005//**

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

/2004/The coordination between the Health Care Resources Bureau and the Family and Community Health Bureau is integral to the smooth operation of the Children's Health Referral and Information System (CHRIS). This data system is managed in the both HCRB and in the FCHB. The CSHCN service monitoring and referral portion of the system is managed in HCRB; the population-based birth defects registry is managed in the FCHB. The population-based newborn screening monitoring program in FCHB makes referrals to the CSHS staff for confirmed cases of selected abnormal metabolic screening results. The two Bureaus are cooperating in the development of the 2003-2006 SSDI grant application with the intent of linking the CHRIS, the PHDS, Part C and Montana School for the Deaf and Blind via a web application for CSHCN referral purposes. //2004//

The CACH section monitors the Healthy Child Care CISS grant and works with the advisory council for that grant. The Four State FAS Consortium project is administered from the CACH section and supports the FAS advisory council appointed by the governor at the end of June 2001. A pilot project to provide home visits for women at risk of drinking during pregnancy was implemented in FFY2002. Contracts were developed with four sites to implement and test the prevention intervention. The project also began organization of a risk assessment survey of prenatal care clients. A list of all prenatal care providers in the state was developed through phone calls and a stratified random sampling technique applied to select sites for the survey. /2004/ The MT FAS project continues to collect confidential information on the risk factors among pregnant women in MT. We will complete the representative sampling in June 2003 and then will summarize and disseminate results. The project is also sponsoring diagnostic clinics in two areas of the state to help estimate the prevalence of children affected by alcohol in utero. Families that attend these clinics receive followup assistance from a case manager. Advocacy workshops are also planned in these communities to help parents advocate for their children. Another objective of the project, which is part of the Four State Consortium on FAS, is to pilot a prevention intervention with women at risk for drinking during pregnancy. A paraprofessional intensive case management home visiting program is being studied at two City-County Health Offices and on two reservations. The Four State FAS Consortium is funded by federal dollars administered by the Center for Substance Abuse Prevention.//2004// The Child, Adolescent and Community Health Section also supports and coordinates the Fetal, Infant and Child Mortality Review Statewide Committee.

Jo Ann Dotson, chief of the FCHB, began participating with the new Kids Count project advisory committee in the fall of 2000. /2004/This activity was facilitated by the Bureau of Business and Research of the University of Montana and resulted in the production of a new Montana Kids Count status book in 2001 and an updated book in 2002. //2004//

Bi-monthly meetings are held with the Office of Public Instruction in order to discuss issues that cross-departmental boundaries, such as dispensing medications in the schools, management of biohazards in schools and management of asthma.

/2004/ The FCHB is initiating an intra-inter-departmental "summit" meeting in July 2003 to begin the process of better coordinating the provision services to CSHCN clients of state agency and their

contractors. The first meeting will focus on sharing what and how services are currently provided and each program's perceptions of the barriers and issues. The participants will then decide how they want to proceed with the coordination effort. Invited to attend this first meeting are Children Special Health Services section in HCRB, newborn metabolic and hearing screening and the birth defects registry in the MCH Data Monitoring Section of the FCHB, Part C of the IDEA in the Program Support Bureau of the Disability Services Division, the Office of Public Instruction, and the Montana School for the Deaf and Blind. Members of the FCHBAC have also been invited to attend. //2004// ***/2005/This meeting resulted in further meetings with agencies interested in pursuing a shared client data system to facilitate the continuity of screening, diagnosis, intervention and on-going tracking. The Montana School for the Deaf and Blind will be using the Children's Special Health Services data system, CHRIS, to help meet their strengthened legislative mandate to track sensory impaired children in Montana to assure appropriate interventions. This system will also be linked electronically with the MCH Data Monitoring Systems's hearing screening/diagnosis tracking software to create immediate referrals. Part C and the Office of Public Instruction are not interested in this effort at this point in time./2005//***

## F. HEALTH SYSTEMS CAPACITY INDICATORS

The examination of population-based indicators that typically present a broad picture of a state's public health serves to clarify both strengths and weaknesses in the public health delivery system and the need for reliable data. The initial introduction of Health Status Indicators illuminated the weaknesses in the state's data collection system. Some have been addressed; others have not. Percent of poverty information is still not derived for SCHIP pregnant women, nor is whether SCHIP infants receive at least one periodic screening. During the summer of 2000, graduate students from Emory University helped define indicator trends and targets. Roger RoCHAT provided epidemiological consultation during that process. Some of the targets have proven to be much more optimistic than actual resources for services allow and have been adjusted. Data will be updated and re-analyzed using regression analysis in 2004 if staff resources allow.

The Health System Capacity Indicators (HSCI) for Montana give a broad-brush picture of state public health capacity to meet basic population-based needs. They do not, however, illuminate the health service disparities between urban and rural or majority and minority citizens. And, they do not represent all services provided to all citizens. Because Montana lacks statutory authority to require reporting of hospital discharge data for all citizens, Montana's statistics rely solely on Medicaid paid claims data.

HSCI 01: The rate of children hospitalized for asthma (ICD-9 codes 49.3.0-439.9) per 10,000 children less than five years of age varies over the five-year span of 1998 through 2002, but is quite low overall. This is more likely a function of inconsistency of ICD-9 coding and misdiagnosis than of actual incidence. And, the data include only Medicaid paid claims data and services paid by no other funding sources. A five-year CDC grant for \$2.5m to develop Montana's environmental health tracking capability will include a pilot project on asthma and is expected to generate more representative data through case ascertainment for a statistical sampling of Montana's children.

HSCI 02: The percent of Medicaid enrollees whose age is less than one year who received at least one initial or periodic screening through the EPSDT initiative ranges from 83% - 98% over the past five years.

HSCI 03: The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen is not maintained by the Montana's CHIP program. Therefore, the data presented in HSCI02 is considered most indicative of this statistic even though children eligible for Medicaid in Montana are not eligible for CHIP.

HSCI 04: The percent of women (15 through 44) with a live birth during the reporting year whose

observed to expected prenatal visits are greater than or equal to 80 on the Kotelchuck Index has ranged from 72.7% to 80.2% over the period of 1998 through 2003. These data are generated from the birth certificate and depend on the completeness of completion of that certificate by the birthing facilities. Because the data appear consistent, it is likely that this represents a fairly accurate indication of the average level of prenatal care across the state.

HSCI 05: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the state by (a) percent of low birth weight (<2500 grams); (b) infant deaths per 1,000 live births; (c) percent of infants born to pregnant women receiving prenatal care beginning in the first trimester; and (d) percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% on the Kotelchuck Index) is available only in Montana total population and is not broken out by pay source between Medicaid and non-Medicaid. Over the period of 1998 through 2002, an average of 6.7% of the annual birth cohort of 11,000 in Montana is born weighing less than 2,500 grams. Infant deaths average .6% of births.

HSCI 06A: The percent of poverty level for eligibility in the State's Medicaid programs for: (a) infants (0-1) is 133% of poverty or, if born to a Medicaid recipient mother no income declaration is required through 13 months of birth; (b) Medicaid children (1-5) is 133% of poverty and (6-18) is 100% and in Montana includes through the 18th year; and (c) pregnant women is 133% of poverty regardless of age range.

HSCI 06B: The percent of poverty level for eligibility in the State's SCHIP programs for: (a) infants (0-1) and (b) children (1-18) is 150% of poverty; and (c) percent of poverty of pregnant women in Montana's CHIP is not collected.

**HSCI 07: //2005/The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year continues to reflect the loss of dental services in Montana and the low Medicaid reimbursement rate for the remaining providers of dental services. In 1999 and 2000, an average of 46% of EPSDT children received at least one dental service; in 2001, 2002 and 2003, this average has maintained at around 34%.//2005//**

HSCI 08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs (CSHCN) Program has averaged 2.5% from 1998 through 2002. Montana children and youth who qualify for SSI continue to qualify for Medicaid. Referrals from SSI are reviewed and applications, clinic invitations or case management referrals are made as appropriate for each client. Staff assist families with the SSI process by linking them with a community-based case manager to facilitate that process. **//2005/ The percent is decreasing. CSHS rarely provides service to Medicaid eligible children. Care coordination is provided for those participating in clinics as part of the clinical function and few receive financial support for a non-Medicaid service, such as out-of-state labs for diagnostic purposes. Frequently CSHS coordinates on a case- by-case basis with Medicaid to assure that medically needed services are covered for families. CSHS is in the same division as Medicaid acute and EPSDT services thus creating a natural partnership. //2005//**

FORM 19 reveals the limitations of Montana's electronic linkages at this point in time. While there are links with the electronic birth certificate system and both the Public Health Data System's immunization registry and the birth defects registry (both of which are accessible to the MCH Data Monitoring section), the electronic death certificate system is currently being developed. The WIC program's current antiquated data system does not link with birth certificates. The program is currently considering replacing their system. Birth certificate data does not link with newborn screening, but mandatory metabolic screening generates essentially universal inclusion -- in 2002, 100% of the newborns in Montana were screened. As mentioned above, hospital discharge survey data are not available to the State Health Agency due lack of appropriate state statutes requiring that reporting. Montana is currently completing it's first point-in-time PRAMS project, which given the low annual 11K birth cohort is a more viable approach to surveying recent mothers than an annual survey. YRBS data in youth tobacco use are collected by the Office of Public Instruction, but are not available

electronically to MCH. PedNSS participation by the WIC program is intermittent and the data are sent to the CDC. MCH does not directly access those data. WIC program data on children ages 2-5 who are either at risk for obesity or technically obese are available in summary form only.

## **IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES**

### **A. BACKGROUND AND OVERVIEW**

Montana's process for the selection and identification of state performance measures began with a conference entitled Data for Planning, Accountability and Leadership: Needs Assessment and Performance Monitoring in State and Local MCH Programs in Montana. The conference, held in July of 1997 was provided through MCH technical assistance support from Health Systems Research, Inc. (HSR), a Washington, DC-based health care research and consulting firm. Mr. Ian Hill, the director of the firm, and Dr. Donna Peters from the University of Alabama came to Montana to provide the training in Great Falls. Presentation of the federal performance measures was included as part of the educational aspect of the meeting and in subsequent discussions regarding state performance measures. The HSR meeting and the priority setting process that followed for the next eight months helped Montana to both understand and embrace the requirement to establish local performance measures developed by the Maternal Child Health Bureau in response to Government Performance and Results Act (GPRA).

Parallel to the priority setting process development of the state MCH performance measures, Montana's first State Health Agenda was being developed. The purpose of the roadmap was to provide background, activities and plans for the young Health Policy and Services Division (created in 1996 following a department reorganization). MCH management determined to use the state performance measures developed as the MCH indicators in the State Health Agenda, linking the federal and state documents.

The priority setting process for the MCH measures involved local and state MCH staff and contractors. A ballot, compiled by state staff and including the priorities identified at the July 97 conference as well as recommendations from other MCH groups was distributed in February of 1998. Guidance and background was provided. The results of the ballot were priority measures for the state.

1. Reduce unintended pregnancy
2. Percent of women reporting alcohol use in pregnancy
3. Quality standards for the health care of the MCH population have been established
4. Incidence of domestic violence in women receiving services in selected MCH program
5. Percent of one-year-old children tested for lead
6. Percent of counties establishing fetal infant child mortality review committees
7. Percent of mothers who breastfeed their infants at six months
8. Percent of pregnant women exposed to second hand smoke
9. Percent of Medicaid eligible children who receive dental services
10. Rate of firearm deaths among youth aged 5-18.

State staff worked with local partners to finalize the objectives, which were submitted in the 2000 Block Grant Application in July of 1999. Responsibility to monitor and affect the performance measures were assigned to the various programs within the Bureau. Despite the fact that MCHBG does not support the WIC program, that program assumed the responsibility to gather data on and affect the performance measures regarding breastfeeding in our state. This program-partnering ties into the federal charges to WIC to promote breastfeeding. Likewise, the Family Planning Program monitors and oversees the unintended pregnancy measure, and other bureaus and sections contribute both data and effort to the various performance measures.

Target setting was a challenge in the first year; in the absence of sequential year's data, the ability to set reasonable targets was questionable. Dr. Roger Rochat, MD, from the Centers for Disease Control was a block grant reviewer in 1999, and assisted the state by helping to identify data gaps. One of the recommendations was to develop epidemiological capacity by helping staff to envision and design projects, which could benefit the various programs in the Bureau. In 2000, two students came to Montana as our first summer student interns, patterned after MCHB's GSIP program, but also bringing with it Dr. Rochat's expertise, contacts, and knowledge of our structure and resources. Intern Kristi Richardson's project, Maternal and Child Health Trend Analysis used regression analysis to help establish targets for those performance measures for which data was available. Several of the federal

measures, notably the CSHCN measures, did not have data available with which to analyze regression. Kristi's work and feedback also helped staff to develop recommendations for revising either the actual state performance measure or the proposed method of data collection or measurement.

In 1999, the Advisory Council to the Family and Community Health Bureau was established and appointed. The FCHBAC is charged with the responsibility to advise the department on matters affecting the MCH population. The council has assumed a major role in monitoring the federal and state performance measures, and in 2001, established a two-year strategic plan, which incorporated the state and federal performance measures. In 2002, that plan was revisited, and the language in several measures revised and one state performance measure (number of MCH standards developed) eliminated. In 2004, the FCHBAC will continue to monitor the performance measures as part of their work with the Bureau. A review of the strategic plan will also be done in 2004, allowing measures to be updated.

## B. STATE PRIORITIES

Selection and prioritization of state needs is an ongoing process requiring assessment of public health indicators and capacity as well as availability of financial and human resources. Changing expectations of public health impacts the priority selection. The evolution of public health in Montana and the nation continue, moving from what was essentially individually-based services, often providing primary care or a proxy for primary care services towards a system that is population-based, including needs assessment, policy development and assurance. Fiscal and human resource challenges affect every state, but are perhaps more distinct or apparent in communities where the rural/frontier nature and sparse distribution of clients and providers place multiple demands upon a very fragile public health infrastructure. Public health in Montana began to try to tap alternative sources for public health services approximately 10 years ago; at that time, billing for direct services (i.e. Medicaid & health insurance) provided services was a viable source and public health actually concentrated effort on that direct service development, exemplified by the co-location and linkages of most of Montana's Community Health Centers with public health departments. More recently, and specifically with the 9/11 event, capability regarding rapid and effective communication (including health alert networks), interagency coordination and command readiness have become key public health capacities. None of those services is billable by insurance or Medicaid, so the scramble to reinvent state and local efforts are accompanied by the scramble to fund what is being developed.

Even in 2003, with the recent experiences with anthrax scares and the call for public health preparedness, we struggle to convince the public and local policy makers about the importance of public health services -- the county commissioners of a rapidly growing county in central Montana recommended last week to dissolve the health department, noting the population could not afford and did not need public health services. Much remains to be done to adequately describe the role of public health and to educate the public, the medical community, and public health providers themselves on the breadth of public health and the importance of infrastructure. In the words of a 55+-year-old public health nurse regarding her recent epiphany regarding the broader role of public health, "it may have taken 10 years of you (state in-service providers) saying the same thing, but I finally get it!"

With a few exceptions, most of the priority needs identified as a result of the 2000 MCH Needs assessment continue to show up on radar screens today, including the need to:

- 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 cancer, 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.

/2004/Activities related to priorities are shifting from direct care to population-based education and partnership efforts with other agencies and providers. The Health Care Resources Bureau continues to take the lead in identifying and attempting to increase access to health and dental care for eligible children, but the lack of resources hampered expansion efforts in the 2003 legislative session. Dental health access was facilitated by legislative changes, which allowed for retired dentists to work part time in the state, and by the creation of and funding for a dental hygiene school in the state. Targeted funding to prevention programs has been very limited, and a move to enhance mental health services for children and substance abuse services for children adolescents was also enhanced by legislative action, which moved the children's mental health services to be co-located with CHIP and Children's Special Health Services. There were no proposals to increase funding for the public health home visiting programs (including MIAMI and Follow Me) during the last session, instead, a proposal to restore the existing funding was supported and passed. Again, in this era of tight funding, not losing resources was almost as good as gaining.

Efforts to update and re-examine priorities are done annually, in the form of pre-contract surveys to all contract counties. The surveys are distributed in February of each year, and elicit county responses on topics such as the priority needs impacting the MCH target populations. In 2003, the priority issues for pregnant women, infants and women of childbearing age all included lack of insurance. Substance use (including tobacco) was a priority issue for pregnant women, and women of childbearing age, as well as constituting the topic four (of five) issues impacting children up to age 22. Substance use also impacted the topic of second hand smoke, identified as the third priority issue for infants. This focus on substance abuse is not new, but the degree of concern and the inclusion of virtually all target groups points to the importance of the topic. Recent efforts to enhance the capacity of home visiting programs to assess and intervene effectively on substance use, and re-organization of the mental health services for children may help address these issues. During the annual fall regional meeting with local health departments in 2002, growing concern about the impact of methamphetamine on MCH was expressed in rural and urban communities across the state.

The Family and Community Health Bureau Advisory Council receives and reviews summaries of the annual pre-contract surveys in June. At the 2003 meeting, the Council was asked to examine the report, and share thoughts and concerns from the perspectives of their target populations and/or of the MCH population in general. Council members generally validated and concurred with the findings reported from the surveys, identifying poverty, insurance access, substance abuse impacts, and mental health services as major issues. Dental health access continues to be identified as a problem, but several council members stated they could see a change for the better on access for children over the last year.

Staff also has the responsibility to monitor data and available statistics in order to pick up issues and/or confirm hunches. Disparity of health outcomes and health access continues to be a major issue in our state. It was interesting to note that members of the council or survey respondents did not identify this issue. State staff may have better access to numbers and therefore broader perspectives regarding the existence of disparities, but the possibility that disparity is such an expectation or norm that it is not viewed as an issue must be considered. The extreme variations in access and health outcomes between income levels, rural vs. urban dwellers, ethnic groups, and ages, must be

examined and addressed.

Montana has some measures and strategies in place to address disparity; far more are needed. Montana has a state specific outcome measure regarding the ratio of infant mortality in the white and American Indian populations. In addition, over 20% of the home visiting program (MIAMI) funds have been designated for services on reservations, and the family planning program recent applied for funds to address the low percentage of minority women who are served by family planning contractors.//2004//

### C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

#### a. Last Year's Accomplishments

***/2005/ In 2003, Montana's required panel of four tests (PKU, galactosemia, congenital hypothyroidism and hemoglobinopathies) were performed on 100% of the in-state reported births. Only two PKU cases were identified and both were referred for treatment immediately after their second screening result was abnormal. There were no confirmed cases of galactosemia or hemoglobinopathies in 2003. There were 2 cases of congenital hypothyroidism, 2 of whom were referred to the responsible physician of the medical home.//2005//***

#### b. Current Activities

***/2005/Montana's required panel of newborn heelstick screening tests remains unchanged. Optional tests are available, some through the Montana Public Health Laboratory and others through out-of-state laboratories. Newborn screening, monitoring, and followup continue to involve collaboration between all the birthing facilities in Montana (currently 34), midwives, the Montana Public Health Laboratory, staff in the Maternal and Child Health Data Monitoring Section of the Family and Community Health Bureau, staff in the Children's Special Health Services Section of the Health Care Resources Bureau, and the medical homes of the newborns.//2005//***

#### c. Plan for the Coming Year

***/2005/ Montana is combining newborn heelstick and hearing screening monitoring and management of the State's birth defects registry into one position. This position will receive data management support and epidemiological support from other FTE's in the MCH Data Monitoring Section. Almost universally, the same staff in the birthing facilities perform/ensure the performance of both the newborn heelstick and hearing screenings. State-supplied technical support for ensuring the validity of the heelstick screening is provided by the Montana Public Health Laboratory. State support of the initiation, followup and reporting of both heelstick and hearing screening will be provided by the newborn screenings monitor/educator in the MCH Data Monitoring Section. Consolidation of the screening monitoring function will reinforce with the community partners that both components of screening should be considered standard practice and equally important for early detection and intervention. Management of the birth defects registry for Montana's annual birth cohort of <12,000 will occupy .50FTE of the time of this position. Epidemiological support will be provided by other staff in the same section.//2005//***

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

**a. Last Year's Accomplishments**

***/2005/During FFY2003 CSHS was able to expand the membership of the advisory council to incorporate broad based representation of parents and youth. This success is tied to two key factors 1) we developed, implemented and honored a policy to provide expenses and a stipend to these individuals, 2) we looked to new resources to find these parents. Some parents are recipients of clinical services, some receive financial assistance, and most participate in a condition specific service system in Montana. We did establish a policy to provide support to parents attending out of state conferences; we have been unable to support much of this activity due to budget constraints. We did support the attendance of one family to the national MDA conference and provide access to local community based trainings.***

***2003's greatest accomplishment was the establishment of a formal collaborative relationship with Parent's Lets Unite for Kids (PLUK), the representative for Family Voices in Montana. This provides access to a large percentage of Montana's CSHCN enabling us to access families who do not receive Title V services or participate in clinical activities, but none the less have CSHCN issues that need to be addressed.//2005//***

**b. Current Activities**

***/2005/***

***Currently CSHS continues to identify families who can participate in program activities. In linking with Family Voice chapter through PLUK, we have been able to provide education regarding CSHCN resources, political participation and collaborative activities. With this level of education occurring, CSHS is able to take the role of trainer to the family representatives who are working to empower families of CSHCN to participate in activities at local and state levels. The funding for this activity came from a CMS Family to Family Systems Change grant, awarded October 2003, which was jointly developed between CSHS and PLUK.***

***Families who are directly involved in CSHS services (financial or clinical) are provided with opportunities to comment on program activities as they arise. CSHS is working to educate families about CSHS up front to establish a level of expectation that can be met. It has also provided a degree of responsibility to parents that has not been present before. Empowering parents to make decisions based on solid information has improved their satisfaction with the program and the level of cooperation.***

***Surveys regarding the satisfaction of clinical services continue. Follow up is done on an as needed basis.//2005//***

**c. Plan for the Coming Year**

***/2005/***

***CSHS will continue to work with Family Voices in providing the family-to-family training activities to increase the ability to empower families to participate in all levels of decision-making in Title V and other programs affecting CSHCNs.***

***Advisory Council activities will continue to include family involvement. This year we will***

**be focusing on setting standards for the CSHS website, reformatting the financial assistance program and looking to further the linkages with other programs.**

**CSHS needs to expand surveying to those who participate in our financial assistance program. With assistance from families, we will create a survey to establish baseline family satisfaction with this program. //2005//**

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

**a. Last Year's Accomplishments**

**/2005/CSHS coordinated with Dr. Marian Kummer to apply for a CATCH grant to determine how to provide optimal care management for children with special health care needs within a medical home. The grant was prepped in July 2003 and awarded in December of 2003.**

**CSHS staff and contractors made an extraordinary effort to identify the medical home of CSHCN utilizing clinical services. 64 % of CSHCN families were able to identified the medical home of their child. Programmatically, the medical home was incorporated into the team structure to assure adequate communication and follow up occurs.**

**The CSHCN director participated in the annual AAP conference to provide an overview of the Title V program, including the medical home concept. This was a new opportunity for CSHS to participate at this level. //2005//**

**b. Current Activities**

**/2005/Two practices are geared to participate the CATCH project, the Children's Clinic in Billings and Family Practice in Wolf Point Montana. The children's clinic practice has held two focus groups, community partners and families to gather input to improve the practice's approach to managing CSHCN. Most were supportive of having a go-to person to deal with issues relating to accessing services in the community. The next step for the Clinic is to determine how to implement and fund this activity. CSHS will assist the clinic in providing a cost analysis. As for the practice in Wolf Point, we are currently establishing the focus group project.**

**CSHS has recently been provided the opportunity to assist the family and community health bureau in locating those families lost to follow-up in the universal hearing program. This program is key to assuring CSHCN are identified and receive early intervention for their hearing loss. We are currently putting this protocol together which will include educating/notifying the medical home.**

**The ULEND project out of Utah State University visited MONTANA to provide us access to their training program. From this we were able to communicate to medical homes the availability of pertinent training on the medical home concept. //2005//**

**c. Plan for the Coming Year**

**/2005/CSHS is looking to participate in the 2004 meeting of AAP expanding on the presentation of 2003. This focus would include the outcome of the CATCH grant, CSHS plans to further the medical home concept through family education and include a**

**family's perspective of the concept.**

**As partners with FCHB, further integration of UNHS into the medical home will occur. This allows CSHS access to more medical homes, the ability to increase awareness of the need to integrate screening into the medical home concept and establish a baseline relationship with many providers.**

**CSHS needs to seriously review the expansion of the medical home concept beyond those families we directly serve. One such area to research is the education of families on how to choose a medical home. CSHS will look into this possibility during the coming year.//2005//**

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

**a. Last Year's Accomplishments**

**//2005/ During the last year, CSHS made progress within their financial assistance program to assure that no payment was made where a third party had responsibility. This has strengthened our ability to educate families about the responsibilities of private insurance, appeals process and the like. This process transformed the program from paying what looked to be owed, to leveraging the responsibilities of other payers, resulting in our ability to assist more children.**

**CSHS continued to refer children to other public/private programs to assist with medical expenses. We provided training to our regional centers to enable them to expand their abilities to make such referrals. We have also encouraged case managers to look for local resources that can assist families. //2005//**

**b. Current Activities**

**//2005/In November of this year, the Governor provided one time cash of \$609,000 to the CHIP program to eliminate the waiting list. This action increased the CHIP coverage to 10,900 children in Montana. This is increased coverage of 1500 children. CHIP now faces the challenge to maintain this enrollment level throughout the next fiscal year without the extension of the Governor's cash. The Department has marked funds for this and the legislature has provided authority to raise private funds to support the program. CHIP management is well prepared to meet this challenge. As a result of the wait list being eliminated, 17 children were transitioned out of Title V financial assistance and into SCHIP**

**As for coverage issues, in working with the CHIP manager and representatives of the BlueCHIP plan, we were able to influence policy decisions related to CSHCN needs. One such example was the implementation of payment for orthodontia for children enrolled in CHIP and participating in the cleft-craniofacial clinic program. As these children are identified we are able to work with BlueCHIP to assure coverage and provide assistance with provider recruitment. This process will continue to be refined and be extended to other third party payers.**

**In light of our dwindling resources, we have implemented a process to refer families to hospital financial assistance programs, prior to using Title V dollars. This is a drastic change for the CSHS program, as previous practice was to access Title V first. From this**

***we have learned there are many community resources that need to be tapped, prior to accessing Title V funds. Additionally we are in the midst of developing the process to bill back Medicaid for clinical services to boost funding to the financial assistance program.***

***Since not all third party payment issues have been simple, we have established a formal relationship with the state Insurance Commissioner's office to refer complicated insurance cases. They have provided expert assistance to families to maximize insurance coverage for their CSHCN.***

***To validate the CSHCN national survey, we have undertaken the process to survey CSHCN families regarding the adequacy of their health insurance coverage. To date, we have a rough draft of this survey and a tentative plan for release. //2005//***

**c. Plan for the Coming Year**

***/2005/Clearly, CSHS needs to expand the education of insurance issues beyond the population receiving Title V services. A plan is in place to apply for a "Champions for Progress" grant to gather the expertise to design, write and distribute a guide to insurance for families of CSHCN. If we achieve this additional funding we will look towards the ABC for health program in Wisconsin to provide direction, recruit interest from the Montana Bar and create a core group of parents to assist in the process.***

***Collaborating with family voices, we will distribute the completed CSHCN health insurance survey to families. The results of this survey will be collated and provided to interest groups working to expand coverage for children.***

***CSHS will look into the possibility of converting our financial assistance program to a premium assistance program thereby jointly purchasing an insurance product rather than continuing to provide limited financial assistance.***

***As the state considers the adoption of a HIFA waiver, CSHS will keep tabs on the process to assure an expansion population includes CSHCN. As currently proposed the HIFA waiver will expand Medicaid coverage to transitional seriously emotionally disturbed children, expansion of the CHIP program for an additional 5000 children, and the restoration of expanded mental health benefits for CHIP children. Since this waiver application must be approved by the 2005 legislature, development activities will occur after the legislative session closes or April 2005. //2005//***

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

**a. Last Year's Accomplishments**

***/2005/Regional pediatric specialty clinics in Missoula (Community Medical Center) and Billings (St. Vincent's Hospital) continue to grow. During FFY03 Missoula provided clinical services to 556 children compared to 388 in FFY02. Similarly in Billings, 1132 CSHCN were provided services in FFY03 compared to 687 in FFY02. The contractors and CSHS staff can attribute this increase in activity to the increased outreach activities completed. Families are finding high quality pediatric services without having to leave the state.***

**CSHS regained the management of the Medicaid targeted case management (TCM) program for children with special health care needs. This past year was spent developing relationships with providers, listening to their concerns and needs and establishing a forum to redesign this program. This activity has brought together a mix of public and private providers to reach consensus regarding TCM activities and how to interface and access services.**

**Given time and resource constraints, CSHS did not compete for the respite grant as previously reported.//2005//**

#### **b. Current Activities**

**/2005/Montana children have access to a variety of community-based services in multiple systems, however there are been limited cross coordination with such services. During this year we have had the opportunity to begin dialogue with Part C providers regarding the financial assistance available to families. The Part C system was adamant (per NTECH) that Title V must pay before Part C. This allowed CSHS to provide education regarding the Title V program and led to an interagency agreement regarding who pays for what. We have been mostly successful, except for children with hearing loss.**

**As the TCM project unfolded, a department wide project was launched to coordinate all Medicaid TCM activities. This has provided the opportunity to increase collaborative efforts with the mental health system and provide an access point to the developmental disability services program. We continue to refine the program and the relationships between service systems. A training program will be established to implement the ideals of family-centered, community based coordination across the various TCM programs.**

**As part of a process to establish Division level goals and objectives, Division management launched a system of care concept project. The CSHCN director leads a management team to bring the concept to life. System of care, for the purpose of this project is defined as, a comprehensive spectrum of health services which are organized into a coordinated network to meet the multiple and changing needs of children and their families. The activities of the project are designed to promote family centered collaboration among the division programs of CSHS, CHIP, Medicaid and Children's Mental Health. To kick this off, the Division will sponsor a screening summit to lead to the revamping of the EPSDT screen to assure children and families are receiving appropriate services, assure services are available and decrease confusion within the system.**

**This year, the directory of specialty clinic services was changed to increase attraction to the resource. Released in April 2004, it is now brightly colored, compacted and includes photos and stories of CSHCN who have participated in CSHS services. Families loved the opportunity to help out and share their successes. Early feedback indicates that medical home providers took notice to the change and denoted it a resource to keep for further reference. This resource was also provided to the local public health departments, federally qualified health clinics, hospital discharge planners, school nurses, special education cooperatives, Medicaid transportation staff, state employees benefits case manager(s), and local health insurance plans. //2005//**

#### **c. Plan for the Coming Year**

***//2005/ CSHS will continue to support regional specialty clinics to assure that sub specialty care is available in state. As grant funds decrease, CSHS will need to work with these two programs to assure self sufficiency can occur. This is a discussion that has not occurred to date. This is a discussion that has not occurred to date.***

***The Medicaid TCM program will have a QA component, which will enable CSHS clinical staff to provide training, education and analysis of the needs of the CSHCN populations.***

***The system of care project will enable CSHS to influence screening tools that will ultimately direct families to the appropriate resources. The draft of the screening tool will be completed in December at which time the Medicaid staff will implement the process. CSHS will remain part of the oversight process.***

***Program staff will continue to advocate for coordination across systems to decrease the burden on families. Increase attention will be paid to the multi-system children who participate in Title V services to decrease repetitiveness. //2005//***

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

**a. Last Year's Accomplishments**

***//2005/ As per previous years, CSHS continues to provide one to one counseling regarding transitional issues for participants of the specialty clinics. Youth speakers were added to educational panels to draw attention to the need for transitional planning and focus on opportunities available to YSHCN. //2005//***

**b. Current Activities**

***//2005/ CSHS assisted the Montana Youth Leadership Forum in developing discussion points to focus on transitional needs in their upcoming summer forum. These discussion points are focused towards the youth identifying what is important to them, how it should look and how to influence the system to get what they want done. We will be reviewing the results of this activity and put it to work. Health insurance continues to be a critical issue for transition. We continue to educate and counsel youth and their families about their options. As per our report last year, we had discussed developing a training program on insurance for youth, instead we have redirected our efforts towards listening to what the youth tell us from the leadership forum.***

***We have spent some time looking at integrating the Transition Timeline from Seattle Children's Hospital into the specialty clinic process. Discussions included integration into care maps, expanding transition into three other clinical areas and educating families of children who are SSI applicants. This process will continue.***

***To bring the issue of transition to the forefront, we are currently developing a partnership with the Rural Institute on Disabilities of the University of Montana. This is the University Center for Excellence in our state. This partnership will allow us to apply for a Champions of Progress grant to generate interest in the transition issues.//2005//***

**c. Plan for the Coming Year**

***//2005/ Montana hopes to receive a Champions of Progress grant to establish a means to***

**bring together all service systems for children to address the current issues of transition. This would include cataloging what currently exists, identifying cross system issues, and developing an overarching action plan. This is one area where the the service systems in Montana have a clear common issue.**

**We will continue to address transitional issues on a 1:1 basis in our clinical and financial assistance programs. As part of our role in PLUK's family to family grant, we will provide educational opportunities for family advocates to understand the need for transition planning and identify steps and resources for them. //2005//**

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

**a. Last Year's Accomplishments**

**/2005/Immunization rates: /2003/ Statewide vaccination rates (the series combination of 4DTaP, 3 Polio, 3 Hib, 1 MMR, 3 HepB) for children aged 24-35 months of age seen in clinic and provider sites in Montana during 2003 was 89.7%. The data were collected from 54 of the 56 counties with public and private vaccine providers and represented 25.41% of the birth cohort. Hepatitis B vaccinations: /2001/ The Montana State Legislature enacted universal Hepatitis B testing of all pregnant women during each pregnancy. Universal vaccination of all newborns is being implemented across the state without legislative mandate. 91% of the newborns are receiving this birth dose before they leave the birthing facility.**

**Reading Well collaborative project developed with Medicaid and the Office of Public Instruction. When children complete their 2 year old immunizations, or their pre-kindergarten immunizations, the families can present the completed short record to the county health department, for entry of the record into the immunization registry, and the family can choose a book from "the reading well." This is a win-win project. Families are encouraged to read with their children, and the incentive helps populate the immunization registry.**

**Incentive developed to encourage WIC families to provide children's immunization record for evaluation. If the families bring their shot records for entry into the immunization registry, they are given an opportunity to put their name in a drawing for a chance to win a gift certificate to a local grocery store.//2005//**

**b. Current Activities**

**/2005//2004/ The National Immunization Survey covering Q3/2002-Q2/2003 found the immunization rate of children 19-35 months of age in Montana to be 75.4% (+6.4) for 4DTP: 3Polio: 3Hib: 1MMR: 3HepB. The rate on this survey for varicella indicates the varicella rate was just 66.3% (+6.8). Because Montana provider rates are very low for administration of that antigen, Montana Immunization Program targeted varicella education as a priority with the private and public vaccine providers. During the Regional Immunization Workshops in 2003, this was a major point of discussion. Feedback following the clinic site review in each provider office during 2004 includes a discussion of their rate for varicella vaccinations.**

**/2004/ Because of a decrease in CDC funding for immunizations in 2004, the State Immunization program is unable to continue to contract with the counties for the adolescent immunization activities that were initiated in 2001.**

**/2003/ The interface between the electronic birth certificate and the PHDS has been**

**completed and tested. Full implementation is being delayed until an enhancement to the client record matching process in PHDS has been made.**

**/2003/ The Immunization Program maintains contracts with 52 counties and 7 tribes to provide immunization services across the state. Federal vaccines through the Vaccines for Children (VFC) Program are provided to 96 private providers and approximately 100 public providers to administer age-appropriate immunizations to VFC-eligible children./2005//**

**c. Plan for the Coming Year**

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**/2004/ Because of a decrease in CDC funding for immunizations in 2004, the State Immunization program is unable to continue to contract with the counties for the adolescent immunization activities that were initiated in 2001.**

**/2003/ The interface between the electronic birth certificate and the PHDS has been completed and tested. Full implementation is being delayed until an enhancement to the client record matching process in PHDS has been made.**

**/2003/ The Immunization Program maintains contracts with 52 counties and 7 tribes to provide immunization services across the state. Federal vaccines through the Vaccines for Children (VFC) Program are provided to the local public health departments, tribal clinics, and 100 VFC-registered private providers to administer age-appropriate immunizations to VFC-eligible children./2005//**

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

**a. Last Year's Accomplishments**

**/2005/ The Department includes the prevention of teen pregnancy as one of its key issues in public health. In 1997 the state Legislature mandated a 10% reduction in the state's 5-year teen pregnancy rate by the end of the 1999 biennium, although no additional funds were allocated. A recent update of Montana 2002 data shows that a 14% reduction has been achieved.**

**The Governor's Interagency Coordinating Council (ICC) adopted Montana's teen pregnancy rate as one of only five key benchmarks for State Prevention Programs. This Council was formed with the stated mission "to create and sustain a coordinated and comprehensive system of prevention services in the state of Montana" until budget cuts severely reduced the program in 2002. The WMHS holds a leadership role in teen pregnancy prevention efforts for the Department. The WMHS Health Educator acts as the Department's Teen Pregnancy Prevention Coordinator and was an active member of the workgroup associated with the ICC when it was fully functioning. This workgroup carried out a vigorous plan that included meetings and prevention activities every three weeks**

*throughout the year.*

*The Program Specialist acts as a key resource for the collection and dissemination of teen pregnancy data. The Trends in Montana Teen Pregnancies and their Outcomes From 1981 - 2000 report has been updated. The updated tables are available to be distributed to local family planning clinics, county health department personnel, media contacts, public policy makers, and university students. Recent data for 2002 shows that the five year (1998-2002) teen pregnancy rate continues to drop for 15-19 year olds and is currently 50.2/1,000. This represents a 14% reduction from the 1993-1997 rate of 58.4/1,000.*

*The Montana Title V Abstinence education project is now located under the Human and Community Services Division. Abstinence-only until marriage is a component of Teen Pregnancy Prevention and WMHS works with the abstinence coordinator on collaborative prevention activities, as appropriate.//2005//*

**b. Current Activities**

*/2005/ The WMHS is distributing the updated Trends in Teen Pregnancy report to local partners focusing on teen pregnancy and teen birth rates, including local health departments, WIC agencies, Offices of Public Assistance, school districts, MIAMI projects, IHS clinics, media contacts and public policy makers. A copy of the report is available on the Department web site.*

*/2005/ Educational materials on teen pregnancy prevention are distributed by WMHS staff to local family planning programs, constituents, students, midwives, school nurses and public health contacts. Annually, WMHS staff update the Unintended Teen Pregnancy Fact Sheet for use with legislators, local teen pregnancy coalitions, public health professionals and within DPHHS.*

*/2005/ The WMHS, MAP, and the STD/HIV section are jointly working on an abstinence policy working group. This group will develop a common policy on abstinence to be used by the different sections and divisions of the Department.*

*/2005/ During SFY2004, the WMHS applied for and received special grant funding for local Male Adolescent Clinics; for Information, Education and Communication (IEC) projects; for Client, Family and Community Involvement (CFC); for Family and Intimate Partner Violence and for Efficacious Contraceptives. Local male clinics use teen male interns to reach an increased number of male clients. The IEC projects fund local clinics to increase awareness of family planning services and to increase knowledge on reproductive health. The CFC projects focus on outreach to special needs populations, parents and school districts to increase awareness and support for family planning services. Research shows that victims of family violence are at increased risk of unintended pregnancy. Through special funds for highly effective contraceptives, including emergency contraceptives, the WMHS focuses on reducing the teen pregnancy rates as well as the teen birth rate.//2005//*

**c. Plan for the Coming Year**

*/2005/ The WMHS will facilitate community acceptance of and access to family planning services and counseling for clients of all ages. The WMHS will contract with 15 delegate agencies to provide family planning services in 29 locations throughout Montana. In working toward this goal with local clinics, the WMHS will assure the active and continued involvement of family and community in the provision of family planning services to those in need.*

***/2005/ Local clinic staff will continue to participate in the State Family Planning Education Committee facilitated by the WMHS Health Educator. One focus area of this committee will be teen pregnancy prevention and training needs of local clinic staff. A needs assessment will be conducted for local staff to determine training needs.***

***/2005/ The WMHS has applied for special initiative funding for male clinics; Information, Education and Communication (IEC) projects; and Client, Family and Community Involvement. A growing emphasis on male responsibility and involvement in teen pregnancy and birth rates continues to increase each year. Teen peer interns hired in local clinics will continue to increase the number of males seen in family planning clinics each year. IEC projects focus on increasing awareness of family planning services and about reproductive health. Some of the IEC funding will be targeted to Native American youth who as a group have a birth rate double that of the Montana teen population as a whole. Funding for Client, Family and Community Involvement focuses on outreach to populations who have difficulty accessing family planning services, outreach to parents, and outreach to school districts to increase awareness and support for family planning services.***

***/2005/ The WMHS will continue to provide special funding for efficacious contraceptives to local family planning clinics.//2005//***

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

**a. Last Year's Accomplishments**

***/2005/ Training materials for public health and dental professionals were supplied to dental screeners and data recorders on a case-by-case basis to assure standardization and utilization of the Basic Screening Survey (BSS) surveillance instrument developed by the Association of State and Territorial Dental Directors (ASTDD).***

***Ongoing training efforts have resulted an increase of public health and school nurses coordinating and serving as screeners.***

***Outreach efforts to encourage use of the BSS instrument and DPHHS screening forms for Billings area schools were accepted and implemented by dental hygienist volunteers. This effort resulted in an increase of nearly 3000 additional school screenings reported for the Billings area including third graders during the 2003/2004 school year.***

***Cooperation with school nurses to assist in follow-up measures to assure access to needed services was also implemented.***

***Consultation was sought by HRSA Region VIII staff, which resulted in suggestions to collect a more representative sample rather than such a large convenience sample of Montana third graders to report performance measurement data and integrating additional surveillance efforts including PRAMS, BRFSS etc.***

***Data were entered into the database indicating 9214 school oral health screenings took place during the 2002/2003 school year through the efforts of volunteer dental professionals, public health professionals and school staff.***

***A report of findings was mailed to all screening coordinators and community health departments statewide to assist in local infrastructure building efforts.//2005//***

**b. Current Activities**

***/2005/ 2003/2004 school screening data has been entered into the database.***

***Data will be analyzed by the MCH Data Manager to develop a report of convenience***

**sample data and explore how data might be further utilized.**

**Screening forms were revised to include recommendations made during a 2002 evaluation meeting with Maternal and Child Health Data Monitoring Section personnel.//2005//**

c. Plan for the Coming Year

**/2005/ASTDD technical assistance will be requested to assist in developing a survey design to acquire a representative sample of Montana third graders using BSS.**

**New forms and guideline manuals incorporating suggestions will be developed.**

**HRSA SOHCS grant funds will be utilized to contract with dental hygienists to conduct a representative sample of third grade children in two regions of Montana in schools that offer free/reduced lunch programs.**

**Data will be compiled and utilized in reporting performance measure data, inclusion of data for the National Oral Health Surveillance System (NOHSS), and needs assessment activities and reports.//2005//**

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

a. Last Year's Accomplishments

/2004/ Montana's vital records reporting of deaths is delayed this year, due to changes in the vital records management and handling. Fetal, Infant, Child Mortality Review continues at the county and tribal level, augmented by legislative changes during the 2003 session which allowed for expansion through partnering of counties and tribes. Montana's motor vehicle death rate continues to be high, due in part to the need for extensive travel to traverse large rural and frontier land mass for basic services including education and health services. Car safety programs sponsored in part by the Department of Transportation and Healthy Mothers, Healthy Babies - The Montana Coalition continue in communities across the state.

b. Current Activities

/2004/ As noted above, Department of Transportation and Healthy Mothers, Healthy Babies - The Montana Coalition continue their efforts to improve effective seat belt use. Discussions with advocacy groups to reintroduce Graduated Drivers License legislation into the 2005 session (beginning in January 2005) are underway. Primary seat belt legislation is also being considered by some advocacy groups, as is legislation to outlaw open container laws.

c. Plan for the Coming Year

/2004/ Legislative support, using FICMR data, and if available, death record data will be used to support the need for legislative changes addressing seat belt use, open container laws, and graduated drivers license legislation.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

**/2005/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.**

**/2002/ Accomplishments in 2000: Of the 13,629 infants and children under age 2, 9458 were breastfed at hospital discharge (69.4%). However, this number is suspect due to a problem with the automated data system. This has not been completely resolved and there may be data missing from one of the fields used to determine this information. For additional activities done in 2000 to support breastfeeding, please see the note for federal performance measure 4.**

**/2003/ Accomplishments in 2001: Of the 13,624 infants and children under age two, 9,558 were breastfed at hospital discharge (70%). For additional activities to support breast feeding, please see the note for FEDERAL PERFORMANCE MEASURE 04.**

**/2004/ Training of WIC staff through conferences and a pre-session at the Spring Public Health Meeting was performed. Updated local agency references with Thomas Hale's Medications and Mother's Milk. Continued distribution of manual breast pumps and piloted several electric breast pump projects.//2005//**

#### **b. Current Activities**

**/2005/ The Montana WIC Program has awarded funds for a peer breastfeeding counselor program. Two state staff will attend training to determine if a program is feasible in Montana. The pilot electric breast pump projects were so successful that expansion to a total of 25 counties/reservations was accomplished. New breastfeeding educational materials were purchased.//2005//**

#### **c. Plan for the Coming Year**

2005/ Determine feasibility of a peer breastfeeding counselor program in Montana. Continue to provide manual and electric breast pumps to local agencies using WIC food dollars when funds are available.

Purchase breastfeeding education materials to be used with participants.

Of children under age 2 years (13,823) 2004 (13,759)

Initiation of Breastfeeding is 70.2% (9,705) 2004 (9,755) 70.9%

Breastfeeding at 6 months of age 25.7% (3,548) 2004 (4,381)31.8% **//2005//**

a. Last Year's Accomplishments

*/2005/In calendar year 2003, 100% of the birthing facilities provided screening information. Ninety-eight percent (98%) of all live births in Montana occurred in birthing facilities (as opposed to home, doctor's office or "other" locations). Of those born in birthing facilities, 89% received were reported as receiving hearing screening prior to hospital discharge. Of the infants screened in 2003 by one month of age, 6 were referred for, and received, an audiologic evaluation confirming a permanent congenial hearing loss by three months of age.*

*The Newborn Hearing Screening advisory group met in October of 2003 to discuss the state program's plans to electronically link the early intervention "players" in the state that create the continuum of services for children with special health care needs (CSHCN) including hearing impaired infants and children. This electronic linkage of service systems will facilitate early identification, referral and intervention. A report was also presented on how non-state funds could be accessed to defray the costs of hearing aids for low-income families. A staff member from the Montana Medicaid program explained how devices, fittings and evaluations are reimbursed at the state level and solicited suggestions from the group on how Medicaid can better serve the hearing impaired population. Representatives from the advisory group were encouraged to attend the national EHDI Conference in D.C. in February, 2004.//2005//*

b. Current Activities

*/2005/The Advisory group met again in April, 2004, to continue the discussion of creating a seamless continuum of services for hearing screening, diagnosis, referral and intervention and to review the valuable information obtained from the members who attended the EHDI conference in D.C. There was discussion about the likelihood that Congress will not continue dedicated funding for UNHS to the states and the need to work as quickly as possible to "institutionalize" the local and state infrastructure to maintain the continuum of services without dedicated funding. The approach being used is to create computer linkages among the partners that will support collaborative efforts to maintain the continuum. Birth certificate data will be linked with the hearing screening data to ensure that all babies are screened. Children with an assessed hearing loss will be entered into the CSHCH data system, which will be directly accessed by both CSHCH staff at the state and the Montana School for the Deaf and Blind (MSDB). State program Part C managers have decided not to participate in this electronic linkage for the time being. MSDB is creating memoranda of agreement with individual Part C contractors to coordinate referrals and local services.*

*The state plans to combine heelstick and newborn hearing screening monitoring and reporting functions within one position were also discussed and concerns about possible negative impact on the level of hearing services from the state were voiced. The EHDI conference attendees discussed with the Task Force the major benefits they had gotten from attending the national conference and their recommendations for the focus of the UNHS program. The theme of the conference was seamless transitions between screening, diagnosis and intervention. The attendees found that many states are struggling to establish/maintain this seamless continuum and reported on some of the efforts they heard about to address the problems. Concern was expressed by attendees that the previously contracted hearing coordinator's contract was not renewed and that early intervention efforts are seen to be suffering as a result. Information from the conference about "sustainability" was reviewed including the ten steps to maintain community improvements. The group was asked to provide input to the state's response to the national EHDI survey.//2005//*

c. Plan for the Coming Year

***//2005/ Montana is combining newborn heelstick and hearing screening monitoring and management of the State's birth defects registry into one position. This position will receive data management support and epidemiological support from other FTE's in the MCH Data Monitoring Section.***

***Almost universally, the same staff in the birthing facilities perform/ensure the performance of both the newborn heelstick and hearing screenings. State-supplied technical support for ensuring the validity of the heelstick screening is provided by the Montana Public Health Laboratory. State support of the initiation, followup and reporting of both heelstick and hearing screening by the birthing facilities will be provided by the newborn screenings monitor/educator in the MCH Data Monitoring Section.***

***Consolidation of the screening monitoring function will reinforce with the community partners that both components of screening should be considered standard practice and equally important for early detection and intervention.***

***Management of the birth defects registry for Montana's annual birth cohort of <12,000 will occupy .50FTE of the time of this position. Epidemiological support will be provided by other staff in the same section.***

***The NBS/BDR position will provide or ensure the provision of programmatic technical assistance to the birthing facilities to improve the rate of screening before hospital discharge.***

***Continue to work with state program partners in the CSHCN program, IDEA Part C, the Office of Public Instruction, and the Montana School for the Deaf and Blind and with the UNHS Advisory Council to assure provision of quality intervention services for infants with identified hearing loss.***

***Continue to contract for vendor assistance to birthing facilities in the use of the HI\*TRACK reporting/data management system.***

***//2005//***

Performance Measure 13: *Percent of children without health insurance.*

a. Last Year's Accomplishments

***//2005/The results of the Montana Statewide Study of the Uninsured State Planning Grant conducted by the Department of Public Health and Human Services found that 17% of Montana children age 0-18 were uninsured. The information was obtained through research, surveys, focus groups, key informant interviews and public meetings. There are 22,000 Montana children who live in households with incomes at or below 150 percent of the Federal Poverty Level. Approximately one-third of these children may be eligible for Medicaid. Therefore, approximately 15,000 children could be eligible for CHIP.***

***CHIP provided health insurance coverage for 13,084 Montana children in FFY 2003. The annual CHIP Enrollee Survey indicates a high level of satisfaction with CHIP. The areas of focus include the following: Customer Service, Child's Personal Provider, Child's Health Care, Child's Dental Care, Timeliness of Care, and Provider Communication.***

***We strive to maintain and improve our network of CHIP providers to ensure access to health care for children with CHIP. At the end of FFY 2003 there was a CHIP provider network of 240 dentists and 3,294 physicians, allied health providers and hospitals throughout Montana. This provider network continues to grow steadily (5% increase in dentists and 10% increase in physicians, allied health providers and hospitals compared to FFY 2002) and ensures access to children with CHIP coverage.//2005//***

b. Current Activities

*/2005/At the end of FFY 2003 there were 9,550 children enrolled and 1,230 on the waiting list. Additional state funding from the Governor in November 2003 allowed additional children to be enrolled in CHIP. We currently have about 10,900 children enrolled and more than 300 children on the waiting list.*

*CHIP screens all applications for Medicaid eligibility and forwards all applicants who appear potentially eligible for Medicaid to local public assistance offices. We refer all applications to the Caring Program for those children found to be over income for CHIP.*

*CHIP sends information about the Primary Care Association members (Community Health Centers, NHSC sites, Migrant and Indian Health clinics) to families who apply for CHIP.*

*We also provide information and referrals to Blue Care, Montana Youth Care and Montana Comprehensive Health Association. Callers to the Department's Family Health Line can also receive resources and referrals to private, low-cost health insurance and other resources in their communities.*

*In conjunction with Medicaid staff, we conduct regular visits to each Native American tribe in Montana to provide information and answer questions regarding CHIP and Medicaid.//2005//*

c. Plan for the Coming Year

*/2005/We plan to maintain our monthly enrollment of 10,900 through the end of our state fiscal year (June 30, 2005). We hope to insure more children in the future as funds become available. We hope to draw down our maximum federal allocation in order to serve the largest number of children with the money available.*

*We will focus on providing information to CHIP families about the importance of maintaining CHIP coverage and obtaining preventive, as well as acute care for their children. Our insurance contractor, Blue Cross Blue Shield of Montana will also provide information to families about children's health issues.*

*We will strengthen our coordination with our partners. In particular, Offices of Public Assistance (Medicaid), Children's Special Health Services and Children's Mental Health Services, Community Health Centers, etc.//2005//*

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

Percent of children receiving services paid for by Medicaid continues in the high 90%. The performance measure is an indicator of a single service only, however, and does not measure adequacy of the services overall. The EPSDT effort continues to inform families of periodicity schedules for children's preventive health services through mailings and outreach efforts.

b. Current Activities

Medicaid outreach has been limited in the current year due to budget issues. A universal application for Medicaid/CHIP/CSHS continues to be in use, improving potential for children to

receive services needed, including Medicaid services. Medicaid redesign efforts have been compiled into a report which was sent to the Governor in June of 2004. Limited impact on children's services are anticipated with the redesign measures.

c. Plan for the Coming Year

Efforts to maintain existing optional Medicaid services will be a major consideration in the upcoming legislative session. Medicaid redesign plan will be an agenda item in the legislative session.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

***/2005/October 15, 2003--State FICMR team reviewed fetal death statistics and provided recommendation for comparison to other states with same fetal death definition  
October 2003-- Developed a listserve to promote communication and discussion among FICMR coordinators about successful prematurity and other infant death interventions  
June 16, 2003--With a grant from the CJ Foundation for SIDS, developed and disseminated Native American SIDS risk reduction materials, prematurity and low birth weight noted as SIDS risk factors//2005//***

b. Current Activities

***/2005/January 15, 2004 conducted a meeting by teleconference for all MIAMI reservation projects to discuss successful interventions for high risk pregnancy clients, compliance and future plans  
March 24, 2004--DPHHS oral health consultant provided information about the link between severe periodontal disease and preterm labor to 35 FICMR coordinators/Public Health Nurses  
March 24, 2004--Provided March of Dimes Prematurity Prevention materials and education to FICMR coordinators/Public Health Nurses  
May 2004--Supported March of Dimes "Walk America" Prematurity Prevention campaign by providing information in the workplace as well as to the local FICMR coordinators  
May 2004--Provided "prenatal smoking cessation" education at the Spring Public Health Conference  
May 2004--March of Dimes Prematurity Prevention materials provided at the Spring Public Health Conference  
Distributed 3,500 toothbrushes with prematurity prevention information attached to WIC Clinics, Healthy Mothers Healthy Babies, FICMR coordinators, and to a reservation prepared childbirth class  
Recruited 3 reservations to FICMR review process for a total of 7 of 7 reservations now participating  
Public Health Home Visiting program has been revamped via RFP and contracts are being finalized to 19 counties and reservations//2005//***

c. Plan for the Coming Year

***/2005/Continue to provide prematurity prevention outreach to FICMR coordinator network  
Continue to utilize and disseminate March of Dimes Prematurity Prevention materials  
Will initiate a discussion with the Indian Health Service Maternal Child Health Nurse Consultant on prematurity***

**prevention outreach for the Native American population**  
**Provide standardization and training of all Public Health**  
**Home Visiting projects**  
**Provide educational outreach regarding low birth weight**  
**prevention activities for the workplace//2005//**

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

#### a. Last Year's Accomplishments

Last Year's Accomplishments:

/2003/ A review of the youth intentional injury/suicide rates showed that in 2003 there were youths between the ages of 15 and 19 who completed suicide. In addition, there was also 1 completed suicide by a child between the ages of 10 and 14. Last year these numbers were 9 and 2, respectively.

/2004/ Accomplishments: in 2003,

1) Five-member professional team from Montana attended Preventing Suicide in Regions VII and VII Communities Working Together to Implement the National Strategy for Suicide Prevention in the Prairies and Mountain West" on October 28 ? 30, 2003 at the Westin Hotel, Westminster, Colorado

2) Governor Martz allocated \$50,000 for teen suicide prevention. Mini-grants of \$10,000 for community based suicide prevention were given to four communities

#### b. Current Activities

Current Activities:

Ongoing activities: in 2004

1) Work on a community toolbox as a collaborative effort between States. Suggest that a component of the toolbox include gatekeeper training and media guidelines as well as assessment and method for improvement of activities. Tools exist, they need to be gathered and refined.

2) Montana is currently looking at models in Florida regarding school prevention and aftercare

3) Four gatekeeper trainings have taken place.

4) Governor Martz allocated \$50,000 for teen suicide prevention, must be allocated by July 01. Four mini-grants of \$10,000 for community based suicide prevention.

5) Met with Margene Tower of IHS, several completed suicides, state and tribes working on community plans, training, and more development including safety plans and working with survivors. Thom Fanning has spearheaded a gatekeeper in the schools in order to bring contagion under control.

6) Native American Youth Suicide Prevention Conference was held in Billings, using the GONA model.

6) Continuing to look at strengthening web-site and building links with the 211 health communication.

#### c. Plan for the Coming Year

1) Continue to review all youth suicide by FICMR teams at the local level

2) Write and disseminate a report on the findings of the four community grants and the

community needs assessment.

3) Support QPR training in communities through the Governor's Initiative on Youth Suicide Prevention

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

a. Last Year's Accomplishments

***/2005/Expanded capability for FICMR reviews through legislative change that allows inter-county reviews. Now have 27 community level teams reviewing deaths for 53 counties and 7 reservations. Now have capability to review about 90% of all fetal, infant and child deaths. These teams assess prematurity issues leading to the death of an infant, and initiate changes or make recommendations as appropriate.***

***Presented Montana FICMR findings at Child Fatality Review national conference//2005//***

b. Current Activities

***/2005/Sustaining the Fetal, Infant and Child Mortality Review program.***

***Providing ongoing support to the community level FICMR coordinators***

***Providing prematurity prevention materials from the March of Dimes to the FICMR coordinators***

***Public Health Home Visiting program has been revamped via Request For Proposal and contracts are being finalized to 19 counties and reservations***

***Years 2001 and 2002 FICMR data being analyzed by contracted MCH epidemiologist***

***Working on second statewide report of fetal, infant and child deaths with assessment of preventable deaths and community level interventions//2005//***

c. Plan for the Coming Year

***/2005/Will provide "Kicks Count" education to public health nurses, including public health home visitors***

***Accomplish standardization and training of all Public Health Home visiting projects***

***Will coordinate a discussion involving two of Montana's three perinatologists about effective prematurity prevention outreach and a regional transport system for at risk pregnant women by June 30, 2005.//2005//***

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

a. Last Year's Accomplishments

***/2005/January 15, 2004 conducted a meeting by teleconference for all MIAMI reservation projects to discuss successful interventions for high risk pregnancy clients, compliance and future plans***

***Convened two meetings for FICMR coordinators in which successful and early outreach and intervention strategies for pregnant women were discussed***

***October 15, 2003--State FICMR team reviewed fetal death statistics and provided recommendation for comparison to other states with same fetal death definition***

***October 2003-- Developed a listserve to promote communication and discussion among FICMR coordinators about successful prematurity and other infant death interventions***

**Expanded capability for FICMR reviews through legislative change that allows inter-county reviews. Now have 27 community level teams reviewing deaths for 53 counties and 7 reservations. Now have capability to review about 90% of all fetal, infant and child deaths. Trimester at entry into prenatal care is ascertained for all infant deaths.//2005//**

**b. Current Activities**

**/2005/Ongoing consultation to FICMR coordinators regarding outreach to pregnant women**

**Public Health Home Visiting program has been revamped to focus on the pregnant women with the greatest needs and contracts are being finalized to 19 counties and reservations//2005//**

**c. Plan for the Coming Year**

**/2005/Organize a teleconference among Public Health Home Visitors regarding successes, challenges, and ideas for identifying and enrolling pregnant women into early prenatal care**

**Using Pregnancy Risk Assessment Survey (PRAMS) data design interventions geared to ascertainment of early prenatal care//2005//**

**FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

**General Instructions/Notes:**

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Continue outreach and education to midwives to ensure that infants not born in birthing facilities receive their mandated heelstick screenings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide educational materials that inform physicians and inform parents about the option to have their babies screened for additional conditions that could be routinely requested in the newborn period but are not now part of the MT panel of tests.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Continue to increase and broaden the representation of CSHCN families on the CSHS advisory council.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Develop a plan to facilitate family representation in data management issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Establish parent partnership project to identify service barriers for CSHCN and develop solutions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Assist in developing family voices chapter in Montana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Medical home project via CATCH grant with Dr. Marian Kummer.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Evaluation of medical home utilization by CSHS clinical participants.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Survey MT pediatricians and family practice regarding knowledge of medical home concept.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Participate with MT chapter of AAP to increase awareness of medical home through group education.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Tie system of care project to medical home concept through work with key pediatricians/family practice providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				

1. Continue to evaluate/refer CSHCNs utilizing CSHS as sole source of medical assistance for other coverage sources	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide education to public health providers regarding medical assistance for CSHCN. (completed 5/04)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Refine referral processes w/CHIP, Medicaid, Caring Program for Children to insure maximum coverage. (complited 03/04)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to provide financial assistance for specialty services not otherwise accesssible or affordable.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Work to identify and document other local resources to assist families with the cost of medical care. (i.e. hospital funds, foundations, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Establish qualification standards & training program for case managers of CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Assess need for regional specialty clinic &/or family support center in central Montana.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Implement capacity building project for regional specialty clinics via data analysis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to support existing regional pediatric specialty clinics, increase focus on self-sufficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Create outcome measures for Medicaid TCM program to assure that all types of TCM meet core values for CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Implement transition scale in cleft/cranio facial specialty clinics.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Plan/develop process to implement transition scale into 3 additional specialty clinics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

3. Sponsor parent/child participation in condition specific transition training (s)&/or activities.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Establish training program for CSHCN youths through the MYLF leadership seminars.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Establish statewide taskforce in conjunction with the Rural Institute to catalog transition services, identify barriers and create action plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. TA to birthing hospitals for parental consent for infant HepB and entry into immunization registry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Contract co. hlth depts for immunizations & maintenance of statewide immunization registry	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. VFC vaccines to tribal clinics, co. hlth depts & registered private providers for eligible children	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Contract with clinics for reproductive health care, including funding for high-cost contraceptives.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. At least 28% of FP clients served by local clinics will be 19 years and under.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. 100% of local clinics will outreach to youth at high-risk of teen pregnancy and birth.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. 100% of clinics participate in teen pregnancy prevention and educate about family involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. The FP Ed. Committee will assess and coordinate training as needed				

for local clinic staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Acquire ASTDD technical assistance to develop survey design to acquire representative sample of MT 3rd graders using BSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Develop new forms and guideline manuals incorporating suggestions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Use HRSA SOHCS grant funds to contract with dental hygienists to conduct a representative sample of 3rd grade children in 2 regions of MT in schools offering free/reduced price lunch programs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Compile data for performance measurement, inclusion in the National Oral Health Surveillance System (HOHSS), and needs assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Support SAFE KIDS/Safe Comm local and regional coalitions with monthly mtgs with EMSC/IP Coordinator	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. By 1/15/04 have a prelim rpt on the amb/ER room/payment feasibility data linkage study	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Cont bimonthly with ICP wkgrp to focus on youth etoh prev efforts aimed at lowering deaths from MVC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Cont team membership on the ambulance/emergency room/payment feasibility data linkage project	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Cont work on amb/er room/payment feasibility data link proj and present info at appro prof mtgs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Continue to distribute manual and electric breast pumps.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Purchase breastfeeding educational materials to be used with participants.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Determine feasibility of a peer breastfeeding counselor program in Montana.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Continue contracting with HI*TRACK vendor to provide TA to birthing hospitals in use of HI*TRACK reporting system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Track newborn hearing screening results from the HI*TRACK system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Refer children with diagnosed hearing loss to the Montana School for the Deaf and Blind via the CSHCN program	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Continue work with CSHCN, MSDB, and advisory council to assure smooth continuum of service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Acquire state and local funds to match federal funds and continue to insure 10,900 Montana children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Maintain the current retention rate for CHIP of 92%	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Refer 100% of children not eligible for CHIP to other appropriate				

programs or plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Send out reminder letters for well-child checkups on children's birthdays.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Publicize well-child periodicity schedule in newsletter.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Continue to screen all CHIP applicants for Medicaid eligibility.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Implement provider profiling and TA to providers to improve performance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Continue to provide prematurity prevention outreach to FICMR coordinator network	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to use and disseminate March of Dimes prematurity prevention materials	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Initiate a discussion with IHS MCH Nurse Consultant on prematurity prevention outreach for Montana's Native American population	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide standardization and training of all Public Health Home Visiting projects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide educational outreach regarding low birth weight prevention activities for the workplace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Serve as consultant to the statewide FICMR team on topics r/t adols particularly suicide and injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Four community grants to impact youth suicide prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Statewide community needs assessment to determine youth suicide prevention resources in community and state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Report on findings of community projects and needs assessment to the governor and disseminate to local entities	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Coordinate at least one State-level professional workshop on youth suicide prevention in 2004	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Provide "Kicks Count" education to public health nurses, including public health home visitors	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Standardize all Public Health Home Visiting projects and provide training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Coord discussion with two of Montana's three perinatologists about effective prematurity prevention outreach and a regional transport system for at-risk pregnant women by June 30, 2005	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				

1. Organize a teleconference among Public Health Home Visitors regarding successes, challenges and ideas for identifying and enrolling pregnant women in early prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Use PRAMS data to design interventions geared to ascertainment of early prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of unintended pregnancy.*

a. Last Year's Accomplishments

***/2005/Unintended pregnancy prevention remains one of sixteen priorities in the Montana Health Agenda, a road map for health service and program action, particularly for the Department's Health Policy and Services Division. This priority section outlines the Department's goal to decrease unintended pregnancy and lists specific objectives relating to unintended pregnancy.***

***/2005/The WMHS maintained contracts with local family planning clinics to assure access to comprehensive reproductive health care for men and women of reproductive age. Additional special initiative funds provided local clinics with funding for male clinics, information, education and communication projects, client family and community involvement, addressing health disparities in reproductive health, and providing efficacious contraceptives to low-income clients.***

***/2005/The service expansion and other special initiative projects have lead to an increase in the number of unduplicated clients served by local clinics. In SFY 2003, the number of clients served increased to 28,684. It is estimated that Title X family planning services prevented approximately 18,480 unintended pregnancies, including 2,618 abortions, during SFY 2003.//2005//***

b. Current Activities

***/2005/The WMHS continues to distribute outreach materials to county Offices of Public Assistance, community action programs, Healthy Mothers, Healthy Babies, local MIAMI Projects, WIC offices, local Breast and Cervical Health Program sites, and Indian Health Services. Family planning programs also receive outreach materials and distribute them to clients and community partners. Outreach materials include the 24-hour toll-free hotline number so clients can find the nearest Montana Family Planning Clinic.***

***/2005/The WMHS provides fact sheets on the topics "What is Family Planning?" "The Benefits of Family Planning Activities," and "Accomplishments of the State Family Planning Program." These fact sheets are used in conjunction with the family planning***

**display and are distributed to local Title X clinics. Department staff also uses the fact sheet to educate legislators on family planning issues.**

**/2005/ Legislation passed in 2001 allows pharmacists to have collaborative agreements with prescribers to initiate drug therapy. Formal ECP training for pharmacists is included in continuing education offered by the University of Montana School of Pharmacy. Currently the Community Health Center in Livingston Montana employs a pharmacist who provides ECPs through a collaborative agreement with a physician. The Nurse Consultant will continue to monitor, support, and promote the provision of ECPs by pharmacists through the use of collaborative agreements when opportunities arise.**

**/2005/ A referral system has been developed for rural agencies that do not have capacity to provide IUD insertions to refer to larger agencies for IUD insertions. This system increases the availability of IUDs for low-income women. The IUDs are provided through the federal regional efficacious contraceptive funds**

**/2005/ During SFY 2004, the WMHS received special initiative funding for local Male Adolescent Clinics; for Information, Education and Communication (IEC) projects; for Client, Family and Community Involvement (CFC); for Family and Intimate Partner Violence and for Efficacious Contraceptives. Local male clinics use teen male interns to reach an increased number of male clients. The IEC projects fund local clinics to increase awareness of family planning services and to increase knowledge on reproductive health. The CFC projects focus on outreach to special needs populations, parents and school districts to increase awareness and support for family planning services. Research shows that victims of family violence are at increased risk of unintended pregnancy. Through special funds for highly effective contraceptives, including emergency contraceptives, the WMHS focuses on reducing the teen pregnancy rates as well as the teen birth rate.//2005//**

**c. Plan for the Coming Year**

**/2005/ During the coming year, the WMHS plans to address unintended pregnancy through continued contracts with its local family planning clinics providing comprehensive reproductive health care in 29 locations to residents of all 56 Montana counties. Because low-income clients are at increase risk of unintended pregnancy, the WMHS will continue to offer comprehensive family planning services targeting low-income men and women.**

**/2005/ Through training and educational activities, the WMHS plans to assist local family planning programs provide quality medical, clinical counseling and education services for all clients. A training needs assessment will be distributed to local family planning clinics to develop educational goals and training programs. Such training improves the service and quality of care in reducing unintended pregnancies among clients of local family planning programs.**

**/2005/ The WMHS will provide health education materials on unintended pregnancy to local programs and other public health partners. These materials will be updated to reflect the increased availability of information in an electronic format. The health educator will continue to investigate on-line resources and other sources of current information that includes unintended pregnancy prevention.**

***/2005/ The WMHS has applied for special initiative funding for Male Adolescent Clinics; Male Reproductive Health; Information, Education and Communication (IEC) projects; Client, Family and Community Involvement. Each of these projects addresses the issue of unintended pregnancy within specific populations among family planning clients. Male clinic projects will focus on male responsibility in reducing unintended pregnancy. Research shows that victims of family violence are at increased risk of unintended pregnancy. The Client, Family and Community Involvement projects focuses on family planning services to clients who have difficulty accessing Title X services.***

***/2005/ The WMHS will continue to provide special funding for efficacious contraceptives to local family planning clinics. These high-cost and highly effective contraceptives will be provided to low-income clients who fall at least below 250% of the federal poverty level./2005//***

State Performance Measure 2: *Percent of women who abstain from alcohol use in pregnancy.*

**a. Last Year's Accomplishments**

***/2005/ Montana's Fetal Alcohol Syndrome Prevention participation in the Four State Consortium (including Montana, North Dakota, South Dakota and Minnesota) continued through contract extension with local providers through fall of 2003. Four sites, including two tribal settings, provided home visiting services including trained paraprofessionals to work with women identified at risk for having a child with fetal alcohol syndrome or effect. Continued participation in the consortium was contingent upon availability of new funding or carry over funding. Montana expended funds in the fall of 2003, and their participation is now considered inactive in the consortium. Reports of the outcomes continue to be developed by South Dakota - the primary contractor with SAMHSA.***

**b. Current Activities**

***/2005/ Montana continues to promote a no alcohol use policy for pregnant women and/or women considering pregnancy. Community based efforts continue to offer education and support through the public health home visiting project (AKA MIAMI). Montana conducted a Request for Proposal for public health home visiting services in spring of 2004. Contracts for new public health home visiting services in 19-20 communities are presently being negotiated. Alcohol use, abuse and/or use/abuse by individuals in the household are risk indicators which qualify women for public health home visiting services by a team of professionals (nurse, social worker and dietician) and an optional paraprofessional member. Minimum standards for home visiting services are established in the new contracts, which target high risk pregnant women and their infants.***

**c. Plan for the Coming Year**

***/2005/ Training for the newly established public health home visiting contractors will be conducted in SFY 2005, and will include education about identification of alcohol use using standardized tools. Reporting of findings will be mandated using the public health data system (PHDS) for county program sites and via hard copy reporting for tribal contractors. 100% of newly contracted sites will be responsible for assessing for alcohol use in pregnant women, and for case management which includes referral to substance use programs and monitoring of compliance.***

State Performance Measure 3: *Whether the state Title V program and its partners have adopted a set of quality standards for the MCH population and recommended them as standards to either public or private providers.*

a. Last Year's Accomplishments

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 4: *Percent of "WIC" infants who are breastfed at six months.*

a. Last Year's Accomplishments

***/2005/Accomplishments in 1999: In 1999 WIC provided numerous opportunities for local agency staff to receive training in breastfeeding promotion and support. WIC purchased a number of nutrition and breast-feeding references to accompany the Competency Based Training Program modules and to update information.***

***/2002/ Indicator data for 2000 is highly suspect due to a problem with the automated system. The problem has not been completely resolved and infants entered into the system may have data missing from one of the fields used to determine breast feeding status.***

***Accomplishments in 2000: A number of staff received scholarships to attend WIC Nutrition: Going for the Gold, the National Association of WIC Directors Nutrition and Breastfeeding Conference. The Regional Dietitian Project was started. Currently two contracts were awarded to provide services to seven WIC programs and their satellites.***

***Accomplishments in 2001: The Regional Dietitian Project continued. Began 4 pilot projects to promote breastfeeding. Breastfeeding cues magnets distributed to local agencies. 13 local agency staff attended the 2nd Annual Mother-Baby Symposium "Breastfeeding in the 21st Century" in Missoula, MT.***

***Accomplishments for 2002: A breastfeeding conference with a nationally recognized speaker was held in Montana. A number of local agency staff attended the National Association of WIC Directors Nutrition and Breastfeeding Conference. Four pilot projects are ongoing in the state for a second year. Each project is addressing breastfeeding promotion and support in the community in a different way.***

***/2004/ Training of WIC staff through conferences and a pre-session at the Spring Public Health Meeting was performed. Updated local agency references with Thomas Hale's Medications and Mother's Milk. Continued distribution of manual breast pumps and piloted several electric breast pump projects.//2005//***

b. Current Activities

***/2005/ The Montana WIC Program has awarded funds for a peer breastfeeding counselor program. Two state staff will attend training to determine if a program is feasible in Montana. The pilot electric breast pump projects were so successful that expansion to a***

**total of 25 counties/reservations was accomplished. New breastfeeding educational materials were purchased.//2005//**

**c. Plan for the Coming Year**

**/2005/ Determine feasibility of a peer breastfeeding counselor program in Montana.**

**Continue to provide manual and electric breast pumps to local agencies using WIC food dollars when funds are available.**

**Purchase breastfeeding education materials to be used with participants.**

**Of children under age 2 years (13,823) 2004 (13,759)**

**Initiation of Breastfeeding is 70.2% (9,705) 2004 (9,755) 70.9%**

**Breastfeeding at 6 months of age 25.7% (3,548) 2004 (4,381) 31.8% //2005//**

State Performance Measure 5: *Percent of state fetal/infant/child deaths reviewed for preventability. (changed from % of counties establishing fetal/infant/child mortality review committees)*

**a. Last Year's Accomplishments**

**/2005/March 27, 2003 briefed the Governor on the findings of the inaugural FICMR report**

**Successfully introduced legislation, which revised the Fetal, Infant and Child Mortality Prevention Act to allow counties and tribal governments to cooperate to review all fetal, infant and child deaths in the State of Montana.**

**Expanded FICMR review capability to approximately 90% of all fetal, infant and child deaths**

**Organized and facilitated three meetings of the State FICMR team.**

**Organized and facilitated two meetings of the Local FICMR Coordinators network.**

**Local FICMR coordinators met with the State Medical Examiner and toured the State Crime Lab**

**Successfully sustained the FICMR program**

**Developed and implemented a Native American SIDS Risk Reduction project**

**Compiled the data from the first "mock review," assessed data for integrity between review sights, and shared findings with local coordinators**

**Developed a listserve to promote communication and discussion among FICMR coordinators about successful interventions and facilitate problem-solving**

**Developed a FICMR power point presentation which included data from the inaugural report and posted it on the DPHHS web site for use by local FICMR teams**

**Developed a FICMR data release policy**

**Provided "smoking cessation in pregnancy" training**

**Recruited 3 reservations to FICMR review; now have 7 of 7 reservations participating//2005//**

**b. Current Activities**

**/2005/Distributed second "mock case review" for inter-panel reliability to local coordinators. Reviews due December, 2004.**

**2001-2002 data being analyzed by contracted MCH epidemiologist**

**Second FICMR data report being developed**

**Prematurity prevention education to local coordinators on ongoing basis**

**Child abuse and neglect education scheduled for October, 2004**

**Obtained youth suicide grant funding for implementation of youth suicide prevention efforts for three FICMR teams**  
**Organizing a SIDS outreach campaign for all alternative schools, to be implemented October, 2004**  
**Grief and bereavement education to local coordinators scheduled for October 2004**  
**Department of Family Services scheduled to discuss child abuse and neglect reporting issues with local coordinators October 2004. //2005//**

c. Plan for the Coming Year

**//2005/Sustain FICMR program at current level**  
**Continue focus on preventable prematurity**  
**Complete second FICMR report and disseminate statewide**  
**Complete analysis of data from mock case review for inter-panel reliability//2005//**

State Performance Measure 6: *Percent of facilities using standardized domestic violence screening tool as part of care assessment and planning.*

a. Last Year's Accomplishments

**//2005/The annual pre-contract survey of MCHBG recipient agencies continues to provide survey data on the use of standardized screening tools for domestic violence among the targeted MCH clients served. In 2003, 30% of the recipient agencies reported using a standardized domestic violence assessment tool. The counties continue to report that their clients experience domestic abuse and that they make referrals for services to address abuse concerns.//2005//**

b. Current Activities

**//2005/Statewide roll-out of the Public Health Data System (PHDS) to local public health departments is 85% complete, with only 8 local public health departments not yet using PHDS. One has no connectivity capacity, two have only dial-up capacity and the other five have completed their paperwork to gain access. The Title V Director has published a policy decision that all MCHBG recipient agencies must use PHDS to record their services to MCH clients to complete the standardization of all client service data.//2005//**

c. Plan for the Coming Year

**//2005/ Continue to promote use of standardized domestic violence screening tool as part of care assessment and planning at annual Spring Public Health Meeting.//2005//**

State Performance Measure 7: *Percent of two year old children screened for lead.*

a. Last Year's Accomplishments

**//2005/ The rate of screening in 2003 is less than 2%//2005//**

b. Current Activities

**//2005/ Screening will continue for children who are Medicaid-eligible and for those with a payment source for the screening test. Without specific funding to support lead screening outreach, availability of payment source will determine lead screening.//2005//**

c. Plan for the Coming Year

***//2005/ Without specific funding to support lead screening outreach at the local level, leaad screening will continue to be limited to screening performed by providers for patients with public or private insurance.//2005//***

State Performance Measure 8: *Percent of Medicaid eligible children who receive dental services as part of their comprehensive services.*

a. Last Year's Accomplishments

Montana Dental Advisory Board meetings were held to discuss provider requests to close existing codes and open new ones resulting in code actions per consensus of the Board.

An updated Client Medicaid Handbook and website contains a more comprehensive description of Medicaid dental benefits for ease of client understanding.

Increased communications and meetings with the Montana Dental Association and the State Oral Health Consultant for better oral health collaboration.

Dental provider informational bulletins were included in the Medicaid Provider Claim Jumper monthly newsletter.

Personal meetings with individual and area provider groups regarding Medicaid concerns and program ideas.

b. Current Activities

To ease the administrative burden for providers, the Covered Services Section of the Medicaid Dental Provider Manual was updated to incorporate many provider suggestions in one convenient place including, dental fee schedule code reimbursement, all Medicaid covered CDT codes, CDT code allowed minimum and maximum age, and all service limitations per code

Updated Basic Dental Emergency Form with current codes.

Updated fee schedule to include minimum and maximum ages on covered codes.

Attendance at the National Oral Health Conference with DPHHS Oral Health Consultant, which provided a wealth of national oral health information

c. Plan for the Coming Year

Montana is exploring several new ideas to address the access issue; one is the "Rent A Practice" for a day. This idea is to increase the number of Medicaid patients a provider is seeing in a low access area by paying a lump sum in addition to the regular fee-for-service reimbursement for an amount of new Medicaid clients.

The dental program is also requesting a fund increase from the Department's budget planning process for the 2005 Montana Legislative session for dental fees or to pay providers incentive money for serving a higher number of clients.

Planned coordination with the new EPSDT Program Officer to prepare new oral health provider and client education materials and training for medical providers to conduct oral health screenings as part EPSDT well-child exams.

State Performance Measure 9: *Percent of pregnant women who abstain from cigarette smoking.*

a. Last Year's Accomplishments

***/2005/ Distributed a guide for MDs for their pregnant clients on smoking cessation. Distributed smoking cessation information at the 2003 Spring Public Health Conference. The Safe Sleep for Baby give-away included information on the risk of SIDS, which included information on the risk of prenatal and secondhand smoke./2005//***

**b. Current Activities**

***/2005/ Provided smoking cessation segment at the March 2004 local FICMR coordinators' meeting. A smoking cessation breakout called "Smaller, Hyperactive Babies that Cry" was presented at the Spring Public Health Meeting in May, 2004. Expectant mothers in the Safe Sleep for Baby program were asked to sign a "no-smoking contract" when receiving baby cribs. One mother out of 16 refused to sign or take a crib, but the rest made the written commitment. Funding for Public Health Home Visiting services were issued to 14 counties and 2 reservations. Smoking cessation is an integral part of Home Visiting services to pregnant and post-partum mothers. A preliminary planning meeting was held with the Montana Tobacco Use Prevention Program to discuss collaboration on reduction of smoking during pregnancy./2005//***

**c. Plan for the Coming Year**

***/2005/ The major thrust for Smoking Cessation/Prevention activities for the coming year will be focused on collaboration with Montana's Tobacco Use Prevention Program to emphasize the connection between smoking and SIDS in babies. This is the second leading killer of infants and continues to claim lives even with the success of the Back to Sleep campaign in reducing the overall rate of SIDS./2005//***

**State Performance Measure 10: Rate of firearm deaths among youth aged 5-19.**

**a. Last Year's Accomplishments**

***/2005/ Support has continued for gun safety and awareness classes for youth provided by Fish Wildlife and Parks, 4-H, local public health departments and schools. Gun safety and safe storage of firearms is routinely included in education provided in home visits to high risk pregnant women and high risk children. Suicide prevention programs at the state and local level are supported by provision of available brochures and other materials. FICMR teams continue to review firearm related deaths of children from 0 to 18 years of age and make recommendations for prevention activities in the local communities./2005//***

**b. Current Activities**

***/2005/The FICMR teams have expanded capability to review children's deaths through inclusion of more counties and reservations. The State and local FICMR teams continue to make recommendations for death prevention at the local level. Some local FICMR teams distributed gun locks at local health fairs./2005//***

**c. Plan for the Coming Year**

***/2005/ Efforts will continue to recruit physicians into the educational process for alerting parents to the necessity of focusing on gun use and storage safety in the home. Outreach efforts will be made to firearm retailers to provide them with information for consumers about child and gun safety. Collaboration will be explored with Healthy Child Care Montana and the Child Care Licensing Bureau to incorporate firearm safety in child care settings.112005//***

**FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Percent of unintended pregnancy.				
1. Contract with clinics for FP services to at least 29,500 clients at risk of unintended pregnancy.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Ensure that 97% of female FP clients using contraception do not experience an unintended pregnancy.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At least 69% family planning clinic clients will be at or below 150% of federal poverty level.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Co-sponsor with the Region VIII Training Center a training based on local staff training needs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Fund FP clinics for efficacious contraceptives for low-income clients (below 250% of poverty)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Percent of women who abstain from alcohol use in pregnancy.				
1. By Jan. 1, 2004, finish testing women in study as per established time intervals and protocols	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. By 1/1/04 finish implementation of core curriculum with women in study as per estab guidelines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. By 2/1/04 submit all data collected to SD Center for Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. By Mar. 1, 2004, the data will be entered in established data system for the four states	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. By 01/01/04 finalize implemen of preven/interven model for women at risk of abusing ETOH during pg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. By 10/1/04 disseminate the interim results from this 4 state study to nat, Journal for publication	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. In collab with 4 state FAS Consort submit findings for presentation to appro conf and mtgs by 9 04	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. By 10 04 develop and submit report of findings to CSAP and to Consortium AC and State AC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pyramid Level of Service			

STATE PERFORMANCE MEASURE	DHC	ES	PBS	IB
3) Whether the state Title V program and its partners have adopted a set of quality standards for the MCH population and recommended them as standards to either public or private providers.				
1. Inactive Performance Measure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Percent of "WIC" infants who are breastfed at six months.				
1. Continue distribution of manual and electric breast pumps.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continue to provide increased early pre-hospital breastfeeding education.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of state fetal/infant/child deaths reviewed for preventability. (changed from % of counties establishing fetal/infant/child mortality review committees)				
1. Sustain FICMR program at current level	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continue focus on preventable prematurity	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Complete second FICMR report and distribute statewide	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Complete analysis of data from mock case review for inter-panel reliability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Percent of facilities using standardized domestic violence screening tool as part of care assessment and planning.				
1. Complete rollout of PHDS to facilitate RADAR data collection.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue annual pre-contract survey of screening tool usage.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Continue to provide domestic violence training at annual Spring conference.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue encouragement of local PHD staff to use screening tool during annual regional meetings.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of two year old children screened for lead.				
1. Obtain annual Medicaid data on lead screening for two-year old children in Montana.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) Percent of Medicaid eligible children who receive dental services as part of their comprehensive services.				
1. Fill the Medicaid Dentail Program Mgr position when required cost				

savings achieved from holding vaca	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue DPHHS OHP Oral Health Partnership mtgs and share info with MDAC, the MDAC and MDA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of pregnant women who abstain from cigarette smoking.				
1. Provide smoking cessation session at 3 04 FICMR coord mtg	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Ask PG mothers in the Safe Sleep for Baby prog to sign a ?no-smoking? contract	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide session on smoking cessation for pg women to PH professionals at the Spring PH Mtg 5 04	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Reallocate MIAMI funds in SFY 05 and request a plan for smoking cessation for pg women by 6/30/04	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Convene planning mtg with MTUPP to begin a collaborative plan to < smoking during pg by 9/30/004	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Form wkgrp with the WMHS and WIC to address smoking of WOCA and smoking and pg by 9/30/04	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) Rate of firearm deaths among youth aged 5-19.				
1. Research child firearm safety best practice principles and share with the State FICMR team 9/30/04	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Seek partners to enact child firearm safety strategies in 3 communities by 9/30/04	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Cont work on amb/ER room/payment feasibility data link proj and present info at appro prof mtgs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**E. OTHER PROGRAM ACTIVITIES**

Due to the economic straits currently experienced by Montana and the resulting cuts in authority to spend federal grant funds, elimination of State Health Agency positions regardless of funding source, as well as imposition of vacancy savings applied to all positions regardless of funding source, there remains little or no discretionary personnel or contractual resources to address program activities not directly related to identified priority needs, National Performance Measures and State Performance Measures.

**F. TECHNICAL ASSISTANCE**

/2004/Technical assistance needs identified in Montana in FFY 2001 included federal assistance, staff and/or resources to help: (1) develop and implement the suicide prevention plan; (2) develop a re-allocation formula for distribution of the MCHBG funds; (3) obtain information about effective mechanisms to access hospital and insurance record information for data use without statutory authority; (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; and, (6) implement a dental access plan. All these efforts except the third have been addressed without receipt of the TA requested. The need for information about mechanisms to access hospital and insurance record data without statutory authority for the State Health Agency to do so remains a concern and continued TA request in the ?Other? category.

General Systems Capacity technical assistance may be requested during the course of the coming year. An SSDI grant is being requested to assist in linking several data systems containing information about CSHCN via an existing web referral mechanism. If that grant is received, TA may be requested to assist in the design of the interface requirements to maximize data sharing where appropriate.

Needs Assessment assistance is requested to help obtain the services of a qualified individual to produce the next 5-year cycle needs assessment for Montana in collaboration with the State Health Agency, local health service providers, other state agencies, consumers and advocates. //2004//

## V. BUDGET NARRATIVE

### A. EXPENDITURES

#### Expenditures

##### Form 3 Expenditures by Fund Category

Montana's primary variation over the last decade has been the increased match provided by local. Montana does not have enough state general funds available for MCH services to secure the MCHBG, and continues to count on the match reported by local contract partners that allows us adequate match for the block grant. Local match has continued to increase, partly due to improved reporting expectations and compliance, and due to the response of locals to the request for accurate reporting which will allow better understanding of true costs of MCH services.

*//2004/ State funds decreased due to the loss of the perinatal, WIC and FP general funds. Local match continues to be up -- local control of match is limited, as is the state match -- the funds are used for MCH services, but for specific areas, providing little opportunity for rapid response to priorities identified.//2004//*

***//2005/ State funds continue to decrease. Public Health Home Visiting/MIAMI was maintained at \$550,000 for the biennium - the funding will need to be requested again during the next legislative session. The funding for the voluntary genetics program was decreased to \$538,000 from \$614,000. Perinatal level program support continues at the approximately \$40,000 level. County general fund match is budgeted lower this year, due to the challenges in maintaining county level efforts. //2005//***

##### Form 4 Expenditures by Target Population

Montana continues to experience variations in expenditures from budgeted amounts for types of individuals served. Variations in local expenditures continue to account for the greatest differences. During FFY 2001, estimated expenditures were close to budgeted amounts, with the exception of approximately \$350,000 more than anticipated expended for Children's services. Other variations are an increase in the "All others" which may be attributed to the group encounter services typically focused on school settings. Counties are also reporting almost \$150,000 of County GF in administrative costs for MCH services. Counties have improved reporting of funds by type of individual served, due in part to increased effort by state staff to assure accuracy of county reports.

Services to children continue to be the major cost in both federal and match dollars. Screening programs, including school health services would be included in those costs. Many county health departments continue to assume school health services as part of their responsibilities, often without funding from the school district or reimbursement from insurance coverage's. Medicaid is investigating school based reimbursement mechanisms, which would provide for increased billing capabilities for schools.

*//2004/ Variability is decreasing slightly, although the high reporting of "other" category is still problematic. Reporting in the "other" category, includes women of childbearing age and families, but is too non-specific to allow for good tracking and analysis. //2004//*

***//2005/ Services to children continue to be the major reported cost of both federal and match dollars by counties. Over \$2 million of the expended non-federal county match was for services for children, including school health services. //2005//***

##### Form 5 Expenditures by Level of the Pyramid

Large variations in expenditures by level of the pyramid continue. Slow but steady increases in Infrastructure and Population based services are evident, as is a decrease in the direct costs. FCHB

staff has emphasized the importance of population based and infrastructure efforts, and have provided in-service and education at meetings regarding both the role of PH in those areas and the mechanism to address population based needs. The Public Health Training Institute in Montana is also educating local staff regarding the population-based role of public health, and the shift is expected to continue.

Shifts in reported expenditures continue to improve, but much work still needs to be done. County GF continues to account for a huge portion of the direct services. One large county accounted for over \$1.5 million of the \$1.83 county general funds reported as expended for direct services.

/2004/ Shifts slowed, with direct health care services continuing to account for a large percent of the state federal partnership. While definition issues continue to confound, a large percent of funding continues to support direct health care. Continued effort to have counties accurately report expenditures is important -- despite extensive education regarding the pyramid, counties continue to consider services directed toward an individual, including home visiting, immunization clinics, health education fairs, classes, as direct because they touch an "individual". //2004//

***/2005/ Direct health service reporting continues to be high, due in great part to the reporting by one county of \$1.8 million for support of mental and physical health of children at the state school as direct care services. (Same as issue reported in 2003). //2005//***

## B. BUDGET

The proposed budget for FFY 2004 as outlined on Form 2 includes the following:

Primary and Preventive Services for Children \$972,269

This budget item includes the budget for the state level Child, Adolescent and Community Health Section and county level MCH anticipated to be spent for infants, children and others, including families.

Children with special health care needs \$858,000

Budget includes the SHS budget of \$783,000 plus \$75,000 of the MCHBG budgeted to be expended by counties for children with special health care needs.

Title V Administrative Costs \$200,000

Budget includes an estimated state cost allocation of \$125,000, plus \$75,000 of local MCHBG expenditures reported as administrative costs.

Unobligated balance \$0

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

Total State Funds \$1,166,561

Budget includes public health home visiting general funds (\$550,000), Funds to support FP (\$25,947) and funds to support the voluntary genetics program (\$590,614). General funds for support of perinatal data and services and the WIC Farmer's Market general funds (\$40,000) were lost in the 2003 legislative session.

1989 Maintenance of Effort Amount \$485,480

Local MCH Funds \$3,000,000

The 2003 budgeted amount was set low in anticipation of locals needing to shift funds ? the 2002 reports did not demonstrate this trend, and the budgeted amount was increased for 2004. Counties continue to overmatch their MCHBG ? the low budgeted amount was due to the increasing demands being reported by local health departments due to WIC cutbacks and devolutionary moves in government responsibility. It is anticipated that counties will continue to support services, but the

dollars may not be included in match reports due to other programmatic challenges.

Program Income \$0

Program income continues to be problematic to get accurately reported. The PHDS system has billing components being developed ? it is anticipated that that resource may assist in improving program income. State staff does not generate income through Medicaid or other billing.

Federal-State Block Grant Partnership \$6,775,694

Other Federal Funds \$17,888,106

Changes described in Agency Capacity

## **VI. REPORTING FORMS-GENERAL INFORMATION**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. GLOSSARY**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. TECHNICAL NOTE**

Please refer to Section IX of the Guidance.

## **X. APPENDICES AND STATE SUPPORTING DOCUMENTS**

### **A. NEEDS ASSESSMENT**

Please refer to Section II attachments, if provided.

### **B. ALL REPORTING FORMS**

Please refer to Forms 2-21 completed as part of the online application.

### **C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS**

Please refer to Section III, C "Organizational Structure".

### **D. ANNUAL REPORT DATA**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.