Maternal and Child Health Services
Title V Block Grant

State Narrative for Montana

Application for 2009
Annual Report for 2007

Document Generation Date: Friday, September 19, 2008

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in 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 State of Montana maintains on file in its Fiscal Division all the assurance required by this application for Maternal an Child Health Block Grant. On file in agency rules are prohibitions of necessary items. The agency assures the MCHBG that the funds will be used for non-contruction programs, that debarment and suspension remain in place as in previous years, that the agency is a drug free work place and tobacco free. The agency has on file all necessary paperwork for lobbying state legislature and the prevention of fraudulent use of fund.

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; expires May 31, 2009.

E. Public Input

Public input is solicited through local public health departments in the form of pre-contract surveys. Counties are also required to include consumer surveys in their contract responsibilities, to further inform them regarding the impact of MCH programs. Administrative Rules of Montana requires counties to conduct periodic needs assessments, which are reported via the pre-contract surveys.

Public input is also obtained from the Family and Community Health Bureau (FCHB) Advisory Council members, who represent various MCH partners and constituents. Updates on the needs assessment process were provided to the FCHB AC at each meeting during the last year, and the needs assessment and the priorities were sent to the AC for review and comment prior to finalizing. Advisory Council members will be invited invited to participate in the video link to the block grant review. A report on review findings is scheduled for August, and a copy of the final reviews are sent to the AC following receipt.

Copies of the block grant are made available to Advisory Council members, and availability of the text and data and updates on the block grant are provided through the FCHB Facts newsletter. The newsletter is distributed electronically every other month, and has a distribution of approximately 180 (in department) and 100 (out of department). A copy of a recent FCHB Facts newsletter is attached.

/2007/ The public input process is unchanged from 2006. A proposal has been made that the FCHB Advisory Council members be governor-appointed (attached). A link to the MCHBG application and narrative will be added to the FCHB website. //2007//

/2008/ The public input process remained similar to 2007. The FCHB Advisory Council continued to meet quarterly in 2007 and provided input on the August 2007 MCH BG Review and on the 2008 MCHBG application. The Governor's Office has replaced the FCHB Advisory Council with the Family Health Committee and it is anticipated that the Governor's appointments will be made in the Fall of 2007. The Governor announced the Family Health Committee Members on August 15, 2007. (attached) The local county health department's lead public health officials' provided input electronically on the state's creation of a new state performance measure. The MCHBG application and narrative are available at http://www.dphhs.mt.gov/PHSD/family-health/FCHB-index.shtml. //2008//

//2009/ The Family Health Advisory Council met every other month throughout fiscal year 2008 at which time the 2009 MCHBG application, as well as FCHB section updates and project reports, were on the agenda. Beginning with FY 09, the FHAC meeting minutes, as well as the will be MCHBG application and narrative are available at http://www.dphhs.mt.gov/PHSD/family-health/FCHB-index.shtml.

The local city-county health departments provided input into the overall MCH BG process at the 2007 Fall Montana Public Health Association Conference and the 2008 Spring Public Health Conference.

Several FCHB Section Supervisors provided information about the MCH BG in their presentations or communications with established and new MCH partners, such as the Community School Readiness Teams, the Head Start Collaboration, and Montana's 12 Child Care Resource and Referral Agencies.

//2009//

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The 2005 Needs Assessment was submitted with the 2007 MCH BG application. Technical assistance specific to the state's revision of the 2005 Needs Assessment process has been requested with the 2008 application. The Needs Assessment is an ongoing process and the results continue to be included in the Family and Community Health Bureau's Strategic Plan. The Bureau's Strategic Plan, which was based on the 5-year MCH Needs Assessment, was used by the Family and Community Health Bureau sections to develop section workplans. The workplans reflect the goals and objectives in the Bureau-wide plan, and also include activities or action steps for achieving the goals. Each section reviews and updates their work plan periodically. Additionally, the entire Bureau meets quarterly at which time the Strategic Plan is included on the agenda as a discussion item and potentjal updates or revisions are discussed.

/2009/

Montana is currently completing a review of the MCH BG Needs Assessment process to improve results for the 2010 submission. Following a thorough review of the 2005 Needs Assessment, a MCH Bureau Graduate Student Internship Program has been conducting a statewide preliminary planning survey to solicit feedback regarding previous methodologies, data gaps and representation. The survey goals are to gather insight from a broad spectrum of MCH stakeholders that will improve the reliability and efficiency of the upcoming MCHBG needs assessment. Among the most important components is determining if an internet based needs assessment could effectively capture the state of MCH in Montana, given the largely rural and frontier population. The preliminary planning survey will be completed in early August 2008, and a plan of action will be identified for completion of the 2010 MCHBG needs assessment. Montana staff will participate in Needs Assessment training opportunities, including the Rocky Mountain Public Health Education Consortium Training in Albuquerque in September and the planned sessions at the MCH Epidemiology Conference in Atlanta in December.

The Bureau continues to use the 2005 Needs Assessment document as the foundation for their ongoing revisions to the Blueprint for Maternal and Child Health in MT, which serves as the Bureau's strategic plan guiding each section and unit's respective work plans. The Maternal and Child Health Coordination (MCHC) Section Supervisor has taken on the role of ensuring that each of the eight priority areas includes feasible objectives based on the capacity of the responsible section, as well as ensuring that the Blueprint includes the outcomes for the previous year's objectives. Based on discussions with the individual sections, a significant number of objectives are continuing into the next fiscal year.

//2009//

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 145,552 square miles, 56 counties, and seven Native American reservations. Western Montana is mountainous, heavily forested, dotted with waterways, and state parks and state forests. The eastern two-thirds of the state is semi-arid to arid and access to water is often a concern. Annual precipitation averages less than 15 inches. Forest and range fires routinely affect local air quality and can exacerbate asthma and other respiratory conditions.

Vast distances, isolation of small communities, sparsely located ranches and farms, as well as severe winter weather can make travel extremely difficult and often dangerous, especially over icy mountain passes or through ground blizzards on the plains. Public transportation is limited, with many areas in the state totally devoid of air, rail, or bus transportation. The Insurance Institute for Highway Safety published a study of traffic safety laws in all 50 states in June 2005. The laws they rated were seat belt use, young driver licensing, DUI, child restraint use, motorcycle helmet use, and red light camera laws. Montana had the poorest ratings for motorcycle helmet use and red light camera laws, with only marginal ratings for young driver licensing, safety belt use, and child restraint use. Montana was the third highest state for motor vehicle deaths per 100,000 people in 2003, accounting for 262 deaths. For 2004, Montana ranked 50th in the nation for motor vehicle fatalities with 2.5 deaths per 100,000,000 miles driven.

POPULATION CHARACTERISTICS: U.S. Census reports the 2000 population was 902,195, 44th in terms of population, with a population density of 6.2 people per square mile. The 2004 population estimates for Montana suggest an overall increase of 2.7% from 2000, with the in-state population redistributing to the western portion of the state and into urban areas. Montana has three metropolitan areas and five areas with a population over 10,000 people. Sixty-four percent of Montanans reside in these eight areas, with the remainder of the population dispersed into smaller communities, farms, and ranches. In 2000, Montana had 0.3% of the total population of the United States, with little change projected by the census for 2004. It is projected that Montana will have an 11% increase in population from 2001 through 2015, 28th in population growth for the time interval. Projected population for 2030 is 1,044,898, ranking 27th in the nation for population growth.

The median age in Montana for 2000 was 37.5 years, higher than the national average of 35.3 years. Projections for 2030 suggest Montana's median age will increase to 46.0 years, representing a 22.7% increase in median age for the state. Montanans over 62 years of age are predicted to increase 115.6% by the year 2030, with a 0.4% decrease in children less than 18 years of age. Montana's population is split evenly between males and females. In 2000, the median age for men was 36.6 and for women was 38.5. Women of reproductive age (15-44 years) comprised 20.5% of the state population, and children and youth under 20 represented 28.5% of the population.

In 2002-2003, Montana pupils scored at or above proficiency for math, science, and reading assessments. Montana ranked 28th in math proficiency and 9th in reading proficiency, according to CFED for 2004. Montanans also tested slightly higher than the national average on the ACT, with 81% of graduating seniors taking the test. For 2003-2004, Montana had a high school diploma rate of 82.9% and a high school completion rate of 84.8%. Historically, Montana's pupil teacher ratio has been significantly smaller at 14.5 pupils per teacher than the U.S. average

of 15.9. IEP percentages (learning disabilities) were slightly higher than the national average during the time interval. For 2003-2004, Montana ranked 47th in teacher salaries ($37,184), and state budget allocations for education were significantly lower than the national average (12% difference). People in Montana 25 years old and over with a bachelor's degree or more in 2003 accounted for 24.9% of the population, ranking 27th in the nation. Estimates for 2004 suggest a 2.4% increase from 2003. Montana's university system comprises of two universities, four colleges, and five colleges of technology. In addition, there are six private colleges, seven tribal colleges, and three community colleges. Montana ranked 22nd in the nation for computer and internet presence in the home.

In 2002, Montana ranked 34th in total crime per 10,000, 29th in violent crimes, and 24th in the juvenile crime index. In 2002, Montana ranked 31st in percent of births to unwed mothers. There were approximately 13.6 TANF recipients per 1,000 population in April 2005, 87.7 food stamp recipients per 1,000 population, with the average amount of food stamps per household equal to $215.44. Both the number of cases and the average amount per case has increased steadily since 2000, according to DPHHS.

Montana is predominately white with approximately 91% of the 2000 population reporting Caucasian as the primary race, compared to 75% in the nation. Eleven American Indian tribes make up the largest minority population in Montana, representing approximately 6.2% of the total population (56,068), the 5th highest state in the nation. Estimates for 2003 suggest a 4.8% increase from 2000, with American Indian births accounting for approximately 12.2% of the births in the state. The number of people of Hispanic origin has been growing faster than other minority groups with the exception of Native Americans, demonstrating a 5% increase from 2000 to 2003 (estimate). Minority groups that may not be captured by census data, but that may have unique health issues, include migrant and seasonal farm workers and religious groups such as the Hutterites. There are also 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.

2000 Census Population Demographics

White	90.6%	Asian	0.5%
American Indian	6.2%	Black	0.1%
Hispanic	2.0%	Other	0.7%

ECONOMIC CHARACTERISTICS: Montana's economic history is one of extraction of natural resources. Currently, the majority of the land is used for agriculture and the production of oil, gas, lumber, and coal. Limited mining for copper, silver, palladium/platinum, and gold continues. However, these extraction processes have left a legacy of environmental pollution. In 2004-2005, Montana had 15 Federal Super Fund sites and 208 CERCA priority facilities. The vermiculite mines in Libby, Montana were 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. According to the EPA in 2005, small sources of vermiculite are still found in a variety of places in and around people's homes and businesses. However, air monitoring indicates it is safe to walk the streets of Libby. DPHHS Environmental Public Health Tracking was established in 2004 with support from a 3-year grant from the CDC. EPHT's vision is to better protect communities from adverse health effects through the integration of public health and environmental information, such as the Libby, Montana exposure. EPHT will improve surveillance of chronic diseases, birth defects, and developmental delays, and link health data with existing data on environmental hazards and exposures, to better inform the public regarding health concerns.

Montana also ranked 50th for employment wages, with the average annual pay equal to $26,001 for 2002 and 2003 estimates increasing only 3.3%. In 2001, at least 9.3% of employed individuals in Montana held more than one job. In December, 2004, the top five employment industries in the state were government, trade, transportation and utilities, education and health

services, leisure and hospitality, and professional and business services. Tourism is becoming a major industry -- non-state residents spent $2.7 billion in the state in 2002. Approximately 9.8 million visitors generated 43,300 Montana jobs. However, tourism jobs are typically in the service sector, which pays relatively low wages for the majority of jobs.

Federal aid to state and local governments per capita for 2003 ranked Montana 12th in the nation. Federal funds accounted for 62 cents of every dollar of state revenues spent. Resources supporting state level efforts for MCH and CSHCN are overwhelmingly federal -- less than 5% of funding for the FCH Bureau or the CSHS section is from the state general fund. Montana depends on its local partners to make up the required match for the MCHBG. Data for 2002 suggests Montana had $6,973,894 in federal funds and grants.

POVERTY: Montana is ranked 11th in the country for percent of the population below poverty level for 2000-2002. According to 2002 Census estimates, 25.5% of children under five and 16.7% of children ages five to 17 live in poverty. Overall, 14.0% of Montana's population lives in poverty, while the national average for 2000-2002 was 11.7%. Preliminary 2003-2004 data suggests Montana has 20.2% of it's children living in poverty, ranking the state 42nd in the nation. Five out of seven reservations are found in eastern Montana, an area with limited natural resources, high unemployment, and disproportionate poverty.Since 2001, Montana's unemployement rate has been lower than the U.S. According to the U.S. Department of Labor, Montana's unemployment rate in 2004 was 4.4%, compared to the U.S. rate of 5.5%. However, unemployment for the tribes ranged from 40.58% to 77.21%, with an average unemployment rate of 59.63% for 2001 Montana Progressive Labor Caucus data. Reservation data collected by Montana DLI suggests lower unemployment rates may exist. Year after year, data on poverty in Montana continues to demonstrate disparities between the population as a whole compared with the seven Indian Reservations.

Annual Average Unemployment Rates on Montana's Reservations

Reservations	2001	% Employed but below poverty	Tribes 2001
Blackfeet	70.0%	26.0%	69.93%
Crow	66.0%	16.0%	60.65%
Flathead	76.0%	22.0%	40.58%
Fort Belknap	71.0%	20.0%	70.49%
Fort Peck	63.0%	23.0%	62.54%
Northern Cheyenne	27.0%	7.0%	64.69%
Rocky Boy's	36.0%	37.0%	77.21%
Reservations Total	59.86%	NA	59.63%

In 2004, Montana ranked 20th in bankruptcy filings by individuals and businesses. Homeownership rates for 2004 data suggest 71.5% of Montanans own their home, ranking 23rd in the nation.

POLITICAL JURISDICTIONS: The state has 46 frontier counties, 8 rural counties, and only 2 urban counties. Fifty-four county health departments contract with the DPHHS to provide MCH and other health services, but the local health departments are county entities under the control of local Boards of Health, and the staff are county employees. The seven Indian reservations have nation status for 11 American Indian tribes occupying 8.4 million acres. This status, coupled with the federal role in public health on the reservations, pose jurisdictional challenges affecting coordination of county and tribal health services for common clients between the two service delivery systems. 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. According to the Tax Foundation, the federal tax burden on Montana is 17.5% for 2005, ranking Montana 35th in the

nation. The state and local tax burden is 9.5% for 2005, ranking the state 39th in the nation. New tax relief measures implemented in 2005, including a 10% tax bracket, child tax credits, reduction of income tax rates, and reduction of the marriage penalty, will provide benefits to thousands of taxpayers and businesses. Child tax credits, reduction of income tax rates, reduction of the marriage penalty, and other changes to the tax laws will benefit many Montanans.

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. 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 ranked 15th in the nation for the percent of health dollars for public health, 19th in per capita public health spending, and 36th in adequacy of prenatal care. Montana has 21 local hospitals, 40 Critical Access Hospitals (CAHs), and 20 Community Health Centers. All hospitals provide access to care for low-income, indigent, Medicaid, and Medicare patients. 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. All but the hospitals in Billings and Great Falls are classified as rural facilities by HCFA. Sixty percent of primary care physicians are located in Silver Bow, Yellowstone, Missoula, Gallatin, Cascade, Lewis and Clark, and Flathead counties, the seven most populated counties in Montana. 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 40 Rural Health Clinics in Montana and several additional sites are currently considering conversion/establishment of a RHC. 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.

According to 2004 CFES data, Montana ranked 50th in the nation for employer-provided insurance. Low-income children and low-income parents consisted of 19.8% and 82.3% of the population for 2004, respectively. CFES gave Montana an "F" in health care for these reasons. 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 and 57% of rural residents are uninsured; 31% to 45% of American Indian residents are uninsured, while 18%-22% of Whites and all others lack health insurance. Most of the businesses in Montana are small businesses and cannot afford health insurance premiums for their employees. Agricultural families are often disqualified from public programs because of high assets, even with low income, and cannot pool for reduced premiums.

Oral health care had become a major public health issue. The Montana Foundation of Dentistry for the Handicapped provides free comprehensive dental care to people who are permanently disabled, medically compromised or elderly, and who cannot afford dental care. Six Montana Community Health Centers (Billings, Butte, Great Falls, Helena, Missoula and Libby) include some dental services, though the waiting lists can be long. Dental clinics are offered in thirteen locations through the Indian Health Service. Montana's point-in-time PRAMS in 2002 reiterated lack of access to dental care for pregnant Medicaid participants was a statewide problem. Data for 2004 suggests Medicaid-payable dentists are also a resource problem, with 14 counties lacking at least one Medicaid-payable dentist and 14 counties with only one Medicaid-payable dentist, representing 50% of all Montana counties. Oral health results from a statewide convenience sample of third graders for 2002-2004 suggested immediate caries were a problem for 25.1% of the sample, with a past caries rate of 50.7%, and an urgent caries rate of 6.2%.

High mortality rates are a large problem for Montana. Montana ranks 46th in the nation for occupational fatalities, with 12.3 deaths per 100,000 workers for 2004. Cardiovascular deaths for 2004 equaled 296.2 per 100,000 people, ranking 11th in the nation. Cancer deaths in Montana

ranked 23rd in the nation, infant mortality 27th in the nation, premature death 22nd in the nation, and total mortality 32nd in the nation. Leading causes of death in Montana are heart disease, cancer, cardiovascular disease, diabetes, pneumonia, chronic obstructive pulmonary disease, and accidental deaths due to unintentional injuries. For Montana Indians, accidents, diabetes, and chronic liver disease and cirrhosis follow heart disease and cancer for the leading causes of death. Whites typically die at an older age than Indians. (Montana Bureau of Records and Statistics, 2003) Montana is 2nd in the nation for death rate by suicide, at 19.3 per 100,000 population in 2001.

Drug abuse in Montana is a growing concern, especially methamphetamine use. The U.S. Drug Enforcement Administration reported 2003 federal drug seizures in Montana included 0.5 kg cocaine, 107.2 marijuana, and 8.8 kg of methamphetamine. In 2002, Montana law enforcement agencies responded to 122 meth labs statewide. BRFSS for 2003 reported 9.3% of students grades nine to 12 reported using meth at least once in their lives. 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.

Domestic violence continues to grow in scope. Statistics for 2001 suggest 7.0% of aggravated assaults were by a spouse or ex-spouse and 6.5% were from boyfriends or girlfriends. PRAMS data for 2002 suggests 8.8% of all Montana women aged 15-45 are abused before pregnancy and 5.0% during pregnancy. However, the Montana Board of Crime Control suggests reported domestic violence to be only 0.45% of the population-at-risk for abuse, suggesting underreporting is a serious issue in Montana.

CDC's State Health Profile for Montana notes childhood health concerns include birth defects, vaccination coverage, infant mortality, prenatal care, and teen pregnancy. Montana has developed a birth defects registry that now contains data for 2000 through 2004. A heightened rate of Downs Syndrome appears in the data, along with other defects of concern including gastroschisis, diaphragmatic hernia, and cardiovascular defects. The Fetal Infant Child Mortality Review (FICMR) program, authorized by the Montana State Legislature in 1997, has published two reports since its inception. There were 1,256 fetal, infant, and child deaths in Montana from 1997-2002, accounting for 1.0% of the cumulative birth cohort (N=130,694). Cumulative review percentages suggest 59.2% of all fetal, infant, and child deaths were reviewed by the 27 local FICMR teams covering 48% of the counties. Nevertheless, the program determined that 39.7% of the cumulative reviewed deaths that contained prevention findings were preventable.

Montana continues to face a health care worker shortage. During the reporting years 2001 to 2002, a task force was created and appointed by the Governor "to accurately assess the shortage of health care workers, and to develop recommendations and strategies to effectively address the issue." As of 2002, there were 2.0 physicians per 1,000 population, as compared to the U.S. average of 2.3 physicians per 1,000 population, according to the Northwest Area Foundation. This statistic ranks Montana approximately 34th in the nation. For the year 2012, DLI predicts only 2,077 physicians and surgeons for Montana, a rate of 2.1 physicians per 100,000 population, based on a 984,043 population projection. Dieticians and nutritionists are projected to reach 216, a rate of 2.2 per 100,000 population. Registered nurses are projected to reach 10,707, a rate of 10.9 per 10,000 population. However, even with all the known shortages, Montana's response has only been to establish a task force commission or panel, which is 1 out of 7 measurable responses.

In 2002, Montana ranked 44th and 47th in the nation for series of immunizations given to 19-35 month old children. In 2003, Montana ranked 24th in infant mortality at 6.8/1000 live births. Three-year cumulative average for people without health insurance coverage was 16.1% for 2001-2003. In 2002, Montana estimates indicated 54% of the adult population to be overweight or obese. The same dataset estimated the adult smoking prevalence rate to be 19.9% of the population. Smoking-attributable direct medical expenditures (state share) are estimated at $216

million. There are approximately 1,439 annual smoking-attributable deaths in Montana, according to the Center for Tobacco Cessation. Montana is 1st in the nation for adolescent male use of smokeless tobacco. 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 2003, Montana had 47,088 enrollees in HMOs in 2003, down from 2002.

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

/2007/

POPULATION CHARACTERISTICS: The 2005 population estimate for Montana is 935,670, constituting a 3.7 increase from April 2000 to July 2005 http://www.census.gov/hhes/www/poverty/poverty04/stategrid.xls .

POVERTY: Census figures for 2002-2004 indicate the percent of Montana's population living in poverty is up to 14.3% http: www.census.gov/hhes/www/poverty/poverty04/stategrid.xls

ACCESS TO HEALTH CARE: Montana has eleven Community Health Centers, with seven satellite sites, one Migrant Health Center with nine satellite sites, and one Healthcare for the Homeless Program with three satellite sites. Four additional communities have submitted Community Health Center applications. Oral health services are available at eight of the centers and through two mobile clinics. http://www.mtpca.org/mtcenters.htm //2007//

/2008/ POPULATION CHARACTERISTICS: The 2006 population estimate for Montana is 944,632 constituting a 4.7 increase from April 2000 to July 2006. Population growth continues to be primarily in and around communities that are already the most urban in the state. Two exceptions are Flathead and Ravalli Counties, where population growth may be producing two new "urban" areas.. The majority of population growth since 2000 has been in counties in western and south-central Montana. The Montana Census and Economic Information Center at the Department of Commerce projects that the state population will continue to grow at similar rates for the next few years.
(http://ceic.mt.gov/Publications/Newsletter_Fall_Winter_06_07_Final.pdf)

The increases cannot be attributed to increased birth rates, which dropped to an all time low (for the last 100 years) to 12.1 from 2000 to 2002, increasing slightly back up to 12.4 for 2003 -- 2005. http://www.dphhs.mt.gov/statisticalinformation/vitalstats/2005report/2005selectedeventsrates.pdf

54 of Montana's 56 local city/county health departments providing maternal and child health services to their residents are contractually required to establish a memorandum of understanding regarding coordination of services with Indian reservations, or a written description of interagency coordination efforts and a list of key personnel, if an Indian reservation is adjacent to the county. The local city/county health departments are contractually required to establish a memorandum of understanding regarding coordination of services with Indian Health or Tribal Health Services, or a written description of interagency coordination efforts and a list of key personnel, if an Indian reservation is adjacent to the county. Several MCH programs, i.e. Public Health Home Visiting, Cleft Palate Outreach Clinics, are operating on several reservations with a goal for 2008 to increase the number of partnering reservations.

POVERTY: Census figures for 2003-2005 indicate the percent of Montana's population living in poverty is up to 14.4% http://www.census.gov/hhes/www/poverty/poverty05/table8.html

ACCESS TO HEALTH CARE: Montana has thirteen Community Health Centers, with seven satellite sites, as well as a Migrant Health Center that provides services statewide and one Healthcare for the Homeless Program. Additional sites continue to be under development for CHC status. Efforts to help develop the oral health services available at most of the sites are underway in the state, supported by Temporary Assistance for Needy Families funding awarded to the state. Further expansion of oral health services has also been proposed in the Targeted State MCH Oral Health Service Systems Grant Program submitted July 2007. //2008//

/2009/ POPULATION CHARACTERISTICS: The 2007 population estimate for Montana is 957,861, up from 902,195, constituting a 6.2 percent increase from April 2000 to July 2007. There were 12,499 live births to residents in Montana in 2006 -- up significantly from the last decade, where the number of births ranged from 10,779 to approximately 11,500. The birth rate of 13.2 is the highest since 1993; however, it is too early to determine if this single year increase will be continued in future years. As with many small population states, Montana's health indicators may change dramatically from year to year, leading the public and sometimes policy makers to assume associations between programs and activities and outcomes. In fact, what may appear to be dramatic changes, such as a child death rate dropping to 25 per 100,000 children aged 1-14 in 2005, down from a rate of 33 in 2000, may be due to very small changes in actual numbers.

ACCESS TO HEALTH CARE: The Montana 2007 legislature authorized funding to support a community health center based upon the federal model. Flathead Community Health Center, in Kalispell, MT is the first CHC to be funded with state dollars. //2009//

B. Agency Capacity

The Title V programs are located within the Health Resources and Public Health and Safety Divisions of the Department of Public Health and Human Services. The structure of DPHHS is described in the organizational structure section of this application. Title V efforts are primarily focused in the Family and Community Health Bureau of the Public Health and Safety Division (PHSD) and in the Children's Special Health Services (CSHS) program, which is located in the Health Care Resources Bureau of the Health Resource Division.

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 Family and Community Health Bureau has a staff of approximately 30, and a budget of approximately $21 million, from 13 funding sources including grants from CDC, HRSA, SAMHSA, USDA, the Office of Population Affairs, and Montana general fund. The largest program and budget is the WIC Program, with a budget of approximately $14 million. The MCHBG is the second largest funding source, at about $2.5 million annually. Approximately 95% of the FCHB budget is federal dollars.

Local providers are crucial partners in the provision of MCH services in Montana. Approximately 42% of the MCHBG is contracted out to local health departments to provide MCH services to the population. Of the $1.1 million of state level match, 1/2 of that is also contracted to local health departments for public health home visiting services to pregnant women and infants. The remaining $500,000+ is contracted to for genetics services for the MCH population.

FCHB is also responsible for coordinating the MCH needs assessment and subsequent further

prioritization of MCH needs and strategic planning that will take place in 2005 and 2006.

The Children's Special Health Services (CSHS) program in the Health Care Resources Bureau administers 30% of the MCHBG. HCRB provides services to children in three ways: direct services to children, indirect services to children, and administrative services.

Direct services to children include cleft cranio-facial clinics, 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.

Co-location of the CSHCN program with the CHIP program has facilitated coordination of applications for services for children between those two programs, Medicaid, and other programs, which may benefit children and their families. The HCRB Bureau manages the Family Health Line, which is the Title V toll free line, directing callers to programs within DPHHS and around the state. The Children's Mental Health Bureau is also located in the HR Division. That bureau is directing development of the Kid's Mental Health Services Areas or KMA's in the state, which may address and improve the mental health service needs of the MCH population.Services are provided to Montana children with special health care needs and their families by the CSHS program staff and their contractors.

Services include specialty clinic services, direct payment of medical services for eligible children who have no source of payment for needed care, identification and referral of children with special health care needs, and consultation and technical assistance. 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. Montana does not have a medical school or a school of public health, and relies on partnerships with private providers to develop and deliver services to the vulnerable populations. The CSHS has developed partnerships with two hospitals in Missoula and Billings for regional specialty clinic services, and is working towards development of a third regional clinic site in Great Falls. The Montana Legislature included a line item to support additional regional clinic development in the 2005 session. Program staff is developing the ability of clinics to bill for services, which will diversify funding available to support these sites, which have been primarily supported by hospital in-kind and MCHBG contract funds to date.

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.

The Family and Community Health Bureau's mission is the "promote the health and well being of

Montana's citizens to help healthy families build health communities." The bureau is organized into four sections: the MCH Data Monitoring (MCHDM) section, the Child, Adolescent and Community Health (CACH) Section, the Nutrition/WIC Section and the Women's and Men's Health Section. MCHBG funding and program efforts are primarily located in the MCHDM and CACH sections.

The MCHDM section manages the 54 local MCH services contracts, oversees the MCH block grant development and performance measure monitoring, and is responsible for the population based newborn metabolic and hearing screening programs. That section has also housed the Point in Time Pregnancy Risk Assessment Monitoring project from 2001 -- 2004; the state intends to apply for CDC funding to reinitiate the program in 2005. The MCHDM section also manages the state's genetics program and contract, which is funded with a tax on individual insurance policies. Legislative changes in 2005 resulted in an increase of that funding source, which will in turn result in a reassessment of contractor role and services.

The MCHDM section houses Montana's birth defects registry, the Montana Birth Outcome Monitoring System (MBOMS), which 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. A renewal application submitted in early 2005 was reviewed, approved, but not funded, leaving the future of the registry in question. At present, the registry, including the active case ascertainment will be continued with carry over dollars, supplemented as possible with MCHBG. The long-range feasibility of continuing this support continues to be in question, especially in view of the MCHBG decreases over the last several years. Birth defect monitoring efforts continue with grant carryover and MCHBG funding at this time -- partnerships with the state's Environmental Public Health Tracking program are being explored. The registry has helped identify and inform investigations of what appeared to be high instances of Down Syndrome and gastroschisis in Montana over the last several years. The gastroschisis investigation continues with the help of student efforts from the Rollins School of Public Health at Emory University.

Montana's "heelstick" newborn screening follow up has been housed in the FCHB since 1995 and is a part of the MCHDM section. Follow up efforts continue to be a partnership between medical providers and hospitals, the public health laboratory, parents, the FCHB and the CSHCN program. Montana presently screens for four department-required blood tests for PKU, galactosemia, congenital hypothyroidism, and hemoglobinopathies. Interest in adding additional tests has been expressed by the medical community, but in light of fiscal constraints and resistance to increases in existing lab charges, no additional lab screenings have been mandated in the last few years. Montana is monitoring national efforts to recommend additional screening tests in the future. At present, our state lab, which conducts newborn screening for the state, lacks mass spectrometry equipment, which will be necessary for inclusion of some of the additional tests. The lab presently works with out of state labs to facilitate provider requests for additional testing.

Newborn hearing screening is also coordinated by the MCHDM section, in conjunction with the metabolic screening program and the birth defect registry. Montana has increased capacity for newborn hearing screening in the state, moving from approximately 30% of newborns tests 4 years ago to more than 80% at present. The state and the advisory group for this program now face the difficult task of how to facilitate screening in the very small communities where limited resources for testing and follow up exist, and to assure effective follow up, especially in small communities. The group will be examining various approaches to this challenge in FFY 2006.

The MCHDM has been the lead player in development of standardized reporting capacity for local public health, concentrating on MCHBG and PHHV reporting requirements. 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. The PHDS has been rolled out to 83% of the local public health departments, and plans to convert the web based structure with increased ease of data entry is presently in process.

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. The 2005 Legislature considered and passed a bill increasing the tax on individual insurances, which provides the funding to support the program. This increase sunsets in 2007, requiring the department to investigate alternative mechanism to fund the programs, with a goal of increasing the base upon which the funding depends.

The Child, Adolescent and Community Health Section houses many of the staff and programs most directly impacting the MCH population. Staff in the section manage and monitor the public health home visiting program for pregnant women and infants, the fetal infant child mortality review, the SIDS prevention, fetal alcohol prevention and youth suicide prevention programs, the early childhood comprehensive systems project, the oral health program, and provides consultation on general child, school and adolescent health issues.

The public health home visiting (PHHV) program has a long history in the state. 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. The program has continued to evolve, with efforts in 2004 targeting focusing the program on pregnant women and infants, and emphasizing home visiting as the preferred mechanism of providing services. At present, there are 19 contractors for PHHV services, including three tribal programs.

Montana's oral health program is also located in the CACH Section. The oral health program focuses on population based and infrastructure services to develop community awareness of the importance of oral health and to build capacity at the state and community levels. The program has benefited from the State Oral Health Collaborative Systems grant program, which has facilitated focus on system development. The oral health program coordinator has worked 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 oral health program also coordinates school-based efforts to enable schools to conduct dental screening and fluoride rinse programs, and 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).

The CACH section also supports efforts to prevent Fetal Alcohol Syndrome and Effect through prenatal prevention efforts. This effort was first supported 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 PHHV/ MIAMI project, adding intensive home visiting and case management for pregnant women at risk of having a child with FAS/FAE. The project also enabled collaborative efforts to support FAS evaluation clinics in the state. Funding for the four-state consortium was no longer earmarked in 2004, and the staff applied for and received a Fetal Alcohol Syndrome Centers for Excellence award from SAMHSA in 2004.

The Fetal Infant and Child Mortality Review (FICMR) program directs and guides local efforts to review deaths of fetuses, infants and children 18 years of age or younger. The purpose of the review is to enable communities to identify risks or challenges in their communities and to implement appropriate prevention measures. State level functions are to compile and examine data looking for patterns and clues indicating statewide and/or legislative policy changes required. Examples of the uses of FICMR data include testimony to the 2005 Montana legislature regarding the importance and need for a graduated driver's license for young drivers, primary seat belt laws for children, and standardized medication administration policy in day care settings. The data was lauded by MCH advocates as useful and supportive of preventive efforts for the MCH population.

SIDS prevention is an ongoing effort in Montana, as in other states. A recent innovation has been the availability of a "Safe Sleep" program, providing safe cribs to needy families across the state. Public Health Nurses in counties and tribal settings may request cribs on behalf of clients who require a safe sleep environment for an infant. Requests for cribs are processed through public health nurses, and the cribs are then ordered and delivered to the public health nurse for delivery to the client. The added benefit of PHN contact and education regarding a safe sleep environment and other preventive information has been a major selling point for the program. Support for the program has been received by the Montana Healthy Mothers, Healthy Babies Coalition, private foundations and the Emergency Medical Services for Children Program.

CACH also provides technical assistance and consultation to local public health and school staff on matters impacting child, adolescent and school health. Efforts to continue general support and development of preventive and supportive 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.

Suicide has, and continues to be recognized in Montana as a major public health concern. The department worked in conjunction with mental health provider, advocates, local partners and others to develop the first Suicide Prevention Plan, which was finalized in 2001. Funding was also obtained from the Governor's office in 2004, and from Preventive Health Block Grant carryover in 2005 to conduct an assessment of resources for suicide prevention in the state, and to support local efforts to prevent youth suicide. A report of the status of effort is attached to this document. DPHHS partnered with others to submit an application for a SAMHSA Cooperative

Agreement to address youth suicide in June of 2005.

The Family Planning program receives a small amount ($25,000) of MCHBG funding which it includes in the contracts with 15 local agencies to provide family planning services in 38 locations. 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. The family planning program serves approximately 28,000 men and women annually, including adolescents. The program helps to decrease the incidence of unintended pregnancies and births to teen mothers, which are MCHBG performance measures.

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 50-1-2020. 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.

/2007/ The Family and Community Health Bureau continues to be the agency within the Montana Department of Public Health and Human Services primarily responsible for services for the maternal child health population. The Bureau has reorganized over the last year. Children's Special Health Services, which is Montana's program for children with special health care needs, has rejoined the bureau and public health division. Major changes in program organization and responsibilities are highlighted here:

Child, Adolescent and Community Health (CACH): This section continues to be responsible for programs and services targeting the childbearing and childrearing populations, offering supportive programs in partnership with local agencies. CACH supports and promotes the Public Health Home Visiting (PHHV) program, which is part of the Montana's Initiative for the Abatem,ent of Mortality in Infants legislation, which was passed in 1989. The initiative included community based efforts to work with high risk pregnant women and infants. The programs provides funding and training to 19 communities, including three tribal programs. The section also supports targeted efforts to identify and support families at risk for Fetal Alcohol Spectrum Disorder, by enhancing the PHHV with the addition of staff able to provide intensive home visiting services for these families. CACH was awarded a Garrett Lee Smith Memorial Grant in 2005, continuing and greatly expanding efforts to develop youth suicide prevention programs in communities across the state. The section is responsible for the Fetal Infant Child Mortality Review and for SIDS prevention efforts in the state. Staff includes the school health and adolescent health consultants.

Children's Special Health Services (CSHS): This section is responsible for system development and service support for children with special health care needs and their families. This section rejoined the bureau on January 1, 2006, and is responsible for regional speciality clinic development, family support enhancement (in conjunction with the state's Family Voices), and limited direct pay for services. The program works closely with clinic sites and with other

programs serving CSHCN and their families, including Part C and the Montana School for the Deaf and Blind. The Newborn Hearing and Metabolic Screening Program and the Birth Defects Registry was moved to the CSHS section in spring of 2006, in order to promote and coordinate clinical follow up and tracking.

Maternal and Child Health Data Monitoring: This section is responsible for development and monitoring of the Maternal and Child Health Block Grant. The section has contracts with 54 of Montana's 56 counties, distributing approximately 42% of the MCHBG award locally to support MCH services identified by and monitored through ongoing community needs assessments. The section also supports abstinence education programs with Abstinence Education funding, and is responsible for the Oral Health Program, which was moved from the CACH section.

Special Supplemental Nutrition Program for Women, Infants and Children (WIC): The WIC/Nutrition Section administers the WIC program in Montana, which offers services through 29 contracts statewide and on in all reservation communities. The section also supports a Farmer's Market Program for WIC clients in select communities.

Women's and Men's Health: This section is primarily responsible for reproductive health services through Title X supported clinics across the state. The section monitors and supports community based efforts to prevent teen and other unintended pregnancies.

The Bureau staff and Advisory Council has developed a strategic plan based upon the information obtained through the MCH Needs Assessment in 2005. Priority needs were established and section activities developed in response to those needs.

An executive order (included as an attachment) to make the FCHB Advisory Council members governor-appointed was proposed. The FCHB Advisory Council members are currently appointed by the FCHB Bureau Chief. The executive order is under review and has not yet been signed. //2007//

/2008/

The Family and Community Health Bureau, Montana's Title V Agency, continues with the basic structure of five sections as described in the 2007 update. The Abstinence Education grant was housed and funding distributed to local partners through the Maternal Child Health Data Monitoring (MCHDM) section. Montana, along with most states, received notification of the need to increase efforts to monitor and verify compliance with grant component in late 2006. After careful analysis, staff within the MCHDM section and FCH Bureau determined that the requirements were burdensome and would require that we decrease local funding in order to support the state infrastructure necessary to comply with requirements. With the support of the Deparment Director and staff from the Governor's office, Montana notified the Administration of Children and Families in January, 2007, of their intent to not accept Abstinence Education Funding beginning with the 2007 FFY.

The Early Childhood Comprehensive Systems grant, which had been housed in the Child, Adolescent and Community Health Section was moved to MCHDM in the spring of 2007. The MCHDM has also submitted a competitive application for the new Targeted State MCH Oral Health Service Systems Grant Program.

Two "units" consisting of focused responsibilities with staffs of two or less have been created during the last year. The first is the MCH Epidemiology Unit, responsible for overseeing the State System Development Initiative (SSDI) grant and advising on and conducting epidemiological analyses and evaluation projects across the bureau.
We were very pleased to hire the Public Health Prevention Specialist assigned to Montana 2003 -- 2006 as our first epidemiologist, and are presently recruiting a second to join the Epi Unit.

The Primary Care Office is the second unit structure within the Bureau. The Primary Care Offices' responsibilities focus on facilitating federal designation of health professional shortage areas, and of supporting recruitment efforts for primary care, oral health and mental health professionals. This section was previously located elsewhere in the division, and compliments the efforts of the Bureau staff to promote and support access to quality health care for the MCH population in the state.

The Governor's Office continues to identify Council members to be appointed to the Family Health Committee, which replaces the Family and Community Health Advisory Council. The Governor's Office announced the new and continuing members on the Council on August 15, 2008.

The Bureau continues to encourage and support staff development through internal and external training opportunities. In the past year, staff attended cultural competency and diversity trainings, as well as Communication and Team Building Skills. Additionally, the Public Health and Safety Division has provided leadership training to all management staff and is providing communication training to all division staff in September 2007. An outgrowth of the managerial training was the creation of the Employee Feedback Group, composed of a representative from each of the five FCHB's sections that meets quarterly and provides feedback to the Division on the effectiveness of the managerial specific trainings. As of September 2007, the Family Health Council has been appointed by the Governor, and the first meeting has been scheduled for the end of October 2007. //2008//

/2009//

The Family and Community Health Bureau comprised of five sections and two units, continued as Montana's Title V Agency. This past year the FCHB modified several sections with the goal of improving the Bureau's ability to efficiently provide maternal and child health services despite the continued decline in block grant funding.

Child, Adolescent and Community Health/CACH: CACH will be directing their energies this coming year on improving perinatal health through the Public Health Home Visiting/ Fetal Alcohol Spectrum Disorders Program and furthering the preventative efforts identified by the 29 Local FICMR teams. Staff is coordinating the Public Health Home Visiting Reassessment Process, involving public health home visiting program as well as working on the 2005-2006 FICMR Report. The Child Health Coordinator position was not refilled due to funding limitations, and the adolescent/youth suicide prevention position is being transferred with the Youth Suicide Prevention to the Addictive and Mental Disorders Division.

Children Special Health Services/CSHS: January 2008 witnessed the beginning of the implementation of mandated screening of all Montana newborns for 29 conditions as recommended by national screening standards, and the addition of the Newborn Screening Program Specialist. The CSHS Supervisor tendered her resignation effective May 9, 2008; therefore, the Bureau is in the process of interviewing for this position. Clinic billing continues to supplement the three Regional Pediatric Specialty Clinics.

Maternal and Child Health Coordination/MCHC: After numerous planning sessions, it was decided to rename the section the MCH Coordination Section and to transfer the Data Coordinator position to the Epi Unit. The term coordination more accurately describes the section's focus, which includes oversight of the local public health departments providing MCH services, coordinating the Department's annual Spring Public Health Conference; and oral health care resources.

Women's, Infants, and Children/WIC: WIC is making steady progress of converting their current electronic data collection tool to the new SPIRIT system with an implementation

date in late 2009. A WIC Futures Study Group, composed of lead local public health officials, local program, and state WIC Staff, was formed this year to discuss the current and future WIC allocation of funds, program direction and how to provide quality WIC services into the future.

Women and Men's Health/WMH: WMH recently published The Trends in Teen Pregnancies and Their Outcomes in Montana From 1991 - 2005 Report. The 2006 data shows that the teen pregnancy rate continues to drop for 15-19 year olds and is currently 47.8/1,000 representing a 21.8% reduction from the 1995 rate of 61.2/1,000. http://www.dphhs.mt.gov/PHSD/Women-Health/documents/teenpregnancyreport.pdf WMH's article Teen Pregnancy Prevention Month: Adolescent Health Viewed Through Teen Pregnancy was featured in the May 2008 Montana Public Health: Prevention Opportunities Under the Big Sky. www.dphhs.mt.gov/PHSD

Epidemiology Unit/Epi: The Epi Unit was enhanced with the hiring of a second maternal and child health epidemiologist, who will be begin work the middle of August 2008. The Data Specialist position is currently being advertised, with an anticipated start date in September or early October.

Primary Care Office Unit/PCO: The PCO was one of the first states in the nation to complete an analysis of the impact of the new designation methodology on health professional shortage areas. A contract with the Area Health Education Consortium was initiated in Spring of 2008 to coordinate and enhance recruiting and retention services in the state.
//2009//

An attachment is included in this section.

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." The Director, Robert Wynia, MD oversees the agency, its 3,000 employees and approximately 2,500 contracts and 350 major programs. DPHHS has a biennial budget of about $2 billion.

The Department of Public Health and Human Services (DPHHS) is a " mega agency" encompassing health and human services for the state of Montana. Statewide reorganization of health and human services agencies in 1995 created DPHHS by combining the Department of Social and Rehabilitation Services, the Department of Family Services, and parts of the Department of Health and Environmental Services and the Department of Corrections. During the reorganization, the environmental component of public health was separated and those functions now are carried out by the Department of Environmental Quality.

The reorganization combined public health and Medicaid services into a single division, knowns as the Health Policy and Services Division. In 2003, that division was split to create the Health Resources Division and Public Health and Savety Division.

The DPHHS Director's Office includes staff and programs that support the attainment of the department goals and the divisions' efforts to implement programs. The department has one deputy director, John Chappius, who also functions as the state Medicaid director. Programs within the director's office are; the Prevention Resource Center; the Office of Planning, Coordination, and Analysis; the Office of Legal Affairs; the Human Resources Office; and the Public Information Office. The Department's four broad goals are:

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

DPHHS is organized into eleven divisions. They are:
Addictive and Mental Disorders Division;
Child and Family Services Division;
Child Support Enforcement Division;
Disability Services Division;
Fiscal Services Division ;
Health Resources Division;
Human & Community Services Division;
Operations and Technology Division;
Public Health and Safety Division;
Quality Assurance Division, and
Senior and Long Term Care Division.

The majority of state level activities and services to the maternal and child population take place within the Public Health and Safety Division (PHSD). The mission of PHSD is to "Improve and protect the health and safety of Montanans." Jane Smilie has been the administrator of the Division since January 2005. The Public Health & Safety Division (PHSD) oversees the coordination of the public health system in Montana. The State's public health system is a complex, multi-faceted enterprise, requiring many independent entities to unite around the goal(s) of health improvement and disease prevention at the community-level. These entities include local City/County Health Departments, private medical providers and hospitals, local Emergency Medical Services, Emergency Management agencies and other units of local government. The public health system is a part of the continuum of care available to the citizens of Montana and the PHSD promotes and supports both the availability and the quality of public health services available to Montanans. The Division is organized into six bureaus:

Chronic Disease Prevention & Health Promotion Bureau - Todd Harwell, Bureau Chief
Communicable Disease & Prevention Bureau - Bruce Deitle, Acting Bureau Chief
Family and Community Health Bureau - JoAnn Dotson, Bureau Chief
Financial Operations and Support Services Bureau - Dale McBride, Bureau Chief
Laboratory Services Bureau - Anne Weber , Bureau Chief
Public Health Systems Improvement and Preparedness Bureau - Bob Moon, Bureau Chief

The Health Resources Division admisistrator is Chuck Hunter. The division brings together health resources for children, including CHIP, Children's Special Health Services, and the Children's Mental Health Program. In addition to the children's services, the division houses the primary care and hospital portions of Medicaid. This division is organized into six bureaus:

Acute Services Bureau -- Duane Preshinger, Bureu Chief
Children's Mental Health Bureau -- Pete Surdock, Bureau Chief
Fiscal Services Bureau -- Beckie Beckert-Graham, Bureau Chief
Health Care Resources Bureau -- Jackie Forba, Acting Bureau Chief
Hospital and Clinical Services Bureau -- Brett Williams, Bureau Chief
Managed Care Bureau -- Mary Angela, Bureau Chief

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 Care Resources Bureau (HRB).

The Family and Community Health Bureau has a staff of 30 and a total budget of approximately $21 million. 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 91% of the total bureau budget is expended at the local level. The FCHB bureau is organized into four sections, which are:

Child, Adolescent and Community Health (CACH) -- Deborah Henderson, Supervisor
Maternal Child Health Data Monitoring -- position vacant
WIC/Nutrition -- Chris Fogelman, Supervisor
Women's and Men's Health -- Suzanne Nybo, Supervisor

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) -- BJ Archambault, Acting Supervisor
Children's Health Insurance Plan (CHIP) -- Jackie Forba, Supervisor.

An organizational chart of the Montana Department of Public Health and Human Services is available at http://www.dphhs.state.mt.us/aboutus/orgcharts/orgchart.shtml. Organizational charts for the Public Health and Safety Division, the Family and Community Health Bureau, and a combined Human Resources Division and the CHIP/CSHS Bureau are attached as a single document.

/2007/ The Department of Public Health and Human Services had a new director appointed in 2005. Joan Miles, JD, is the former director of the Lewis and Clark County health department. Director Miles also worked as a clinical labortorian in the state and was a Montana state legislator.

The Family and Community Health Bureau has a staff of 32 and a total budget of approximately $21 million, including funding from 13 federal and state sources. The FCHB bureau management includes:

Family and Community Health-- Jo Ann Walsh Dotson, Bureau Chief and MCH Director
Child, Adolescent and Community Health (CACH) -- Deborah Henderson, Supervisor
Children's Special Health Services (CSHS) -- Mary Runkel, Supervisor and CSHCN Director
Maternal Child Health Data Monitoring (MCHDM) -- Ann Hagen-Buss, Supervisor
WIC/Nutrition -- Joan Bowsher, Supervisor
Women's and Men's Health -- Colleen Lindsay, Supervisor //2007//

/2008/

The FCH Bureau is very lucky to have retained the excellent managers recruited in 2005 and 2006. The listing of bureau leadership is the same as the list included in the 2007 update. Searches are in process for a second epidemiologist, and for quality assurance/contracts specialists in CSHS, WIC, and WMH. As of September, 2007 the WIC and WMH sections are fully staffed. //2008//

/2009/

The Family and Community Health Bureau staff remained fairly stable this past year. A second MCH epidemiologist will begin working in August 2008 and a new Children's Special Health Services Section Supervisor has been hired.

MCH BG funding cuts lead to the decision not to rehire the School Health Coordinator Position, resulting in the formation of new partnerships with the Injury Prevention Coordinator within the Chronic Disease Prevention and Health Promotion Bureau and the Statewide Suicide Prevention Coordinator housed in the Addictive and Mental Disorders Division. A Memorandum of Understanding with the Human and Community Services

Division has enhanced the FCHB's Public Health Home Visiting Program and diversified the oral health services to include a free, online preventative oral health care training for Head Starts and Early Head Start Programs and child care providers and funding 18 Community School Readiness Teams to sponsor community events focusing on the importance of early oral health intervention.

Each FCHB Section and Unit regularly updates their respective Activity Plans, the foundation for addressing the health needs of the maternal and child population. The individual Activity Plans are based on the continually evolving Blueprint for Maternal and Child Health in Montana, which relates to the Public Health and Safety Division's Strategic Plan as well as the Bureau's 2007 Legislative Goals.

http://www.dphhs.mt.gov/orgcharts/orgchart.shtml
http://www.dphhs.mt.gov/PHSD/org%20charts/PHSD-org-charts.shtml

//2009//

D. Other MCH Capacity

The MCHBG supports 10.69 FTE at the state level. These FTE are all or part of 16 staff members' time. The amount of FTE supported by MCHBG and the role of the staff member are described below:

Section	Staff member	FTE Paid by MCHBG	Role
CACH			
	Dennis Cox	1	Adolescent/School Health
	Deborah Henderson	0.5	CACH Section Supervisor
	Wilda McGraw	1	FICMR, Child Health
	Cindy Mitchell	0.5	Admin Support
	Cheri Seed	0.5	Oral Health
	Sandra Van Campen	0.5	PHHV/FAS Prevention
MCHDM			
	Sib Clack	0.35	NB Screening & Birth Defects
	Kindra Elgen	0.50	MCH Data Manager
	Rosina Everitte	0.17	MCH Epidemiology/Statistician
	Jack Lowney,	1.00	MCHBG & Contracts
Subtotal of CACH and MCHDM		6.02	
CSHS			
	Archambault, B.	1.00	Nurse Consultant and Acting Supervisor
	Donnelly, M.	0.80	Nurse Consultant and Data System
	Gruby, T.	0.87	Accountant
	O'Donnell, M.	1.00	Clinic Coordinator
	Scott, C.	1.00	Outreach Coordinator
Subtotal		4.67	
Total		10.69	

Jo Ann Dotson's time is cost allocated across the bureau based on staff time, incorporating some MCHBG based on 6.02 FTE. Jackie Forba's time is fully covered by CHIP.

The FCHB Bureau has a staff of 30 and the HRB a staff of 18. All other FCHB state staff and

portions of the MCHBG supported staff are paid from other funding, including federal funds (WIC, Title X, Newborn Hearing Screening, SOHCS, SSDI and FAS) and a small portion of general fund. HRB staff outside of the CSHS program is supported by a combination of federal CHIP and state match.

FCHB has one federal staff person, Dianna Frick, who is responsible for coordinating the 2005 needs assessment and the subsequent MCH needs prioritization and strategic planning. Dianna's position will be in existence for two years (Sept. 2004-Sept. 2006) and is a result of FCHB's successful application for a Public Health Prevention Service fellow through the Centers for Disease Control and Prevention.

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 04, that estimate is for approximately 5.3% 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 7.2% of their expenses as administrative costs.

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 2004 County Health Profiles, there were approximately 124 public health nurses, 84 registered sanitarians, 14 registered dieticians and 41 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.

The Public Health Data System (PHDS) 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. Administration of the PHDS has been transferred to the Public Health Informatics Section in the Division.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 12,390 phone calls received in 2004 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 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.

March of Dimes and is the Region VIII Councilor forthe Association of Maternal Child Health Programs.

/2007/ The FCHB experienced extensive staff changes during 2005-2006, due in part to retirements and family members moving out of state. Four of the bureau's five sections have new managers, including the CSHS, which was vacant for approximately 2 years. The MCHBG

supports 12.25 FTE at the state level.

Employee name	Section	Role
Dennis Cox	CACH	Adolescent/Youth Suicide Prevention (vacant as of 7/31/06), currently recruiting
Deborah Henderson	CACH	Section Supervisor
Julie Chafee	CACH	FICMR, Child Health, School Health - hired in 2006
Candy Burch	CACH	Admin Support - hired in 2006
Rae Brown	CACH	PHHV, FASD Prevention - hired in 2006
Ann Hagen-Buss	MCHDM	Section Supervisor - hired in 2006
Camie Zufelt	MCHDM	Data Manager - hired in 2006
Shannon Koenig	MCHDM	Admin Support - hired in 2006
Theresa Gruby	MCHDM	Accountant & Contracts
Margaret Virag	MCHDM	Oral Health - hired in 2006
Mary Runkel	CSHS	Section Supervisor - hired in 2006
Mary Lynn Donnelly	CSHS	Nurse Consultant and Data System
Michelle O'Donnell	CSHS	Clinic Coordinator
Corliss Scott	CSHS	Admin Support and Outreach
Sib Clack	CSHS	NB Screening & Birth Defects
Shari Pettit	CSHS	Nurse Consultant
Rosina Everitte	FCHB	MCH Epidemiology/Statistician (vacant as of 7/15/06, Dianna Frick hired and will begin 9/18/06)

An executive order (included as an attachment) to make the FCHB Advisory Council members governor-appointed was proposed. The FCHB Advisory Council members are currently appointed by the FCHB Bureau Chief. The executive order is under review and has not yet been signed. //2007//

/2008/The FCHB had limited staff changes during the last year, with most of the new staff hired in 2007 experiencing great success in their new roles. The Bureau staff is at present 39, with the MCHBG supporting 12.35 of those staff at the state level. Approximately 42% of the MCHBG also continues to be distributed through formula to 54 of the state's 56 counties, supporting the delivery of MCH services statewide.

//2008//

/2009/The MCH BG supports 11.6 of the 34 FCHB staff. A funding formula, based on the county's maternal and child health population, is used when allocating approximately 42% of MCHBG to the local public health departments. In FY 08, 53 of the 56 counties provided MCH services. CSHS continues to receive 30% of the MCH BG funding, supporting staff, Regional Pediatric Specialty Clinics, direct pay services and other activities of the section..

//2009//

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 a 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 and functional work committees.

There are two Advisory Councils that advise the department on programs and services in the Family and Community Health Bureau and the Children's Special Health Services program. The Family and Community Health Bureau Advisory Council is charged with advising "… the Family and Community Health Bureau (FCHB) and the Department of Public Health and Human Services on matters impacting the Bureau's target populations, including pregnant women, women of childbearing age, infants, children to aged 22." The AC Purpose and Guidelines document and the list of 05-06 members is attached. The Council meetings every two months via TC, and advises the department in the interim via e-mail and by phone.

The Family and Community Health Bureau Advisory Council is instrumental in helping link and guide the Bureau. In Calendar 06, the Bureau will undergo a strategic planning update, facilitated by the PHPS and informed by the needs assessment submitted in this application. The strategic planning process will include AC members, contractor representatives, program managers and staff. The FCHBAC members provided effective advocacy for MCH programs during the 2003 and 2005 State Legislature and played key roles in preserving the state's general fund support of the public health home visiting program for high-risk pregnant women and infants addressed in legislation as Montana's Initiative for the Abatement of Mortality in Infants or MIAMI.

The Children's Special Health Services (CSHS) section is located in the Health Care Resources Bureau and 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 also works towards coordination at the state level. The State CHIP program is also 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.

The PHSD and FCHB also have other Advisory Councils. At present, the PHSD has approximately 35 councils, many of them linked to specific grants. The FCHB has The Birth Outcome Monitoring AC, The Dental Access Coalition, the Family Planning Medical Standards Committee, Fetal Alcohol Syndrome Advisory Council, Fetal Infant & Child Mortality Review Work Group, the Newborn Hearing Screening Task Force, Newborn Screening Advisory Board, the Suicide Prevention Work Group and the WIC Steering Committee. The Governor's office is examining all ACs, and anticipating combining some of these functions into the FCHB AC structure, which will be done over the next year.

FCHB and HRCB Staff participates on several intra and interagency groups targeting the MCH population. Examples of those groups include:

Connecting for Kids -- Primarily designed as an intra agency group, this group began meeting in 2004, in order to address challenges of linking existing programs and services. Programs, including DD, foster care, and others, were facing instances in which children's insurance or other services stopped with no transition plan. This group's stated purpose is to "… look at the systems that serve children in Montana, to enhance coordination of programs, and improve communications between programs to deliver services in the most efficient manner possible".

Healthy Kids - Quarterly meetings are held with the Office of Public Instruction (which is the state's Department of Education) 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. Dennis Cox helps facilitate that group, setting the agenda every other meeting.

Kid's Count Advisory Council -- This projects is directed by the Bureau of Business and Research of the University of Montana. Funded in Part by the Annie E. Casey Foundation, this project helps to inform health policy discussion and decisions. The project publishes and distributes a Montana specific report every year. This advisory council meetings quarterly. The department also supports the printing and distribution of the Kids' Count Book to local communities.

March of Dimes Board of Directors -- This board meets monthly. Jo Ann Dotson represents public health on this board. The Bureau shares common goals to improve pregnancy outcomes and decrease infant mortality, including that attributable to prematurity, with the March of Dimes organization.

/2007/Reorganization resulted in the move of the CSHS section to the Family and Community Health Bureau effective January 1, 2006. The CSHS Advisory Committee now functions as a subcommittee to the Family and Community Health Bureau Advisory Council. An executive order (included as an attachment) to make the FCHB Advisory Council members governor-appointed was proposed. The FCHB Advisory Council members are currently appointed by the FCHB Bureau Chief. The executive order is under review and has not yet been signed. //2007//

/2008/
As noted above, the Primary Care Office was moved to the Family and Community Health Bureau effective January 1, 2007.

The "Connecting for Kids" group has been examined over the last year. The focus on developing a system of care for children's Mental Health has emerged as a top priority, and a system of care Committee created. The Connecting work group continues to meet to deal with individual client needs, but the primary effort has shifted to the System of Care. Bonnie Adee, the former ombudsment in the Governor's Office assumed the role of Children's Mental Health Bureau Chief in 2006, and is guiding the development of a system of care statewide. FCHB staff have participated in the meetings, and will continue to monitor progress of that effort.

FCHB Managers, four of 5 whom were hired in 2006, have become valuable members of many agency and statewide organizations. Mary Runkel (CSHS Manager) was invited to participate on a Montana Academy of Pediatrics subcommittee, and participated as the state level participant in the Genetics Meeting in Denver this spring. Joan Bowsher (WIC Manager), a former county agency preparedness division leader, was asked to represent MCH on the state level Preparedness Planning Committee. Ann Hagen-Buss (MCHDM Manager) and Deborah Henderson (CACH Manager) are working with the Human and Community Services Division as they expand oral health and home visiting services and implement the Early Childhood Services project in partnership with the Early Childhood Services Bureau in that division. Colleen Lindsay (Women's and Men's Health Manager) was also asked to participate in an advisory capacity in the development of a comprehensive sexual health education proposal which may be submitted in the next legislative session. Attached is a pictorial representation of each Section's numerous partnerships formed this past year.

The Bureau's Strategic Planning process resulted in a more concentrated focus on each section's current and formation of future partnerships with governmental and private organizations who support the National and State Performance Measures and the Health Systems Capacity Indicators and goals and objectives related to other grants managed within the Bureau. //2008//

/2009/Montana is often referred to as The Treasure State, of which probably the greatest treasure is its people. It is these people, in the public and private organizations where they work, who are invaluable to the Bureau's ability in addressing the National and State Performance Measures and the Health Systems Capacity Indicators. The attached partnership charts are a pictorial representation of the numerous collaborations that have been maintained and/or initiated this past year.

The Bureau's Strategic Planning process expanded to include a more careful analysis of staff capacity to take on additional funding streams, albeit supplementing the MCH BG funds, especially in light of the fact that any additional employees must have legislative approval. At this time, the WIC and CACH Sections are leading statewide task forces charged with studying and making a recommendation(s) to the Family Health Advisory Council on the WIC and Public Health Home Visiting Programs.

In this past year, the "Connecting for Kids" group refocused attentions on individual case management for children requiring transition services, thereby limiting the FCHB role. The Early Childhood Services Systems grant was transferred to the Early Childhood Services Bureau, with the FCHB remaining involved on the project task force. //2009//

An attachment is included in this section.

F. Health Systems Capacity Indicators

Introduction

/2009/ Montana's ability to report data for the Health Systems Capacity Indicators continues to improve. The July 15, 2008 submission is the first time linked birth and Medicaid data have been available to report on HSCI 05. While the analysis is preliminary due to the recent acquisition of the data, the continued discussions with Medicaid and other partners related to data availability strengthen partnerships between programs and health professionals and result in greater capacity for interpretation and use of data sources for MCH programs. //2009//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	11.1	14.9	23.1	25.1	25.1
Numerator	61	82	131	145	145
Denominator	54869	54869	56797	57879	57879
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

As of the 2008 submission, hospital discharge records are used to report on this indicator. 2005 and 2006 data were changed from Medicaid records to discharge data. Previous to the 2004 data, the numerator is Medicaid data and the denominator is census data. The discharge data is not yet available for 2007. Reporting of hospital discharge records is not required in Montana. Not all facilities report discharge data and reporting may not be standardized. However, this source is the only statewide indication of hospitalizations for asthma among children under 5.

Notes - 2006

As of the 2008 submission, hospital discharge records are used to report on this indicator. 2005 and 2006 data were changed from Medicaid records to discharge data. Previous to the 2004 data, the numerator is Medicaid data and the denominator is census data. The discharge data is not yet available for 2007. Reporting of hospital discharge records is not required in Montana.

Not all facilities report discharge data and reporting may not be standardized. However, this source is the only statewide indication of hospitalizations for asthma among children under 5.

Notes - 2005
As of the 2008 submission, hospital discharge records are used to report on this indicator. 2005 and 2006 data were changed from Medicaid records to discharge data. Previous to the 2004 data, the numerator is Medicaid data and the denominator is census data. The discharge data is not yet available for 2007. Reporting of hospital discharge records is not required in Montana. Not all facilities report discharge data and reporting may not be standardized. However, this source is the only statewide indication of hospitalizations for asthma among children under 5.

Narrative:
/2009/ Montana does not have an ideal population-based data source for this indicator. For the 2003 and 2004 indicators Medicaid claims data are used as the data source, although the records included only represent a subset of Montana's pediatric population. In addition, due to the way Medicaid data are collected, it was not possible to determine whether all of the hospitalizations for children diagnosed with asthma were related to asthma. The numbers prior to 2005 are not considered a good indication of the rate of asthma hospitalizations, as the data source is not population-based.

The results for this indicator have varied since 1998, and the number of children hospitalized who had asthma appeared quite low until 2005, with numbers less than 100. This is believed to be due to inadequate reporting, however, and not necessarily reflective of the true rate of hospitalizations. The rate prior to 2005 also appears low compared to HSI 01 results from other states and jurisdictions, although data sources vary so the comparability is questionable. As of 2008, hospital discharge records are used as the data source for this indicator. The 2005 and 2006 data were changed to also reflect the same datasource. Hospital discharge records are not yet available for 2007.

In 2006, 145 admissions in the hospital discharge dataset were for children under 5 with a primary diagnosis code for asthma. 152 admissions for children under 5 had a secondary diagnosis code for asthma. In 2005, 131 hospitalizations for children under 5 had a primary diagnosis code for asthma and 190 had a secondary diagnosis code for asthma. In 2004, 110 admissions for children under 5 recorded a primary diagnosis code for asthma, and 122 admissions had a secondary diagnosis code for asthma.

As children in lower-income (and possibly Medicaid-eligible) households may be more at risk for asthma due to quality of housing, limitations in medical care and exposure to other risk factors, it was believed that the rate of hospitalizations among children with asthma enrolled in Medicaid (54.1 in 2005, 52.7 in 2006 and 64.9 in 2007), was higher than that of the general population. Due to the way Medicaid data are reported, actual hospitalizations for asthma could not be identified, only hospitalizations among children with asthma. The hospital discharge records are an indication of hospitalizations for asthma, but do not reflect records from all hospitals in the state (although all of the largest are included). Reporting of discharge data is not required in Montana, and reporting may not be standardized. IHS and VA facilities are not included, and the completeness of reporting varies from quarter to quarter and year to year. However, hospital discharge records that are available are currently considered a more complete source of data for this indicator than Medicaid. //2009//

Montana's Title V program does not have an asthma component, but the program does collaborate with projects related to asthma and healthy environments. Previously, Montana's Environmental Public Health Tracking (EPHT) Project is working with communities to identify the primary environmental health risks, some of which are possible risk factors for asthma. However, in 2006 the Environmental Public Health Tracking Project was not funded and the tracking

activities have ceased. The 2007 Montana Legislature approved the use of general funds for asthma surveillance and control. ***/2009/ As a result, the Chronic Disease Bureau of MT DPHHS recently initiated an asthma program and hired a coordinator. A report on the burden of asthma in Montana was released in 2007. //2009//***

Environmental health was identified as a priority area during the Family and Community Health Bureau's (FCHB) current strategic planning activities. FCHB is Montana's Title V program. Goals and objectives have yet to be developed for this priority area, but FCHB expects to explore partnerships related to environmental health, and possible ways to include environmental health education into existing programs. Some of the risk factors linked to asthma would be included in these efforts.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	87.0	84.3	88.3	22.7	88.0
Numerator	4298	4359	4635	1160	4717
Denominator	4943	5172	5249	5106	5359
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FFY 2007. cz

Notes - 2006
This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FFY 2006.

Notes - 2005
This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FY 2005.

Narrative:
Montana's Medicaid program is in a different division of the MT Department of Public Health and Human Services than the state's Title V program. Collaboration does occur where appropriate around MCH-specific activities. For instance, the Children's Special Health Services (CSHS) section collaborated with Medicaid's Early, Periodic,
Screening, Diagnosis and Treatment (EPSDT) program to promote the awareness of the medical home concept for CSHCN. Hearing and mandated genetic screening also occur for the majority of Montana's children, regardless of whether they are Medicaid enrollees or not. Efforts to increase the percent of infants screened are ongoing through the development of new partnerships, support of current relationships and exploration of new legislation or guidelines to support screenings.

/2009/ The percentage of Medicaid-enrolled infants who receive at least one initial periodic screen has ranged from 84% - 88% over the past five years (the 2006 numbers are considered an abberation, due to differences in data collection for that year). //2009// Due

to the small size of Montana's population, 10 years of data might provide a more realistic indication of trend for this indicator. Changes in Medicaid policies, eligible population, access to providers, and other factors that could affect access to screenings and cause the data fluctuations are not reflected by the numbers. ***/2009/ The variations in the five years reflected here indicate that Montana's percent of infants screened is staying at about 85% or higher. //2009//***

The Family and Community Health Bureau submitted an application for the Targeted State MCH Oral Health Service Systems Grant Program with successful applicants to be notified by September 1, 2007. Included in this application were strategies specifically addressing how Community Health Centers could increase their numbers of EPSDT screenings.
/2009/ Montana was not one of the 20 states funded with the Targeted State MCH Oral Health Service Systems Grant. //2009//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	100.0	0.0	0.0	0.0	
Numerator	1	0	0	0	
Denominator	1	1	1	1	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Data are not available for this indicator.

Notes - 2006
Data are not available for this indicator.

Notes - 2005
A report of the CHIP data base children by age and by procedure codes is not available and is not feasible to program a new report in time to submit with the annual submission of MCHBG. In addition the number of children under one year is not available on the state level vital statistics. Data entered is not correct.

Narrative:
Montana's CHIP program does not collect data that can be used for this Health System Capacity Indicator. The data presented in HSCI02 are considered most indicative of this statistic even though children eligible for Medicaid in Montana are not eligible for CHIP. At this time MT CHIP has no plans to collect these data.

Health Systems Capacity Indicator 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 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	79.6	81.1	80.2	78.8	79.0
Numerator	9060	9214	9251	9818	9662
Denominator	11384	11355	11539	12462	12225
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Both the numerator and the denominator reflect data on live births to resident women, regardless of the place of occurrence. The 2007 data do not yet include complete reporting for births to MT resident that occurred out of state.

Notes - 2006
Both the numerator and the denominator reflect data on live births to resident women, regardless of the place of occurrence.

Notes - 2005
Both the numerator and the denominator reflect data on live births to resident women, regardless of the place of occurrence.

These data were updated in 2007 to reflect the appropriate age range (15-44 years).

Narrative:
The data source for this indicator is birth records. Vital records data for the most recent year are still provisional at the time of the block grant submission, so the indicator may shift slightly with finalized numbers. However, the preliminary indicator is generally similar to the final.

In 2005 and 2006, the percent of women with adequate prenatal visits according to the Kotelchuck Index decreased slightly. However, over the past 5 years, Montana has seen a trend towards an increase in prenatal visits. ***/2009/ The indicator appears to hover near 80% //2009//***.

The American Hospital Association Data reported a decline in the number of hospitals throughout the state providing obstetrical care, from 34 in 2004 to 32 in 2005. This number does not include Indian Health Services (IHS) facilities, and so is not a complete representation of delivery sites. However, it may indicate some limitations on where pregnant women can access prenatal and obstetric services.

Several programs coordinated through Montana's Family and Community Health Bureau (FCHB), the State's Title V program, contribute to education on and support for prenatal care. The Public Health Home Visiting (PHHV) program provides home visits to at-risk pregnant women. WIC offers nutrition education and resources. The Fetal, Infant and Child Mortality Review (FICMR) offers information on preventing premature births. As these programs have expanded and become more visible and known in communities over the past several years, the messages on prenatal care are reaching more and more women. Where possible, programs such as WIC are also connecting women with sources of prenatal care, such as Medicaid or private providers. County Health Departments that receive Title V funds (54 of 56 counties) also provide services on a sliding fee scale.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	86.7	88.7	88.7	86.1	91.2
Numerator	46369	57700	58602	51200	54826
Denominator	53457	65079	66078	59448	60134
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007
Please note that the denominator is considered an estimate. Eligibility estimates are not available from the Medicaid program. The estimate of the number of children 1-21 eligible for Medicaid was calculated using the Current Population Survey (CPS) table creator. The 2007 CPS reflects income data for 2006.

Notes - 2006
This data came from the Montana Medicaid Program. It was pulled from MMIS the medicaid database using a querying system called QueryPath.

Notes - 2005
This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FY 2005.

Narrative:
These data come from the Montana Medicaid Program's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) report. The percent of eligible children who have received a Medicaid paid service has remained fairly steady over the past several years, although the number dropped slightly in 2006. The reason for the drop is unknown.

Montana's Maternal and Child Health program has limited influence over Medicaid-provided programs. Several MCH programs collaborate with Medicaid to try to increase care or educate Medicaid providers and program staff on possible services and interventions. For instance, the WIC and Children's Special Health Service (CSHS) programs both assist their clients to verify whether they are eligible and initiate enrollment in Medicaid where appropriate. CSHS, the Child, Adolescent and Community Health (CACH) section and the Oral Health Education Specialist have all developed relationships with Medicaid to collaborate on programs that will help serve children and facilitate their access to Medicaid services.

Montana struggles with access to providers, particularly providers who will accept Medicaid, which certainly affects this indicator. As populations within the state shift towards larger population centers, rural areas are having more difficulty recruiting and keeping providers. Transportation challenges and distances involved in getting to a health provider can deter families from using services. In some of the state's population centers, providers are over-booked and it may be a challenge to find a physician accepting new patients or Medicaid-eligible clients.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	34.1	32.9	34.3	33.6	39.7
Numerator	3849	3931	4182	4099	4897
Denominator	11276	11960	12182	12182	12320
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
This data came from the EPSDT report from the Montana Medicaid Program. It is annual report for the FFY 2007.

Notes - 2006
This data came from the EPSDT report from the Montana Medicaid Program. It is annual report for the FFY 2006.

Notes - 2005
This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FY 2005.

Narrative:
The percent of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible children who have received dental services during the year has remained fairly steady and lowover the past five years, never above 35%.

Montana's maternal and child health (MCH) program has limited ability to affect Medicaid programs. However, the Oral Health Education Specialist (within the MCH program) continues to collaborate with Medicaid on dental access issues.

Montana struggles with a shortage of dental professionals in the state. The shortage is even more severe in rural areas and when considering dentists who accept Medicaid and child clients. For children with behavioral problems or special needs, finding a dentist who will accept them as a client can be even more challenging. There were 361 dentists and denturists in Montana who accepted Medicaid clients during state fiscal year 2005 (7/1/04 to 6/30/05) and 332 in state fiscal year 2006 (7/1/05 to 6/30/06), a decline of 29 in a one-year period. As of December 31, 2005, CHIP had 269 dentists practicing in 279 locations, leaving 14 Montana counties (25%) with no CHIP enrolled dentist. As of December 31, 2006, there were 252 dentists treating CHIP-eligible children. According to the Montana Primary Care Office, 37 of Montana's 56 counties are designated as Dental Health Professional Shortage Areas

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	0.8	1.0	1.1	0.0	0.0
Numerator	12	18	22	0	0
Denominator	1555	1892	1957	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
In 2007, 1929 children under 16 in Montana were receiving SSI payments. According to Montana state statute, children who receive SSI benefits automatically receive Medicaid. Therefore, there are no children who receive SSI benefits and receive services through the children with special health care needs program whose services are not paid by Medicaid. According to the block grant guidance, the goal of this indicator is "for the state CSHCN program to provide rehabilitative services for blind and disabled children less than 16 years old receiving benefits under Title SVI, to the extent medical assistance for such services is not provided by Medicaid." Due to the fact that Montana has met this goal, we have no data to report for this indicator.

Notes - 2006
According to Montana state statute, children who receive SSI benefits automatically receive Medicaid. Therefore, there are no children who receive SSI benefits and receive services through the children with special health care needs program whose services are not paid by Medicaid.

Notes - 2005
This indicator is essentially unchanged for 2005, although it was predicted to change significantly from 2004 due to CSHS ability to provide resource and referral information to this population. This service was not instituted until May of 2006 and therefore has not yet affected the reporting of this measure. Medicaid coverage for eligible applicants continues to provide for rehabilitative services. CSHS continues to cover some genetic testing for Medicaid clients in out of state labs that are Montana Medicaid providers. During FFY 2005, 22 SSI beneficiaries received comprehensive evaluation through a Title V sponsored Cleft/craniofacial or Metabolic clinic, not paid for by Medicaid.

Narrative:
During a review of the guidance for this indicator, and discussions with the Montana Children's Special Health Services Program, it was determined that no children meet the criteria to be reported in the numerator for HSCI 8. The guidance states the goal of this HSCI as "for the state CSHCN program to provide rehabilitative services for blind and disabled children less than 16 years old receiving benefits under Title SVI, to the extent medical assistance for such services is not provided by Medicaid." In Montana, all children eligible for SSI are also eligible for Medicaid. It was determed that in 2006 ***/2009/ (and 2007) //2009//*** no SSI beneficiaries under 16 in Montana received services through the CSHCN program that were not paid for by the Medicaid program.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2006	matching data files	7.9	6.7	7.1

Notes - 2009
Until 2008, the payer source was not reported for MT birth record files. Previously, the state has been unable to report on this indicator. The numbers reported this year are from a dataset containing live birth data for 2004-2006. The Medicaid program indicated which women with a record of a live birth in 04-06 participated in Medicaid at some point during the second and third trimesters of pregnancy. These data include MT residents who gave birth in MT. These numbers will not exactly match the values reported for NPM 18 and HSCI 04, as those are reported using 2007 live birth records. Matched live birth-Medicaid records for 2007 were not available in time for submission in the block grant.

Narrative:
Vital statistics records do not currently capture payment source related to birth records. The data presented above do not actually represent the percent of low birthweight in the Medicaid and non-Medicaid populations. At the time of the block grant submission, discussions were underway about whether low birthweight data were available through Medicaid. Because low birth weight is collected as a risk code and not as a part of claims data, there were some doubts about the accurateness of using the risk code to determine the percent of Medicaid births that were low birthweight. Preliminary results indicated that there were approximately 4346 births covered by Medicaid during 2006, and 72 births that had some sort of low birth weight coding, which would result in 1.7% low birth weight. These preliminary data indicate that Medicaid paid for 35% of the births, and those births accounted for only 8% of the low birth weight infants. Because of the known limitations with how the low birth weight Medicaid data are collected, and because the preliminary percent of low birth weight is so low for the Medicaid population, this was determined not to be an accurate reporesentation of low birth weight among Medicaid-paid births. At the time of block grant submission, Medicaid staff were running a more detailed report on the available data to determine what could be gleaned from Medicaid records.

A new birth certificate will be implemented in 2008 that collects payment source for births. For detail on low birth weight-related activities in Montana, please see the narrative for State Performance Measure 8.

/2009/ Montana's MCH program gained access to birth records linked to some Medicaid data for the first time in 2008. Previously, the state had been unable to report on this indicator, as Medicaid data on deliveries was of questionable reliability. The data indicate a substantial difference in low birth weight between Medicaid and non-Medicaid populations. The analysis is preliminary at this point due to very recent access to the data. The state's ability to access and report these data is directly linked to the State Systems Development Initiative (SSDI) and HSCI 9A, which relates to the ability to access relevant information, as SSDI funds the bulk of the MCH Epidemiology capacity for the state. //2009//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	matching data files	1	1	1

Notes - 2009
Until 2008, the payer source was not reported on MT birth records. Previously, the state has been unable to report on this indicator. Linked live birth-infant death-Medicaid records were not available in time for submission in the block grant.

Narrative:
Vital statistics records do not currently capture payment source for birth records. A new birth certificate will be implemented in 2008 that collects payment source for births. The Montana Office of Vital Statistics recently linked infant birth and deaths records, which may provide a data source for this measure when data from the new birth certificate are available. Infant death data may also be available through Medicaid claims data. New Medicaid staff are working with Bureau staff to identify Medicaid data that could be used to report on block grant indicators. Data were not available at the time of the block grant submission.

Because the percentages reported here are not based on actual data on infants covered by Medicaid, no interpretation can be made.

/2009/ A request was submitted to Medicaid to identify infants who were enrolled in Medicaid at or around the time of their deaths. Although linked birth-death records are available, Medicaid data for those infants was not available at the time of the block grant reporting. The state's possible future ability to access and report these data is directly linked to the State Systems Development Initiative (SSDI) and HSCI 9A, which relates to the ability to access relevant information, as SSDI funds the bulk of the MCH Epidemiology capacity for the state. //2009//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	matching data files	75.2	86.9	83.2

Notes - 2009
Until 2008, the payer source was not reported for MT birth record files. Previously, the state has been unable to report on this indicator. The numbers reported this year are from a dataset containing live birth data for 2004-2006. The Medicaid program indicated which women with a record of a live birth in 04-06 participated in Medicaid at some point during the second and third

trimesters of pregnancy. These numbers will not exactly match the values reported for NPM 18 and HSCI 04, as those are reported using 2007 live birth records. Matched live birth-Medicaid records for 2007 were not available in time for submission in the block grant.

Narrative:
Vital statistics records do not currently capture payment source for birth records. A new birth certificate will be implemented in 2008 that collects payment source for births. Because the percentages reported here are not based on actual data on infants covered by Medicaid, no interpretation can be made.

/2009/ Montana's MCH program gained access to birth records linked to some Medicaid data for the first time in 2008. Previously, the state had been unable to report on this indicator, as Medicaid data on deliveries was of questionable reliability. The data indicate a substantial difference in initiation of prenatal care between Medicaid and non-Medicaid populations. The analysis is preliminary at this point due to very recent access to the data. The state's ability to access and report these data is directly linked to the State Systems Development Initiative (SSDI) and HSCI 9A, which relates to the ability to access relevant information, as SSDI funds the bulk of the MCH Epidemiology capacity for the state. //2009//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	matching data files	68.3	78.2	75.1

Notes - 2009
Until 2008, the payer source was not reported for MT birth record files. Previously, the state has been unable to report on this indicator. The numbers reported this year are from a dataset containing live birth data for 2004-2006. The Medicaid program indicated which women with a record of a live birth in 04-06 participated in Medicaid at some point during the second and third trimesters of pregnancy. These numbers will not exactly match the values reported for NPM 18 and HSCI 04, as those are reported using 2007 live birth records. Matched live birth-Medicaid records for 2007 were not available in time for submission in the block grant.

Narrative:
Vital statistics records do not currently capture payment source for birth records. A new birth certificate will be implemented in 2008 that collects payment source for births. Because the percentages reported here are not based on actual data on infants covered by Medicaid, no interpretation can be made.

/2009/ Montana's MCH program gained access to birth records linked to some Medicaid

data for the first time in 2008. Previously, the state had been unable to report on this indicator, as Medicaid data on deliveries was of questionable reliability. The data indicate a substantial difference in the adequacy of prenatal care between Medicaid and non-Medicaid populations. The analysis is preliminary at this point due to very recent access to the data. The state's ability to access and report these data is directly linked to the State Systems Development Initiative (SSDI) and HSCI 9A, which relates to the ability to access relevant information, as SSDI funds the bulk of the MCH Epidemiology capacity for the state. //2009//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2007	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2007	175

Notes - 2009
Effective July 1, 2007 the CHIP income guidelines were changed from 150% to 175% FPL ($36,138 for a family of four).

Narrative:
These data come from the state CHIP and Medicaid programs. The poverty level-related eligibility for Medicaid in Montana is lower than in other states nationwide (according to TVIS data for 2004) for infants, but similar to other states in the region. For CHIP, a comparison of Montana's poverty level-related eligibility for infants shows that it is lower than the majority of other states nationwide and within the region. However, effective July 1, 2007 the income guidelines for CHIP were changed from 150% to 175% of FPL ($36,138 for a family of four). CHIP also received funding to establish a program for CHIP children with high cost dental needs. The anticipated impact is for an additional 2,100 children to be enrolled in CHIP, for a total enrollment of approximately 16,000 children.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2007	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children	2007	

(Age range 1 to 18) (Age range to) (Age range to)		175

Notes - 2009
Effective July 1, 2007 the CHIP income guidelines were changed from 150% to 175% FPL ($36,138 for a family of four).

Narrative:
These data come from the state CHIP and Medicaid programs. The poverty level-related eligibility for Medicaid in Montana is lower than in other states nationwide (according to TVIS data for 2004) for infants, but similar to other states in the region. For CHIP, a comparison of Montana's poverty level-related eligibility for infants shows that it is lower than the majority of other states nationwide and within the region. However, effective July 1, 2007 the income guidelines for CHIP were changed from 150% to 175% of FPL ($36,138 for a family of four). CHIP also received funding to establish a program for CHIP children with high cost dental needs. The anticipated impact is for an additional 2,100 children to be enrolled in CHIP, for a total enrollment of approximately 16,000 children.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2007	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2009
Montana's SCHIP (CHIP) does not cover pregnant women unless they are under 18 years of age (covered unber CHIP as children).

Narrative:
These data come from the state CHIP and Medicaid programs. The poverty level-related eligibility for Medicaid is lower than most other states (according to TVIS data for 2004) for pregnant women, but the same as other states in the region. Montana's CHIP program does not cover pregnant women over 18 years of age.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	1	No

Notes - 2009
A limited amount of hospital discharge data is available in MT.

Recently, linked Medicaid and birth files have become available, but they are limited in scope. Discussions between health department epidemiologists and Medicaid analysts are taking place to try to establish a linked birth-Medicaid dataset that would potentially be updated regularly, but it is still in the planning phases.

Narrative:
The Family and Community Health Bureau (FCHB), Montana's Title V Program, does not have purview over the majority of the databases and surveys mentioned, with the exception of WIC, PRAMS, newborn screening, and the birth defects surveillance system. Therefore, while the Bureau is often involved in discussions regarding vital statistics data and linkages, it may not be the decision-maker.

Montana's Office of Vital Statistics recently linked infant birth and death records for a limited time period. They are moving towards linked birth and death records for a broader time period and population, but no estimated completion date has been set. ***/2009/ Linked birth and death records are now available for 1988-2007. //2009//***

FCHB does have access to de-identified birth records and the death records for 1989-2005, but these files are not linked. FCHB has access to Medicaid claims files through a staff member trained in Query Path, the Medicaid data system, and by submitting requests to Medicaid staff. Medicaid claims data are not linked to birth records. Some small studies have been undertaken in MT DPHHS to link Medicaid claims data with vital records. A similar activity is planned by FCHB as a part of the SSDI grant for the 12/1/07-11/30-08 budget period. This activity will help to determine the feasibility of linking Medicaid and birth records for specific analyses, and possibly on a more ongoing basis. ***/2009/ Live birth records linked with some Medicaid enrollment data were available to the MCH program for the first time in early summer 2008. Additional data is expected to be available on an ongoing basis, although the extent and***

timeliness of the available data has not yet been determined. //2009//

The WIC data system is expected to undergo an upgrade over the next several years. The current system is somewhat unwieldy and is not linked to birth certificates. FCHB does have access to WIC data, but not linked WIC-birth certificate data. ***/2009/ With the hiring of a new MCH Epidemiologist in summer of 2008, the MCH epidemiology unit will be able to explore collecting some WIC participation data in a format that will facilitate linking it with birth record data. The feasibility of the data storage and linkage will be investigated in late 2008 and into 2009. //2009//***

Efforts to link birth certificates and newborn screening data are currently underway. A linkage is available to some extent, but links for the reporting year are sometimes not available in time for block grant submission. The Newborn Screening Coordinator in the Children's Special Health Services Section of FCHB is coordinating the effort.

Some hospital discharge data for 2000-2005 were obtained by the Public Health and Safety Division in 2007. The data are expected to be available in future years, pending negotiations with the Montana Hospital Association. ***/2009/ The hospital discharge data available in Montana is a unique and valuable data source with some limited use to the MCH program. IHS and VA facilities do not report, and reporting by facilities varies by quarter and year. In addition, the reporting is not standardized or required, and not all relevant data are collected. However, it collects some data that are not available through other sources. //2009//***

Montana has birth defects surveillance data through 2005. Active collection of birth defects data was suspended in 2005 when the newborn screening grant application to CDC was approved but unfunded. Discussions continue regarding possible future methods of collecting and using birth defects data. All of the data collected thus far are maintained by FCHB.

Montana received a PRAMS grant for a Point-in-Time survey in 2002. The funding application for a PRAMS grant in 2006 was not successful. The 2002 data are maintained by FCHB. At this time, FCHB is unable to conduct an independent PRAMS-like survey due to funding and staff limitations. However, possible additional and alternative data sources continue to be explored. MCH data capacity development was identified as a Bureau priority during strategic planning.

The Montana Assessment project was initiated in late 2006 to review the data systems of the Public Health and Safety Division (including the MCH data systems) and determine an inclusive process for future review and revision of public health data systems. The project will be completed in 2007 with recommendations for a data review process. ***/2009/ A Public Health Home Visiting (PHHV) reassessment project was initiated in 2008. //2009//***

In May of 2007, the Family and Community Health Bureau MCH Epi Unit conducted an assessment and planning project for epi activities. Roger Rochat, an MCH Epidemiologist at Emory University, and the FCHB MCH Epidemiologist conducted interviews with Bureau staff and partners to identify priority MCH epi activities, including data linkages and analyses.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2009

Narrative:
Montana's Office of Public Instruction (OPI) conducts and maintains the data from the Youth Risk Behavior Survey. While the raw data are not available to the Title V program, the results of the survey are distributed in published form, and are also easily searchable and obtainable from the OPI website or the national YRBS website. The YRBS has been conducted in Montana every other year since 1993, with the most recent results available for 2007. Montana's Title V program frequently uses YRBS data for grant applications and reports, and it was a valuable source of information for the five-year maternal and child health needs assessment.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Montana's maternal and child health needs assessment process is continuous. Data are collected and analyzed throughout the five-year period. The needs assessment document is an opportunity to compile data and reflect on the complete picture of MCH needs and programs in Montana. Following the submission of the 2005 MCH needs assessment, and using the assessment as a guide, Montana's Family and Community Health Bureau (FCHB) will begin a strategic planning process to further prioritize MCH needs and identify how the FCHB can address them. The strategic planning process will continue the assessment process and ensure the use of previously collected assessment data. In addition, questions were included on the stakeholder survey sent to providers regarding how the process could be useful to them. The needs assessment results will be distributed to stakeholders around the state and available on the state website, which will help to generate interest in the process and encourage use of the needs assessment results. Finally, counties receiving MCH block grant funds are required to conduct their own needs assessments every five years, and those results are incorporated into the state's data collection process.

Beginning in 2002, meetings were held at the state level to determine how the state would develop the needs assessment. The Family and Community Health Bureau within the Montana Department of Health and Human Services submitted applications for two student interns in 2003. The students were responsible for conducting key informant interviews with stakeholders throughout the state and updating data from the 2000 needs assessment during June-August of 2004. FCHB also submitted an application for a Centers for Disease Control and Prevention Public Health Prevention Specialist to be assigned to Montana to assess the needs of the MCH populations. The prevention specialist arrived in Montana at the end of August, 2004.

Two groups at the state-level were primarily responsible for shaping and directing the needs assessment process: the Family and Community Health Bureau Advisory Council (FCHB AC) and the Family and Community Health Bureau Managers. The FCHB AC includes representatives from partner organizations throughout the state, including the March of Dimes, local health officers, WIC, family planning, education, urban and rural local health departments, Indian Health Services, nurses associations, and providers. The Council was involved in determining the approach and the final format of the needs assessment survey, as well as reviewing the final document. The FCHB AC will also be an integral part of the strategic planning process and the ongoing prioritization of maternal and child health needs and activities.

The Family and Community Health Bureau Mangers is comprised of the chief of the Family and Community Health Bureau and the managers of the four sections of the Family and Community Health Bureau: Maternal and Child Health and Data Monitoring; Child, Adolescent and Community Health; Women's and Men's Health; and, Women Infants and Children (WIC)/Nutrition. The managers decided the approach and focus of the community participation component of the needs assessment, participated in the development of the surveys, and reviewed and advised on the content of the final needs assessment document.

/2008/ This past year the five sections continued to update the section workplans, which are based on the goals and objectives outlined in the FCHB strategic plan. Each section's workplan includes their specific action steps for achieving the goals and objectives outlined in the FCHB Strategic Plan. The FCHB strategic plan was in turn based on the results of the statewide 2005 MCH Needs Assessment. Each section conducts periodic reviews of their workplan and updates their progress in achieving the activities related to the eight priority areas. The FCHB Section Managers and the Bureau Chief have begun discussions on planning for the 2010 Needs Assessment. It is anticipated that the Governor-appointed Family Health Advisory Council, formerly the FCHB Advisory Council, will be actively involved in the 2010 Needs Assessment process. //2008//

/2009/ Needs assessment development continues this year on several fronts. The Bureau strategic plan has been examined and aligned with the Division strategic plan; section workplans enhanced and updated. Each section continues to conduct periodic reviews of their workplan and updates their progress accordingly. A Graduate Student Inten Program (GSIP) assignee from MCHB is working on a statewide needs assessment planning survey during the summer of 2008, and staff are planning to participate in a Rocky Mountain Public Health Education Consortium training in September, as well as a training at the MCH Epidemiology conference in December. The FH AC is meeting in August to develop a report and recommendations for the Governor per executive order. //2009//

B. State Priorities

Selection and prioritization of state needs is an ongoing process requiring assessment of health status and system functioning indicators 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.

The following list of priority needs was generated based on a statewide survey of consumers and those caring for infants, children and families. A copy of the consumer and professional survey is attached to this section. The survey was distributed to WIC and Head Start clients, WIC and Head Start program staff and primary care and public health providers.

This survey provided public input into the development of a list of priority needs, which was further assessed based on the following criteria:

· Existence of data supporting the need
· Evidence that the MCH population, including infants, children, adolescents, children with special health care needs, women of childbearing age and their families were the target audience of the priority.
· Availability of resources and capacity within the public health system (not necessarily the MCH agency) to help address the issue.

This priority list will be the basis of the strategic planning process, which will involve the FCHB Advisory Council, the FCHB staff and local partners and consumers during FFY 06. The needs assessment will inform participants in the strategic planning process. It is anticipated that further prioritization will take place during the strategic planning process, and that the priority list will continue to change and evolve as new data, which will be part of the ongoing needs assessment, is revealed.

This list does not address overarching issues, which impact every one of the priorities. The issues include:

· The importance of a functioning public health system -- the public health system addresses the core functions of public health including assessment, policy development and assurance through the essential services. Included in those services are the responsibility to have appropriate training of public health professionals and partners, epidemiological capacity with which to analyze information regarding the population, and excellent networking among traditional and non-traditional public health providers.
· Recognition of disparity and its impact on the health of the MCH population. -- Examples include disparity in the efforts to promote the health of females in society, as well as disparity

between ethnic groups, age groups (i.e. school-aged children) and urban and non-urban dwellers. Recognition of, and efforts to address these disparities is an overriding concern, as they impact all MCH priorities.

Priority Issues

1. Increase access to health care for MCH populations, including children with special health care needs.
2. Increase insurance coverage of MCH populations.
3. Promote and improve oral health services for MCH populations.
4. Reduce the rate of intentional injuries in MCH populations, including, but not limited to the incidence of domestic violence and youth suicide.
5. Promote and support families to raise children in safe and nurturing environments.
6. Reduce the rates of preventable illness in children and adolescents, including obesity and vaccine preventable illnesses.
7. Prevent substance use in MCH populations.
8. Promote access to mental health services for MCH populations.
9. Promote efforts to continue to decrease the incidence of unintended pregnancies.

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. The Family and Community Health Bureau Advisory Council receives and reviews summaries of the annual pre-contract surveys. Staff also has the responsibility to monitor data and available statistics.

/2007/
For the 2007 MCH Block Grant (MCHBG) submission, Montana adjusted the state's priorities to reflect the priority areas in the newly-developed Family and Community Health Bureau (FCHB) strategic plan. FCHB is Montana's Title V program. The revised list of FCHB priorities is below (please note that the priorities are not ranked). Underneath each priority is a list of any related state and national performance measure(s). The new priority areas are based on discussions and strategic planning activities, and are an evolution from last year's priorities, which were in turn based on the 5-year MCH needs assessment. The priorities listed in this year's MCHBG application are expected to stay the same for the next 5 years, although periodic reviews of the strategic plan may result in some revised and updated priority areas. A discussion of the strategic planning process and the development of this year's priorities follows the list of priority areas.

State Priorities
1) Environmental health
Montana expects to develop a state performance measure related to environmental health in the future. A new project called Healthy Air Daycare, which assesses the environmental health of daycares as a part of licensing visits, has recently been implemented and data are expected to be available within the next year.

2) Family support and education
NPM 2, NPM 3, NPM 5, NPM 6, NPM 8, NPM 10, NPM 11, NPM 15, NPM 16
SPM 1 (unintended pregnancy)
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 7 (firearm deaths among youth aged 5-19)

3) Mental health and substance abuse
NPM 8, NPM 15, NPM 16
SPM 2 (abstaining from alcohol use during pregnancy)
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 6 (abstaining from cigarette smoking during pregnancy)

4) Nutrition and obesity prevention
NPM 11, NPM 14

5) Promotion of preventive and accessible health care
NPM 1, NPM 2, NPM 3, NPM 4, NPM 5, NPM 6, NPM 7, NPM 9, NPM 12, NPM 13, NPM 17, NPM 18
SPM 5 (Medicaid-eligible children who receive dental services)

6) Reproductive and sexual health
NPM 8, NPM 15, NPM 17, NPM 18
SPM 1 (unintended pregnancy)
SPM 2 (abstaining from alcohol use during pregnancy)
SPM 6 (abstaining from cigarette smoking during pregnancy)

7) Unintentional injuries
NPM 10
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 7 (firearm deaths among youth aged 5-19)

8) Family and Community Health Bureau capacity development
FCHB capacity development relates to all of the performance measures. Increased staff capacity in data management, organizational relationships and management skills will contribute to their work in all MCH areas.

Strategic Planning Process
Subsequent to the completion of Montana's five-year MCH Needs Assessment in 2005, FCHB began to develop a five-year strategic plan. Two large stakeholder meetings were held in late 2005. The meeting participants included FCHB staff, FCHB Advisory Council Members, Children's Special Health Service (CSHS) Advisory Council members, and other Department of Public Health and Human Services (DPHHS) partners in MCH activities.

The first meeting, in October, established the drafts of the vision, mission, guiding principles and priority areas. The priority areas were based on the results of the statewide MCH needs assessment. Following the meeting, a small workgroup was formed for each of the priority areas, and the workgroup members developed goals and objectives related to each area.

The second large stakeholder meeting, in December, used the CAST-5 tool to identify and discuss FCHB capacity needs. Holly Grason, of Johns Hopkins University, was the facilitator. The following capacity needs were identified as priorities:

Data Capacity:
- Adequate data infrastructure (access to more and better data/strategic use of data)
- More capabilities related to translation and communication of data
- Staff with basic data skills in all units/programs of FCHB, and additional staff with advanced skills in data analysis

Organizational Relationships:
- Improved collaborative working partnerships with state and local health programs
- Expanded relationships with additional stakeholders, policy makers, advocacy groups, funders, and the business sector

Skills:
- Staff with basic data skills in all units/programs of FCHB, and additional staff with advanced skills in data analysis
- Enhanced management and organizational development skills among staff

Three small workgroups, one for each capacity need topic area, were formed to brainstorm current activities and desired activities related to each capacity need. The brainstormed ideas were then turned into goals and objectives. To include the capacity needs in the strategic plan, an eighth priority area was developed.

The most recent version of the strategic plan is attached to this section. Next to each priority area is a description of the scope of activities that fall under that area and the goals and objectives developed thus far. Please note that the strategic plan is still in draft form and not all sections are complete. Many of the objectives are still being revised so that they fit into the SMART format. The plan is currently being reviewed within each of the FCHB sections to ensure that all ongoing, planned and appropriate desired activities have been included and that the plan is still relevant given recent staff turnover and alterations in projects. The FCHB staff position(s) responsible for each objective and for the ongoing evaluation of that objective will also be determined in the section meetings or larger Bureau meetings. FCHB anticipates finalizing the strategic plan in the Fall of 2006, with periodic reviews and updates to occur after that point. //2007//

/2008/ The most current version of the strategic plan is attached to this section. The strategic plan continues to be a working document assisting the FCHB in addressing the priority needs as identified with the 2005 Needs Assessment. The sections within FCHB have developed workplans based on the priorities, goals and objectives outlined in the Bureau strategic plan. The priority needs, which remained the same as in 2007, are as follows:

1) Environmental Health: It was determined that the Healthy Air Daycare data was not of a quality that could readily be adapted to creating a state performance measure. The Bureau's Oral Health Program is planning to strengthen their partnership with the Department of Environmental Quality with a goal of educating communities on their fluoride levels as a leveraging tool for increasing the numbers of schools participating in the fluoride mouth rinse program.

2) Family support and education
NPM 2, NPM 3, NPM 5, NPM 6, NPM 8, NPM 10, NPM 11, NPM 15, NPM 16
SPM 1 (unintended pregnancy)
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 7 (firearm deaths among youth aged 5-19)

3) Mental health and substance abuse
NPM 8, NPM 15, NPM 16
SPM 2 (abstaining from alcohol use during pregnancy)
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 6 (abstaining from cigarette smoking during pregnancy)

4) Nutrition and obesity prevention
NPM 11, NPM 14

5) Promotion of preventive and accessible health care
NPM 1, NPM 2, NPM 3, NPM 4, NPM 5, NPM 6, NPM 7, NPM 9, NPM 12, NPM 13, NPM 17, NPM 18
SPM 5 (Medicaid-eligible children who receive dental services)

6) Reproductive and sexual health
NPM 8, NPM 15, NPM 17, NPM 18
SPM 1 (unintended pregnancy)
SPM 2 (abstaining from alcohol use during pregnancy)
SPM 6 (abstaining from cigarette smoking during pregnancy)
SPM 9 (public, middle and secondary schools that require comprehensive sexuality education as

a part of their health curriculum)

7) Unintentional injuries
NPM 10
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 7 (firearm deaths among youth aged 5-19)

8) Family and Community Health Bureau capacity development
The FCHB Section Managers and staff continued to review and refine the section work plans to insure that the activities and goals were represented and related to the Bureau strategic plan and that their objectives met the SMART (specific, measurable, achievable, realistic and time-bound) format. Subsequently, the Bureau plan's goals and activities were reviewed and modified as needed and accomplishments were noted throughout the past year. //2008//

/2009/

The Bureau continues to use the 2005 Needs Assessment document as the foundation for their ongoing revisions to the Blueprint for Maternal and Child Health in MT., which serves as the Bureau's strategic plan in addressing the eight priority areas originally identified in the 2005 Needs Assessment. The priority areas are: 1) Environmental Health; 2) Family Support and Education; 3) Mental Health and Substance Abuse; 4) Nutrition and Obesity Prevention; 5) Promotion of Preventive and Accessible Health Care; 6) Reproductive and Sexual Health; 7) Unintentional Injuries; and, 8) Family and Community Health Bureau Capacity Development.

The MCHC Supervisor has taken on the role of ensuring that each of the eight priority areas includes feasible objectives based on the capacity of the responsible section, as well as ensuring that the Blueprint includes the outcomes for the previous year's objectives. Within each priority area, new objectives for Fiscal Year 2009 have been identified and assigned to a FCHB Section(s) responsible for its implementation. Throughout the coming year, the FCHB will be meeting to specifically address the new 2009 Objectives. Additionally, based on discussions with the individual sections, a significant number of objectives are continuing into the next fiscal year.

The Blueprint for Maternal and Child Health in MT also includes a reference to the Public Health and Safety Division's Strategic Plan and to the Bureau's 2007 Legislative Goals which were required prior to the start of the 07 Legislature. It is anticipated that within the next 2 months, the Bureau will submit their 2009 Legislative Goals. //2009//

An attachment is included in this section.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	99.9	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	4	2	2	7	9
Denominator	4	2	2	7	9
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100

Notes - 2005
Two confirmed cases of PKU were referred for case management and primary care provider consultation to a contracted pediatric specialist of The Children's Hospital in Denver, Colorado. An additional initial positive PKU came from a postmortem test on a deceased newborn. No potential or confirmed cases of galactosemia occurred in 2005. Staff in the Children's Special Health Services section do direct follow-up with the contracted pediatric specialist for PKU and GALT positive results to ensure that appropriate consultation is provided for the affected baby's primary care physician and dietary management by the family.

a. Last Year's Accomplishments
In 2007, the Montana Newborn Metabolic (bloodspot) Screening Program required testing for four conditions: phenylketonuria (PKU), galactosemia (GALT), congenital hypothyroidism (CH), and hemoglobinopathies (HB). The Metabolic Screening Program was a partnership between the Children's Special Health Services (CSHS) section of the Family and Community Health Bureau, the Montana Public Health Laboratory, and with the baby's medical home provider.

The newborn screening tests (NBS) were performed on 99% of the live births in Montana thereby ensuring that if a baby had one of these treatable disorders the baby would be referred for appropriate care before suffering irreversible developmental disability or death. The NBS fee for mandated laboratory testing remained $41.70 per infant, with an additional charge for any reflex or repeat testing.

In addition, the Montana Public Health Laboratory cooperated with the Wisconsin State Laboratory of Hygiene to offer an expanded panel of bloodspot screening tests on a voluntary fee for service basis, if ordered by the infant's birth facility or healthcare provider.

CSHS matched birth records to assess the completeness of mandated screening, and monitored laboratory results to ensure that infants with initial out of range values for mandated conditions were re-screened. CSHS made referrals for special consultant services, when necessary, to advise health care providers about appropriate diagnostic and treatment follow-up in response to abnormal screening results. This facilitated prompt confirmatory testing and appropriate treatment (where indicated) for all infants who screened positive for the mandated conditions. CSHS staff linked primary providers and families with resources, including referrals to special health clinics for babies with confirmed conditions. This ensured early intervention and the best possible outcome for the affected babies and their families.

The 2007 Legislature passed and the Governor signed Senate Bill 162 which authorized expansion of the mandated newborn screening panel to the recommended national standard of 29 conditions (28 by bloodspot, plus a separate screening program for hearing) as endorsed by the American Academy of Pediatrics and the American College of Medical Genetics. SB 162 also provided funds to CSHS for contracted long-term follow-up services for NBS, including the expanded panel of conditions and an additional full-time employee to oversee the program. http://data.opi.mt.gov/bills/2007/billhtml/SB0162.htm

A Request for Proposal, in accordance with state requirements, was developed by CSHS staff in 2007 and secured the availability of the desired long-term follow-up services with the Montana Medical Genetics Program at Shodair Children's Hospital in Helena.

The scope of the contract, in cooperation with the child's medical home, included: coordination of prompt diagnostic testing for screen positive infants; provision of consultative services of specialist physicians on a twenty-four hour/seven days per week basis; provision of RN care coordination to ensure continuity of care for diagnosed clients; provision of the consultative services of specialist physicians, RN care coordinator, genetic counselors, and registered dieticians to the medical home for each patient and family; provision of the on-site services of specialist physician, RN care coordinator, and registered dietician for all CSHS-sponsored metabolic multidisciplinary team clinics in Great Falls, Billings, and Missoula; and finally provision of opportunities for families of children with confirmed diagnoses to obtain family-to-family support services through referral to appropriate organizations or local groups.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Link newborn metabolic screening data with Montana birth certificates				X
2. Identify babies with Montana birth certificates who have no newborn screening data within two months of their birth and determine reason for no screening			X	
3. Ensure that all newborns with confirmed conditions detected by expanded newborn screening are referred to the contractor for long-term follow-up and consultation with the primary care provider in the medical home.		X		
4. Contract with qualified program to perform long-term follow-up services, including counseling and education, for children and parents of children identified with metabolic or genetic disorders.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHS worked on amending the ARM published January 18, 2008, informing the public, clinic coordinators, health care providers, and others on the NBS program changes; recruiting, hiring, and training the Newborn Screening Program Specialist who began on January 2, 2008; and developing this NBS program goal: CSHS will ensure that every newborn, with an initial positive or screen positive result for any of the 28 mandated conditions, is tracked by CSHS to a normal result or to appropriate clinical care.
http://www.dphhs.mt.gov/legalresources/administrativerules/title37/chapter57.pdf

Shodair recruited and filled key positions in early 2008, allowing CSHS to inform the primary care physician, of an infant who tested positive, access to an appropriate professional Shodair consultant.

The Montana Public Health Laboratory (MTPHL) receives all bloodspot specimens and screens for PKU, GALT, CH, HB, and cystic fibrosis (CF) and through a contractual arrangement with the Wisconsin State Laboratory of Hygiene (WSLH) the panel is completed. Currently, more than 4% of babies need a repeat screen due to unsatisfactory specimens or an out of range test result on the initial newborn screen.

CSHS is responsible for short term follow-up to ensure that repeat screening occurs, and facilitates secure information sharing of positive screening results with the contractor.

CSHS continues to match NBS records with birth certificates to identify babies who may not have been screened.

c. Plan for the Coming Year

In 2009 the Montana Newborn Metabolic Screening Program (MTNMSP) plans to consolidate, evaluate, and improve the systems put in place in 2008 to accomplish expansion of the newborn screening panel. Key elements have been identified and include:

1)Updating and developing new professional and lay educational information via different venues: web sites, provider manual, on-site hospital visits, disorder-specific fact sheets, and parent brochures

2) Continue monthly meetings between Montana Public Health Laboratory (MTPHL) and CSHS personnel to address issues related to expanded newborn screening. For example, a cooperative effort is underway to decrease the time from specimen collection to approved results, by identifying delays prior to and during shipping to the lab over the long distances in Montana.

3) Continue regular meetings between CSHS and professionals employed by Shodair Children's Hospital to address concerns and refine policies and procedures for tracking screen positive patients through diagnostic testing to treatment and long-term follow-up. The Shodair will provide professional staff, including a metabolic geneticist, for three regional metabolic clinics to be held twice this year.

4) The current Newborn Screening Follow-up Contract is in effect until June 30, 2009, with provision to allow for one-year renewals.

5) Implementing an improved search function for both finalized and pending birth records so as to expedite the identification of unscreened infants, especially for out-of-hospital births attended by midwives, resulting in timely follow-up for these infants.

6) CSHS will facilitate the formation of a MTNMSP Work Group, composed of representative professionals and stakeholders including medical specialists, pediatricians, family practice physicians, nurses and other healthcare professionals, laboratory specialists, administrators, and parents or other individuals with an interest in promoting newborn screening. The Work Group will assist in developing a program that ensures the availability of and access to quality newborn screening and follow-up services as well as interact with the MTPHL and CSHS and make recommendations about the design, implementation, and improvement of the program.

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)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	54.2	54.5	55	55.3	55.6
Annual Indicator	54.0	54.0	54.0	54.0	56.5
Numerator	188	188	188	188	
Denominator	348	348	348	348	

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	56.5	56.5	56.5	56.5	56.5

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

A sample of parents representing multiple regional pediatric specialty clinics were surveyed at the Regional Pediatric Specialty Clinics in Billings and Missoula. The surveys are not identical but represent parent satisfaction. All respondents reported a satisfaction rating of over 91%. Gaol for 2006 is 93% with a standard survey tool developed by clinic site, CSHS, and parents.

a. Last Year's Accomplishments
In June 2007, the Children's Special Healthcare Services (CSHS) Activity Plan, which functions as an accountability tool for the CSHS staff to track and monitor program activities and performance, was presented to the CSHS Advisory Subcommittee for their input and approval. The CSHS Advisory Subcommittee meets twice a year and reports and provides recommendations to the Family Health Advisory Committee. A current list of subcommittee members is attached.

CSHS continued to collaborate with Parent's Let's Unite for Kids (PLUK) on a number of issues. Plans to develop an educational resource material for families dealing with transition issues related to their child with special health care needs (CSHCN) moving into young adulthood was a primary focus this past year. Additionally, PLUK participated on the CSHS Advisory Subcommittee. http://www.pluk.org/

CSHS paid a parent's registration fee to attend the Association of Maternal and Child Health Program's (AMCHP) 2007 National Meeting. The parent shared her experience with the CSHS Advisory Committee and opined that more parents might prefer reimbursement for direct services or specific information related to their child's diagnosis rather being offered the opportunity to attend a national conference. The parent also shared that if CSHS were to continue providing funds for attendance at national conferences, it would be beneficial for parents to be prepped prior to their attendance.

A Regional Pediatric Specialty Clinic Survey (RPSCS) was collected from a parent or guardian who had attended a specialty clinic with their child. The initial results indicated an "overall great or good" score of 91% and the parents/guardians also provided feedback related to their overall clinic experience and the clarity in which the clinic's services were explained. CSHS also continued conducting clinic exit interviews which allow clients to provide feedback on their experience and clarify information they have received.

Monthly telephone conferences were held with the three regional clinic coordinators and included a discussion of the clinic survey results. Issues such as how to schedule appointments so as to meet the parent needs relating to transportation and weather conditions were discussed and solutions shared amongst the CSHS and clinic coordinators.

CSHS offered the CSHS Financial Program to over 90 families, with each family receiving a stipend, which is a set amount of funds, for their use on services not covered by insurance, yet necessary for their child's treatment plan. CSHS consoled each parent on how best to maximize their child's allocation prior to CSHS reimbursing the child's provider.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued active parent participation in CSHS Advisory Subcommittee to the Family Health Advisory Council.				X
2. Review comments from exit interviews for program modifications at the Regional Pediatric Specialty Clinics.				X
3. Ongoing collection and analysis of the Client Satisfaction Survey from the Regional Pediatric Specialty Clinics.				X
4. Parent participation and input on the CSHS Activity Plan.				X
5. Partnership building with Parents Let's Unite for Kids (PLUK), MSDB, parents and CSHS.				X
6. CSHS Medical Director to continue to provide technical assistance and guidance				X
7.				
8.				
9.				
10.				

b. Current Activities
CSHS continues to have regular contact with Dr. Laura Nicholson, CSHS Medical Director.

CSHS and PLUK developed "Montana Parent's Handbook on Transition: Adult Living", released in May 2008, which provides comprehensive transition information for CSHS parents/clients. CSHS also assisted PLUK on the Family to Family Health Information and Education Center Grant application. This grant includes activities aimed at addressing the transition issues faced by the CSHS population.

The CSHS Advisory Subcommittee underwent changes to expand community and parent representation.

This year's Client Satisfaction Surveys indicate that some families travel up to 300 miles to attend specialty clinics. An Advisory Subcommittee work group was identified in May 2008 to research how CSHS might assist with this concern.

A CSHCN Parent participated in the interview process for the Newborn Screening Program Specialist, who began work in January, 2008.

CSHS continues to work with parents to determine how best to maximize the CSHS stipend that they receive for uncovered medical services for their child.

c. Plan for the Coming Year
The Client Satisfaction Survey process at the regional pediatric specialty clinics will continue at intervals through FFY 2009. CSHS will analyze and share the date results with the clinic

coordinators with the intent for these groups to determine feasible workable solutions to common concerns

The CSHS Advisory Subcommittee work group will continue to evaluate how CSHS might be able to assist families with the costs of transportation to specialty clinic and follow up appointments and therapies that were recommended at a clinic evaluation.

CSHS will continue to promote parent participation by sponsoring parent attendance at workshops and seminars related to their child's condition, and through expanded parental participation on the CSHS Advisory Subcommittee.

CSHS will continue to work with parents in choosing how to spend their allocated CSHS funds as related to their child's diagnosis and treatment plan that is covered by CSHS.

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)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	52	52.2	60.2	52.6	52.6
Annual Indicator	51.7	51.7	51.7	51.7	45.9
Numerator	361	361	361	361	
Denominator	698	698	698	698	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	50	50	50	50	50

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006

Notes - 2005
In 2004, number was calculated on 12.8% of population under age 18 x CSHS program data for CSHCN with medical home. For 2005 reporting, CSHS is maintaining the reporting of national survey data for continuity purposes. Program data on Primary Care Providers among the CSHCN population is reported in narrative section.

CSHS continues to emphasize coordination of care between pediatric specialty clinics and primary care providers. With the addition of the 3rd Regional Pediatric Specialty Clinic Site in 2006, this number is expected to grow. Continued education of primary care providers though staff attendance at th Montana Academy of Pediatrics annual meeting and other onsite visits are

also expected to support this PM.

Following the MCHBG review, the targets for 2006 - 2010 were reset to more realistically reflect the data source being used.

a. Last Year's Accomplishments

The importance of establishing a medical home was a component of the Children's Special Health Services, (CSHS) activity plan. CSHS provided support and education to help families establish medical homes as a part of healthcare coordination for their children through the Regional Pediatric Specialty Clinics (RPSC) and CSHS client contacts. The CSHS website provided medical home information links for providers and parents, success stories of individual children; and links to multiple community resources such as Parents Let's Unite for Kids (PLUK) and Montana School for the Deaf and Blind (MSDB). http://www.dphhs.mt.gov/PHSD/family-health/cshs/cshs-index.shtml

Client-specific Primary Care Provider (PCP) information was tracked through the Child Health Referral and Information System (CHRIS) using information from the CSHS financial assistance program and the Regional Pediatric Specialty Clinics. Data collected in the past year, indicated that 67% of the families reported that their child had a primary care provider. During visits to the multi-disciplinary specialty clinics, referrals were routinely made to Primary Care Physicians for follow-up care. The PCP is considered an extended member of all the multidisciplinary teams and is responsible to ensure that follow-up care has been provided to the child.

CSHS sponsored 341 regional clinic days attended by over 2781 clients and their families. At each clinic visit, information about the child's PCP is reviewed and clinic reports are provided to the PCP for follow up care.

CSHS and the RPSC Coordinators attended the Fall 2007 Montana Academy of Pediatrics meeting and participated in the discussion about the medical home concept.

CSHS also participated on a Montana Pediatric Academy sub-committee that addressed issues such as service delivery, the need for corresponding required documentation, and the importance of adequate provider reimbursement as related to the medical home concept.

CSHS continued to contract with Laura Nicholson MD, a Developmental Pediatrician and the CSHS Advisory Subcommittee Chair, to provide monthly advisory assistance on several issues including the medical home concept. She also continued to educate peers within the medical community about the medical home concept.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All regional pediatric specialty clinic participants are tracked and referred to medical home as needed	X			
2. Analyze data from 2006 CSHCN national needs assessment.				X
3. Continue to support and update the Children's Special Health Services (CSHS) web-site, which includes medical home links.				X
4.				
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
CSHS subscribes to Pediatric Clinics of North America, Exceptional Child, Spina Bifida, and PKU News and continues to share articles with the Clinic Coordinators and CSHS staff.

CSHS continues to participate on the Montana Academy of Pediatrics (MAAP) subcommittee to address topics such as reimbursement rates, transportation issues, and how to increase the number of children with a medical home.

Clinic Coordinators continue to be directly responsible for ensuring that each child seen in the RPSC has a primary care provider (PCP) and that all treatment recommendations from specialty clinics are communicated to the PCP for coordination and continuity of care.

CSHS continues to collaborate with Dr. Laura Nicholson who provides project planning advice, identifies strategies to define the medical home concept, and continues to promote the medical home concept within the statewide pediatric community.

The CSHS section supervisor attended the Annual Association of Maternal and Child Healthcare Partnerships meeting in Alexandria, VA in 2008 to obtain information about how the medical home concept can be actualized in a rural state like Montana. One especially relevant seminar emphasized the importance of communication among healthcare providers to maintain and support the child's medical home. This issue continues to be a topic of discussion for the CSHS Advisory Subcommittee.

c. Plan for the Coming Year
CSHS plans to continue the relationship with Laura Nicholson, MD, to provide support and direction for the CSHS in addressing the issue of all CSHS having a medical home, as well as acting as the CSHS spokesperson in the pediatric community.

CSHS will continue to work with and train the Regional Pediatric Clinic Coordinators on the importance of a medical home for each child seen at their clinics.

CSHS plans to begin the process of web-enabling the Child Health Referral and Information System (CHRIS) software application by developing functionality to allow a child's PCP to view specialty clinic schedules with specialty provider information, to make electronic client referrals for new and existing clients for clinic evaluations, and to access newborn screening (hearing and metabolic) information for their clients. The electronic capability will provide PCPs with current information about available services statewide and do much to facilitate care for newborns and CYSHCN. CSHS will focus on providing training and technical assistance to the individuals involved in the newborn screening data collection and entry so as to ensure that information provided to the medical home is of high quality and accurate.

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)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	50	50.3	78.5	50.4	50.5
Annual Indicator	48.8	48.8	48.8	48.8	55.2

Numerator	350	350	350	350	
Denominator	717	717	717	717	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	55.2	55.2	55.2	55.2	57

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2005
These data are from the National CSHCN Survey results. Verification of specific benefit plan coverage is not addressed. Children's Special Health Services (CSHS) continues to work to improve adequacy of coverage through partnerships with Montana Medicaid, CHIP, and other insurance companies.

MCHBG reviewers noted the 78.5 target was very high. Note subsequent year targets had been made prior to initial MCHBG submission.

a. Last Year's Accomplishments
In 2007, Children's Special Health Services (CSHS) provided services to a total of 3877 children through the Regional Pediatric Specialty Clinics (RPSC) and the CSHS program. Among these children, 62% reported some type of health care coverage. RPSC and CSHS staff provided care coordination and support for clients and their families in order to identify cost effective care and limit out of pocket expenses. The status of all clients' health care coverage was assessed and clients who did not have adequate insurance coverage were given information about other payee sources such as the Children's Health Insurance Program (CHIP), Medicaid, and CSHS.

The Children's Health Insurance Program (CHIP) referred 382 children to the Children's Special Heath Services in 2007. The 2007 Montana Legislature passed SB22 which allowed CHIP to increase their coverage of children whose families make up to 175% of the poverty level which increased the number of children covered by the CHIP program and decreased the number of children previously eligible for and needing financial assistance from the Children's Special Health Services program. CSHS continued to partner with CHIP to provide funding for services not covered by the CHIP program such as reimbursement for hearing aids, nebulizers, and coordination of services. http://data.opi.mt.gov/bills/2007/billhtml/SB0022.htm

CSHS continued to provide limited direct pay financial assistance for specialty care to qualifying uninsured and underinsured families who were at or below 200% of the poverty level. In FFY 2007 $90,079 was spent on 90 children. Families were encouraged by CSHS staff to actively manage their child's health care dollars by identifying the services they wanted covered by CSHS dollars which therefore increased family participation and satisfaction. In addition, CSHS staff continued to provide education to families about advocating for assistance from hospitals and other providers for services for their children.

A partnership between Developmental Disability Services (DDS) and CSHS continued to provide Supplemental Security Income (SSI) applicants with resource and referral information on other healthcare coverage options. A general letter about the CSHS program and contact information was mailed to 10% of the applicants.

CSHS implemented a process to bill insurance companies for Metabolic and Cleft/craniofacial multi-disciplinary clinics during FFY 2006 and began receiving reimbursement from Medicaid and CHIP. During FFY 2007, staff made presentations to three major third-party payers about cleft/craniofacial disorders and metabolic disease in order to establish the critical role of multi-disciplinary teams for a coordinated treatment plans and develop favorable policy interpretation for children with special health care needs. Insurance companies began to intermittently reimburse for multidisciplinary clinic evaluations and appeals were made on a case by case basis for denied claims. Money generated from specialty clinic billing was used to support clinic services.

CHIP and private insurance coverage for hearing aid benefits for children was pursued in 2007.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued limited financial assistance for medical services.	X			
2. Continued partnership with Medicaid program regarding specialty services in Montana.				X
3. Ongoing shared referrals with CHIP.		X		
4. Communication with providers to accept negotiated rate				X
5. CSHS established provider status with Medicaid and CHIP for multidisciplinary team clinics.		X		
6. Continue to partner with Medicaid and CHIP for approval of payment for orthodontic care for CSHCN with craniofacial conditions.		X		
7. Provide information to CHIP and other insurance regarding coverage needs of CSHCN.				X
8.				
9.				
10.				

b. Current Activities

CSHS and RPSC staffs continue to assess client health care coverage at every contact.

CSHS continues to partner with CHIP and Medicaid to increase access for needed benefits for CYSHCN. Their partnership was successful in increasing the number of Missoula orthodontists willing to participate in the cleft/craniofacial clinics.

Hearing aides are now a covered CHIP benefit. CSHS is working with CHIP and the Montana School for the Deaf and Blind (MSDB) to determine a hearing aid service fee schedule.

As of June 30, 2008, CSHS assisted 73 families with their ability to pay for their child's specialty care.

CSHS continues to partner with the Disability Determination Bureau to provide SSI applicants with information about the availability of other programs that may provide them with assistance.

Current year billing of insurance companies for metabolic and cleft/craniofacial clinics has provided additional revenue to augment the RPSC sites. The specialty care at the regional pediatric clinic sites saves many families from the necessity of costly travel out of state to access services.

c. Plan for the Coming Year
Through the Regional Pediatric Specialty Clinics (RPSC), CSHS will continue to educate families regarding health coverage options such as CHIP, Medicaid, and private insurance.

CSHS will continue to provide ongoing education to RPSC staff about private insurance options, prior authorization, waiting periods, and pre-existing exclusions with the goal that this type of education will assist in having the Clinic Coordinators and all health care providers collaborating and coordinating care for their mutual clients.

In the coming year, the Regional Coordinators will be trained on how to educate the families to develop productive working relationships with their insurance companies and how to communicate with billing offices of hospitals, laboratories, and other health care providers. Coordinators will explain to families how to request written explanations of charges from the insurance carrier as well as how and why careful follow up is important to ensure that all the allowable charges are paid for by the family's insurance carrier.

CSHS plans to continue working with CHIP, Medicaid, and private insurance regarding issues important to CYSCHN.

CSHS staff is planning to continue communication with insurance companies, working to maximize reimbursement for clinic multi-disciplinary evaluations and educate them about the cost benefit analysis of a multi-disciplinary team concept.

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)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	71.9	72.2	72.4	72.6	72.8
Annual Indicator	71.6	71.6	71.6	71.6	88.6
Numerator	250	250	250	250	
Denominator	349	349	349	349	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	88.6	88.6	88.6	88.6	90

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2005
For 2005 reporting, CSHS is maintaining the reporting of national survey data for continuity purposes.

Initial steps in the development of the 3rd Regional Pediatic Specialty Clinic were taken. Funding to contract with a community provider was available January of 2006. This 3rd site will provide regional access across Montana, thus assuring families of easier access to special care and coordination of follow-up at the community level. Standarized parent satisfaction surveys will be developed and conducted at this site.

a. Last Year's Accomplishments

Children's Special Health Services (CSHS) continued to focus on the support and expansion of the Regional Pediatric Specialty Clinics (RPSC) which provide families with regional access to specialty clinic care. There were three RPSC sites, located in Missoula, Great Falls, and Billings. Information about the RPSC and CSHS can be accessed at http://www.dphhs.mt.gov/PHSD/family-health/cshs/cshs-index.shtml

In collaboration with the Indian Health Services (IHS) providers, CSHS sustained the rural cleft/craniofacial clinics in two remote reservation areas in Browning and Wolf Point for the Blackfeet Tribal Nation and the Assiniboine & Sioux Tribal Nation respectfully. Follow up care was provided by the public health providers in conjunction with IHS.

The 3rd North Central RPSC site in Great Falls, which began providing services in April 2006, provided services to 601 children through 7 different specialty clinics, including cystic fibrosis, pediatric rheumatology, cleft/craniofacial, endocrine, metabolic, genetic, and nephrology and endocrine.

To help with regional access for families, the Helena South Central Metabolic Clinic was transferred to the Regional Pediatric Specialty Clinic in Great Falls in April 2007. The Great Falls RPSC nurse coordinator provided family support as children transitioned to a new clinic location.

The North Central and Western RPSC sites added nephrology clinics 2 times per year thus saving many families a trip to Seattle. A total of 44 children were seen in Nephrology clinics during FFY 2007.

CSHS staff continued to support the RPSC Coordinators, who are a vital link between CSHS, their institutions and the families accessing services at the pediatric sites, with continuing education through monthly telephone conferences and onsite data and other trainings.

The RPSC Coordinators conducted Client Satisfaction surveys for the Cleft/craniofacial and Metabolic Clinics. Results from the surveys rated overall clinic services as 91% good/positive. Results also indicated that Specialty Clinics were held "the right amount of times" (75%) versus 8% "not often enough." The Coordinators also continued to provide individual one on one exit interviews with the clients/families to assure the parents understand the team recommendations, have the opportunity to ask additional questions and to assess how much assistance families will need to implement planned treatment activities.

CSHS continued to expand the Child Health Referral and Information (CHRIS) software application and database allowing partners, such as the Montana School for the Deaf and Blind (MSDB), to use CHRIS as a case management tool to track CYSHCN services.

CSHS requested legislation through the Executive Planning Process to support the RPSC infrastructure. The request was denied; however, CSHS provided the clinic sites with additional funding through the clinic billing process.

Montana's public health nurses, who provide home visiting services to CYSHCN, assisted the families in accessing services such as specialty clinic evaluations and programs such as CHIP. Medicaid targeted case management provided some funding to support these activities.

CSHS involvement with the Medicaid Targeted Case Management (TCM) Work Group was

suspended during FFY 2007 due to Medicaid staff changes. In a rural state, Medicaid TCM is an important source of funding for Public Health Home Visiting which is an important link to services, especially those related to CYSHCN case management.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ongoing financial support, training and consultation for Regional Pediatric Clinic Sites				X
2. 3rd Regional Pediatric Clinic Site expanding.			X	X
3. Electronic link with Montana School for the Deaf and Blind (MSDB) established-facilitates tracking/shared services for hearing and vision impaired infants, children, and youth.				X
4. Conduct outreach to community partners				X
5. Partnership with Parents Lets Unite for Kids (PLUK) for resource manual for parents.				X
6. Utilize clinic billing money to support Regional Pediatric Specialty Clinic Sites.				X
7. Standardize all CHRIS reporting for users, i.e. Registered Dietician's, Clinic Coordinators, NBS Coordinator, and Shodair.				X
8.				
9.				
10.				

b. Current Activities

CSHS continues to support the 3 RPSC and the two reservation cleft/craniofacial clinics with financial support; ongoing continuing education for the RPSC Coordinators including a presentation from the MSDB on diagnosis of deafness and loss of hearing and current treatment options and recommendations; collaborating with Utah Leadership Education in Neurodevelopmental Disabilities Regional Program (ULEND) to provide additional metabolic nutrition training; and when necessary financing specialist to travel to a RPSC such as Helena's Pediatric Neurologist travels to the Great Falls RPCS.

CSHS continues as a network provider for additional insurance companies thus allowing CSHS to use the insurance billing revenue to provide additional funding to the RPSCs.

A new partnership was created this year with the Shodair Children's Hospital beginning to use the CHRIS system in conjunction with MSDB and CSHS.

CSHS is now participating on the TCM Work Group to assure representation of CYSHCN case management issues.

CSHS recently was awarded an Early Hearing Detection and Information grant to be used for enhancement of their current newborn screening activities.

CSHS continued active outreach to other public and private agencies providing services to CYSHCN. Staff completed community visits to Bozeman, Helena, and Great Falls and talked with hospital discharge staff, Public Health nurses, Newborn Intensive Care Units/nursery staff, and Early intervention staff.

c. Plan for the Coming Year

CSHS will continue to collaborate with and provide support to the three RPSC sites and Wolf Point and Browning outreach sites. The Cystic Fibrosis and Pediatric Rheumatology clinics will be undergoing some changes this coming year because the state specialists providing those services are either retiring or changing positions. Maintaining these two clinics will be a primary focus this coming year.

CSHS will continue to evaluate the services provided at the RPSC sites by utilizing the information that is obtained from the Client/Parent Surveys and exit interviews. This information forms the basis for future coordinator training topics as well as providing the CSHS staff with client/parental insight on how to improve clinic services to better meet the client/parent's needs.

The FCHB will continue to collaborate with public and private community based partners such as IHS, MSDB, the Shodair Children's Hospital Medical Genetics Program, The Follow the Child Project foster child home visiting program, and Parent's Let's Unite for Kids. These partnerships strengthen the CSHS' abilities to develop child and family focused programs as these organizations are all about child/family focused programs.

CSHS will maintain its current web site and the CHRIS database so as to make available up to date information and links to important sites for parents and medical providers.

If CSHS's Early Hearing Detection and Information grant is funded, it would provide funds to start the process of web-enabling the CHRIS application allowing primary care providers (PCP) access to the RPSC schedules resulting in a more seamless referral of a CYSHCN to an appropriate provider within their local region. Additionally, CHRIS would be updated to make available newborn screening results for providers to share with newborn's parents.

CSHS staff will continue to participate in the Medicaid TCM work to assure a funding source for Public Health home visiting to CSYSHCN.

CSHS staff will continue outreach efforts to other communities in the state with the goal of visiting at least five additional sites within the next FFY.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	6	6.5	6	6	6.5
Annual Indicator	5.4	5.4	5.4	5.4	46.2
Numerator	8	8	8	8	
Denominator	147	147	147	147	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	46.5	46.5	46.5	46.5	47.5

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2005
No change has been made in the data from previous year.
Transition issues are addressed for all youth aging out of Regional Pediatric Specialty Clinics services and CSHS addresses transition of health care for youth aging out of the CSHS financial assistance program.

During the 2004-2005 school year 944 students graduated from regular high school with an active IEP, which is required to contain transition information. The degree of health transition information included in IEP's is undefined. CSHS plans to work with OPI and other community and state agencies to determine how best to participate in inclusive transition planning.

Targets reviewed - no change made.

a. Last Year's Accomplishments
On a one-to-one basis, Children's Special Health Services (CSHS) staff and clinic coordinators provided information on transition issues, such as the names of health care providers who offer their services and insurance coverage options, to the youth and their families.

Results from screenings conducted at the three Regional Pediatric Specialty Clinics, were reviewed by the CSHS staff and clinic coordinators. These results identified other issues faced by patients and their families during the transition period. The Cleft/Craniofacial screening results indicated that many of their challenges included trying to complete treatment prior to the youth losing their parent's insurance or the need to wait for the youth to finish other required treatments or complete their growth and developing an acceptable treatment plan as the youth transitions to young adulthood, were similar to that of other clinics. Montana's treatment data suggests that adolescent males may not complete treatment as teens, which appears to be true of other team data. An identified barrier to health care transition in Montana is obtaining a medical home with an appropriate treatment plan that is acceptable to both parents and the young adult client.

The CSHS Sub-Committee composed of seven pediatric physicians, three clinic coordinators, and three parents, met quarterly and discussed the barriers identified by the clinic surveys and generated possible solutions for addressing these unique transition issues faced by this population.

CSHS collaborated with numerous public and private entities on how to provide transition services, within the parameters of what is available in the state of MT, and the information and knowledge gained at these encounters was shared with clinic coordinators, local public health agencies, and other interested parties. CSHS participated on the Part C: Family Support Advisory Subcommittee (FSAS); the Office of Public Instruction's Joint Committee for Healthy Kids (OPI/JCHK); the University of Montana's Rural Institute Training Program (UM RITP); and the Catalyst Center Topical Conference (CCTC) call series. Staff also attended the Mountain States Genetics Regional Collaborative Center's and the Montana Children's System of Care Conferences.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Provide limited support to youth receiving financial assistance for Children's Special Health Services (CSHS) and at regional clinic visits regarding health care transitions		X		
2. Offer financial support and information to pre-teens and teens for peer educational opportunities.				X
3. Communicate and provide input to the MT-TIRC Advisory Board				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CSHS staff continues to participate on the Part C: Family Support Advisory Subcommittee, OPI/JCHK, the UM RITP, and the CCTC call series to learn more about transition issues and shares this information with the clinic coordinators and others.

CSHS attended meetings of the Mountain States Genetics Regional Collaborative Center and the Montana Children's System of Care Conference that also addressed the transition process.

CSHS assisted the American Cleft Palate Association in planning their April 2008 Pre-Conference Symposium to discuss transition issues.

CSHS in partnership with PLUK developed "Montana Parent's Handbook on Transition: Adult Living", which provides comprehensive transition information. The publication was released for distribution May 2008. The Regional Pediatric Specialty Clinic Coordinators, CSHS, PLUK and the Office of Public Instruction are coordinating the distribution of the handbook.

A FCHB Staff member was appointed to the advisory board of the Montana Transition Training, Information and Resource Center (MT-TIRC), whose mission is to provide access to timely, high quality transition information, training, and resources for young people with developmental disabilities, their families, and their communities. The first meeting of this advisory board was held on June 16, 2008 in Missoula and the information learned at this meeting as well as future meetings will be shared with the CSHS staff and the Family Health Advisory Council.

c. Plan for the Coming Year
CSHS and Clinic Coordinators plan to begin offering Metabolic Camp scholarships to teenagers earlier in the year with the goal of increasing the numbers of eligible youth attending the camps. The attendees will be asked to provide their insights as to the usability and clarity of the transition information provided at the camps for continuing the scholarship assistance.

With input from the CSHS Advisory Subcommittee, CSHS plans to develop or adopt a standard transitional care questionnaire for the three clinics. This questionnaire will focus on the medical aspect of the transition from childhood to adulthood, including managing the medical condition, obtaining health coverage and services, and follow through with the treatment plan.

The FCHB staff member who is serving on the Montana Transition Training, Information and Resource Center advisory board, will continue to attend the meetings and provide information to the CSHS staff, clinic coordinators, and the CSHS Advisory Subcommittee through the end of her

appointment on July 2, 2009. The MT-TIRC plans to develop a transitional care questionnaire to examine the feasibility of offering social services, or financial assistance during this transition period. CSHS will work with the Bureau's representative on the development of this data collection tool which will include input from the 15 members, including two parents of children with special needs and five young adults with developmental disabilities.

CSHS will continue to discuss with the three Regional Pediatric Specialty Clinic coordinators the Client Survey Results and develop strategies whereas to make certain that there is communication between the client and health care provider so as to ensure that young adults are involved in the decision-making process of their treatment plan which includes transition planning.

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.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	90	90	91	80	80
Annual Indicator	89.7	90.9	79.6	73.6	74.9
Numerator	2440	2603	12952	12231	
Denominator	2721	2864	16271	16618	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	80	80	80	80	80

Notes - 2007
The source of data is the National Immunization Survey (NIS), July 2006-June 2007 data (http://www2a.cdc.gov/nip/coverage/nis/nis_iap.asp?fmt=v&rpt=tab03_antigen_state&qtr=Q3/2006-Q2/2007). Please note that the 95% confidence interval for this indicator is +/- 5.7. A numerator and denominator were not readily available for this data, therefore none are included. These data are expected to be updated once the final 2007 data are available.

A survey of providers indicates that the average vaccination rate among children who are able to access a provider is 81.2%. This rate includes Varicella as one of the antigens. The series evaluated in the 2007 provider survey was 4DTaP: 3Polio: 1MMR: 3Hib: 3HepB: 1Varicella. Using a census estimate of 11430 two year olds in the state, this survey would indicate that 9,281 children who were seen by providers had completed their immunizations by the end of their second year.

An electronic immunization registry was established in Montana several years ago. Participation in the registry has been gradually increasing since its inception. Until the statewide registry is more complete, we will continue to use the NIS as the source of data.
According to the NIS survey, Q3/2006-Q2/2007, 68.2% (+6) of two year olds had completed the series of 4DTaP: 3Polio: 1MMR: 3Hib: 3HepB: 1Varicella. Using the same census estimate, this

would indicate 7,795 children were up to date by the end of their second year. The NIS survey includes children who may not have a medical home.

Notes - 2006
The source of data is the National Immunization Survey (NIS) (http://www.cdc.gov/vaccines/stats-surv/nis/tables/0506/tab03_antigen_state.xls). Please note that the 95% confidence interval for this indicator is +/- 6.3. The numerator and denominator are estimates based on the NIS report of 73.8% of MT children 19 to 35 months with appropriate vaccination coverage. The denominator is pulled from the estimated population of MT children listed in the NIS 2006 User's Guide.

A survey of providers indicates that vaccination rates among children who are able to access a provider (the data source in previous year) remain high, around 90%. The data source was changed to the NIS this year, and 2004 data were revised to reflect NIS data to be in closer compliance with the MCHBG guidance.

An electronic immunization registry was established in Montana several years ago. Participation in the registry has been gradually increasing since its inception. 2006 registry data reported 7145 children who have completed their immunization schedule by the end of their second year. Using an census estimate of 11692 two year olds in the state, this provides an indicator of 61.1%. However, not all providers participate in the registry and not all IHS sites are reporting. We expect the indicator from this source will increase as reporting improves. In the meantime we will use the NIS as the source of data.

Notes - 2005
PLEASE NOTE: In 2008 the data source for immunization rates in 2005 was changed from a provider survey to the National Immunization Survey (NIS) estimates. This provides three years of data for MT using the same source (2005, 2006 and 2007), and also more closely follows the MCH Block Grant guidance on data sources for this indicator. The notes below are for the previous data reported (indicator was 91.9, numerator was 2568, denominator was 2,793).

The data for this performance measure are collected using an immunization survey, which samples public and private immunization providers throughout the state. The data were collected from 53 of the 56 counties, including Tribal and IHS clinics, and represent 25% of the birth cohort. The survey only collects data on children ages 24-35 months. The policy of the Montana immunization program is to only consider children to be late in receiving all age-appropriate vaccinations when they have reached 24 months. While they do evaluate coverage at 19 months, they only asssess actual coverage and lack of coverage among 24 month-olds and older.

The state recently implemented an electronic immunization registry. This registry is expected to provide population-level data on Montana's immunization rates within the next several years as reporting improves and links with vital statistics data are developed.

The numerator represents the number of children assessed by the survey who were appropriately immunized. The denominator represents the number of children assessed.

The immunization rate refers to the series combination of 4 DTaP: 3 Polio: 3 Hib: 1 MMR: 3 Hep B. For 2005, the 4:3:3:1:3 rate was 91.9%, exceeding our objective.

During the next year, varicella will be added to the required vaccine regimen. Because of this change, the immunization rate is expected to drop, then gradually increase as varicella vaccination rates increase.

a. Last Year's Accomplishments

The statewide immunization information system (SIIS) has been rolled out to 110 private provider sites in a "read only" role. The "read only" role allows private providers to query a client's immunization history from the SIIS and print out a Montana Blue Form as well as other reports. The Blue Form is used to show the vaccines history of the student which is required for pre-school and school entry.

The Reading Well Collaborative partnership with Medicaid and the Office of Public Instruction (OPI) continued in 2007. This collaborative partnership was developed several years ago when Medicaid was doing charts pulls to verify how Medicaid dollars were used for children immunization. It was determined that it would be easier and benefit both Medicaid and the State Immunization Program if the SIIS was used. To encourage parents to allow their children's vaccine history to be entered by the local health jurisdiction into the SIIS, they were given a children's book for every child's record aged 24 to 35 months. OPI partnered in March 2004 and the program age was extended to include all Montana children aged 4 years or older who received their kindergarten shots.

A baseline for the percent of children who received a 2nd MMR prior to kindergarten was established in 2004. In that year, 81.43% of children had received a 2nd MMR prior to kindergarten. By 2006, 98% of new kindergarteners had received a 2nd MMR, and the percent remained fairly high at 96% in 2007. 445 of 461 schools (97%) participated in the survey to determine the coverage of 2nd MMRs. The participating schools had an aggregate enrollment of 11914 kindergartners, representing 99% of the total enrollment (11976) in all the surveyed schools. Exemptions for religious reasons were claimed by 164 (1.38%) students and 29 (0.24%) students at the surveyed schools had medical exemptions.

Varicella single antigen immunization rates of 2 year old children in Montana, as measured by the July 2006-June 2007 National Immunization Survey data, indicate that 82% have received the first dose of varicella vaccine, up from 76% in the 2006 survey. Although the confidence intervals on the estimates are wide, the data suggest that coverage rates are gradually increasing. The status reported by the health education specialists after clinic reviews during 2007 found that 87% of the children aged 24 -- 35 months seen in provider offices have received the varicella vaccine or have a record of chickenpox disease.

The Tdap/Td booster rate for children in grade 7 was just 76%. The local public health nurses were working with the schools to vaccinate those children who were inappropriately attending class without their Tdap/Td booster or a signed exemption to the vaccination.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The statewide immunization information system (SIIS) will have the following functions performed: de-duplication of data; a comparison of hepatitis B newborn doses administered to the total births per county; and an assessment of immunization practic				X
2. SIIS education for medical personnel in local health jurisdiction to access immunization records will be provided to school nurses, local hospitals, emergency rooms, and private provider offices				X
3. The vaccine status of children in daycare facilities will be assessed.				X
4. The vaccine status of children in kindergarten and grade 7 will be assessed.				X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
Electronic import of records from the birth registry into the SIIS has been delayed by the contractor for Vital Statistics. Significant issues were detected in the test files. When the IT contractor completes the work for Vital Statistics, another test file will be requested.

The electronic import of immunization records from the Indian Health Service are currently conducted weekly by one Tribal Health Department. The other Tribal Health Department's MOU is not yet in place. Nurses in that Tribal Health Dept. are entering their immunization records directly into SIIS.

All Vaccine for Children (VFC) providers will be visited in 2008 by State Immunization Staff. Problems identified regarding vaccine storage, handling and delivery issues in 2007 that required corrective action will be re-evaluated in 2008.

The Cervical Cancer Task Force completed their evaluation of the HPV vaccine issues in Montana. The HPV vaccine, purchased with $400,000 of state funds, will be made available to county health departments, Title X clinics and Community Health Centers for insured children 9 yrs -- 18 yrs, who are insured but the policies require high deductibles or co-pays. Other eligible females will be those aged 19 -- 26 years who have no other means to pay for the vaccine. This vaccine will be available on July 1, 2008. The adolescent nurse consultant is developing the vaccine distribution plan and working with schools and public health to provide educational material.

c. Plan for the Coming Year
1) Focus on the varicella vaccinations for day care attendance.

2) Continue improved varicella surveillance. The WIZRD (Web-base Immunization Registry Database) SIIS can record disease history for chickenpox, which may have an impact on adolescent surveillance. WIZRD now allows the capability to record history of chickenpox disease. By identifying those adolescents that have had chickenpox, we can concentrate efforts during a school or community chickenpox outbreak on the adolescents and younger children that have not received 2 doses of varicella vaccine.

3) Continued focus on the Tdap/Td booster rates for children in grade 7. Emphasis has been placed on decreasing the number of cases of pertussis in the school setting, to encourage active participation with school nurses, school administrators as well as the local public health nurses.

4) Educational brochures regarding HPV for girls ages 9 -- 18 will be offered to the schools for distribution to the parents. The brochures include all other adolescent vaccines, so will be appropriate for both genders.

5) Regional Immunization Workshops for Local Health Jurisdictions will be conducted during the coming year. These workshops are our annual opportunity to provide updates as well as training in the 5 regions of the State of Montana. New training each year, and update information that has been provided in previous trainings will be introduced.

6) The 4th dose DTaP immunization rate for 2 year old children in Montana has risen to 78% from 76%. While the trend is up, this is still an important area for improvement for 2008, to assist

in lessening the impact of pertussis on the local communities. The immunization staff will continue improving the DTaP immunization rate.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	18.5	18	15	9.6	17
Annual Indicator	15.4	17.3	17.0	17.6	16.4
Numerator	330	349	349	359	335
Denominator	21378	20144	20551	20453	20417
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	16	16	15	15	15

Notes - 2007
The data are provisional, as reporting for births that occurred to MT residents outside of Montana is not yet completed. The denominator is the latest census estimates for females ages 15-17 in MT in 2007.

Notes - 2006
Numerator data includes births to resident teens (regardless of place of occurrence) ages 15-17 from vital records. Denominator data is census estimates for 15-17 year old girls in Montana in 2006. The objective for 2006 was determined based on data reported in previous years that made the indicator appear lower than it actually was. The indicator was updated for the July 15, 2008 submission.

Notes - 2005
Numerator data includes births to resident teens (regardless of place of occurrence) ages 15-17. Denominator data came from the 2005 estimates for 15 to 17 year old girls in Montana. Denominator was updated in 2008.

a. Last Year's Accomplishments
Pregnancy prevention was identified as a need by adolescents in the 2005 Maternal and Child Health Needs Assessment. The Women's and Men's Health Section (WMHS) of the Family and Community Health Bureau (FCHB) maintained contracts and provided technical assistance to 14 Delegate Agencies (DA) offering services in 27 locations serving all 56 counties in MT. Three WMHS staff members, the Health Education Specialist and two Program Specialists, served as state level contacts for technical assistance and data related issues. See webpage for the locations. http://www.dphhs.mt.gov/PHSD/Women-Health/directory.shtml

The Delegate Agencies assured that women and men of reproductive age, including adolescents, had access to comprehensive reproductive health care, educational information and services that included how to prevent unintended pregnancy. The agencies' sliding fee schedules, based on family size and income, also ensured the affordability of these reproductive health services and

supplies.

In the 2007 calendar year, Delegate Agencies served an estimated 7,906 adolescents and also provided specific outreach projects designed for adolescents because they are considered at high risk for teen pregnancy and birth.

House Bill (HB) 2, passed in the 2007 Legislative Session, allocated additional State General Funds for delegate agencies to provide efficacious contraceptives to low-income clients, including adolescents.

The WMHS Health Education Specialist acted as the WMHS Teen Pregnancy Prevention Coordinator and organized a statewide campaign in May for Teen Pregnancy Prevention Month. The Health Education Specialist created outreach packets that included a press release, sample letters to the editor, posters, and educational brochures that were distributed to the Delegate Agencies.

The WMHS Program Specialist acted as a key resource for the collection of teen pregnancy data that would be included in the updated Trends in Teen Pregnancies and Their Outcomes in Montana fact sheet, replacing the 2002 report. The WMHS Program Specialist also coordinated with the FCHB epidemiologist on the final report.

WMHS received Special Initiative funding from Department of Health and Human Services (DHHS) Office of Population Affairs (OPA). These funds were distributed to Bridger Clinic for the Partners in Prevention Project. Bridger Clinic collaborated with several agencies to provide supplementary comprehensive sex education and family planning services to teen mothers and fathers and others at risk youth for teen pregnancy prevention.

The WMHS Health Education Specialist is a member of a Region VII Regional Training Advisory Council (RTAC) which meets once a year to help plan trainings for delegate agencies. RTAC reviewed training needs assessment, conducted bi-annually, from Region VII Title X programs to assist in the training plan. Trainings included education and clinical components.

The WMHS Health Education Specialist is a member of the State Family Planning Education Committee (SFPEC). The SFPEC consists of delegate agency staff which meet bi-monthly which reviewed and approved materials and identified priorities for all delegate agencies. The SPEC identified Teen Pregnancy Prevention Month as a priority and continued to coordinate a statewide outreach campaign.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. In SFY 2009, maintain contracts with 14 agencies with services in 27 clinic sites for reproductive health care, which includes funding for high-cost contraceptives.				X
2. In SFY 2009, at least 28% of FP clients served by local clinics will be 19 years and under.	X			
3. In SFY 2009, 100% of local clinics will provide outreach to youth at high risk of teen pregnancy and birth.			X	
4. In SFY 2009, the FP Education Committee will assess and coordinate training as needed for local clinic staff through a minimum of 8 conference calls.			X	
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities
WMHS continues contracting with the 14 DAs and providing technical assistance and educational and outreach materials.

The Trends in Teen Pregnancies and Their Outcomes in Montana From 1991 - 2005 Report was finalized in May 2008 and a distribution plan is being developed. The 2006 data shows that the teen pregnancy rate continues to drop for 15-19 year olds and is currently 47.8/1,000 representing a 21.8% reduction from the 1995 rate of 61.2/1,000.
http://www.dphhs.mt.gov/PHSD/Women-Health/documents/teenpregnancyreport.pdf

Special funds from OPA were also distributed to DAs for expanding male family planning services including adolescents.

WMHS ensured that the DAs received outreach packets for the 2008 May Statewide Campaign for Teen Pregnancy Prevention Month.

WMHS is assessing the potential for creating a statewide adolescent health taskforce, with the mission of examining high-risk teen age behaviors, including pregnancy.

WMHS continues to meet and discuss future training needs for delegate agencies with RTAC. At the Family Planning Conference in May 2008 a session was dedicated to adolescent counseling for clinicians.

The SPEC continues to meet and discuss materials and family planning priorities on a bi-monthly basis.

WMHS applied for Expansion Funding in SFY 2008, if awarded in SFY 2009, it would supplement the Delegate Agency's ability to expand services in underserved communities targeting low income women and men, including adolescents.

An attachment is included in this section.

c. Plan for the Coming Year
WMH intends to contract with the 14 Delegate Agencies and provide technical assistance and up-to-date outreach and educational materials to them.

The State Family Planning Education Committee (SFPEC), facilitated by the WMHS Health Education Specialist will continue their bi-monthly meetings focusing on promoting Teen Pregnancy Prevention Month through a statewide outreach campaign.

WMHS Health Education Specialist will continue to meet with RTAC to evaluate training needs for delegate agencies and Region VII Title X agencies.

WMHS Health Education Specialist will provide training on Teen Pregnancy Prevention at the Fall 2008 Montana Public Health Association Conference. The presentation will include an overview of state data released in May 2008, risk and protective factors, statewide indicators, best practices, and skills building for communities.

WMHS Health Education Specialist will provide educational materials on teen pregnancy prevention, protective and risk factors, best practices, and comprehensive sexuality education at

the Fall 2008 Parent Teacher Association Conference in Great Falls, MT.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	41	42	40	40	40
Annual Indicator	13.0	41.6	33.2	45.9	45.9
Numerator	1683	4283	3413	4693	4693
Denominator	12907	10295	10295	10225	10225
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	46	46	46	46	46

Notes - 2007
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2005-2006 school year, from the Montana Office of Public Instruction.

Notes - 2006
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2005-2006 school year, from the Montana Office of Public Instruction.

Notes - 2005
For 2004 estimates, oral health convenience data was utilized. Prior to 2004, estimates were derived from Medicaid data only. For 2005 estimates, a random oral health sample was collected. Data percentages extracted from the random sample were utilized to extrapolate the numerator applicable for this measurement, as the random sample was only a proportion of the target population.

a. Last Year's Accomplishments
The report, Montana 2005 -- 2006 Study of Oral Health Needs: 3rd Graders and Head Start Children written by Rosina Everitte, MPH consultant, reporting the results of the 2005/06 statewide stratified random sample oral health data was shared with the Family and Community Health Bureau (FCHB). The Oral Health Education Specialist (OHES) and MCH Epidemiologist ensured that the data followed the Association of State and Territorial Dental Directors (ASTDD) protocols for data collection, so as to allow Montana the opportunity to submit this information for inclusion in the National Oral Health Surveillance System (NOHSS). The NOHSS website is found at: http://www.cdc.gov/nohss

The FCHB continued to collect convenience data on third grade children provided by schools and/or Community Health Departments throughout the state on a volunteer-participation-only

basis. These entities utilized the ASTDD Behavior Surveillance Survey (BSS) to assist the communities in identifying children with oral health care needs and the state in accessing oral health data not readily available through any other data source. The BSS screened third grade children for the presence of sealant on at least one permanent molar tooth. Information regarding this nationally recognized screening tool is available at the following web-site: http://www.astdd.org

In the summer of 2007, the OHES met with Sharon Kott of the Gallatin Dental Alliance/Montana Area Health Education Center (MT AHEC) and Office of Rural Health regarding this organization's 3rd grade Oral Health School Screening Program. This independent organization is a potential model for a community-based oral health school screening program. The organization is primarily volunteer, donation driven, and partners with valuable community health entities such as dental hygienists, dentists, nursing students, and school nurses. Their oral health data is collected utilizing the BSS screening tool.

A shared partnership was established with the MT/AHEC and they are represented on the Montana Oral Health Alliance (MOHA). Their expertise helped to guide the development of the 3rd grade oral health screening component of the MOHA Community-Based Prevention Work Group (CBPWG) 5 Year Strategic Plan.

The OHES maintained membership on the Office of Public Instruction/Joint Committee for Health Kids (OPI/JCHK). This committee is an OPI/DPHHS collaboration which meets quarterly. The OHES promoted the inclusion of 3rd grade oral health screenings within the mandated School Wellness Policy.

The FCHB made application for the HRSA Targeted Oral Health Grant funding in July 2007. Montana was not among the 20 funded states.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor 3rd grade sealants in the public school system through FCHB collection of the volunteer -participation-only convenience data.			X	X
2. Write the Public Report of the analysis of the 2005-06 controlled stratified-random sample.			X	X
3. Disseminate Public Report written of the analysis of the 2005-06 controlled stratified-random sample to all oral health stakeholders.			X	X
4. Provide stakeholders with information sources that provide evidence that supports the placement of sealants in the pits and fissures of permanent teeth in children, adolescents, and young adults.		X	X	
5. Continue partnership with MT AHEC/Gallatin Dental Alliance and their School Screening Program			X	X
6. OHES continue membership on the JCHK Committee				X
7. Through ASTDD membership the OHES will stay abreast of current BSS screening protocol, training materials, and opportunities for technical assistance.			X	X
8.				
9.				
10.				

b. Current Activities
In March of 2008 the OHES participated in the first MT School Wellness in Action Summit sponsored by the Office of Public Instruction and MT Team Nutrition. An Oral Health display was exhibited and oral health education and the strategy of utilizing the ASTDD BSS to screen 3rd grade students were presented as essential components of a School Wellness Policy to 44 individuals representing 13 Community School Wellness Teams.

The MOHA continues collaborating with the Gallatin Dental Alliance/MT AHEC regarding their 3rd grade oral health screenings, through continued development of the CBPWG 5 Year Strategic Plan. The OHES advocated for a MT AHEC presentation at the HRSA/Oral Health Grantee Meeting in June of 2008 and ensured that interested participants received their resource, Basic School Screening Manual, created by the Michigan Department of Community Health and adapted for the Gallatin Dental Alliance. It is available on the MT AHEC and Office of Rural Health web site @ http://healthinfo.montana.edu/index.html

The OHES and MCH Epidemiologist are submitting the report "Montana 2005 -- 2006 Study of Oral Health Needs: 3rd Graders and Head Start Children" to NOHSS. This process involves receiving technical assistance from Kathy Phipps of the ASTDD.

OHES continues to participate in the OPI/DPHHS JCHK meetings.

c. Plan for the Coming Year
The FCHB's new MCH Epidemiologist will assist the OHES with writing the summary report of the base data from "Montana 2006-2006 Study of Oral Health Needs 3rd Graders and Head Start Children" findings. The current comprehensive report "Montana 2006-2006 Study of Oral Health Needs 3rd Graders and Head Start Children" is technical and the summary report will present the data in a manner more comprehensible for use by programs, stakeholders, and legislators. The OHES will subsequently disseminate this report to the oral health stakeholders of Montana. Technical assistance with this project will be provided from ASTDD.

The FCHB's new MCH Epidemiologist will collaborate with the OHES to formalize a strategy for reporting oral health convenience data collected by various MT schools and County Health Departments back to every community. The MCH Epidemiologist and OHES will develop a training protocol for convenience data collection, a quality assurance plan, and a plan for ongoing collection and use of oral health data. Technical assistance with this project will be provided from ASTDD when required.

The OHES will continue facilitating the ongoing meetings of the MOHA, and overseeing the implementation of the CBPWG 5 Year Strategic Plan. The MT AHEC will continue to serve as a member on the MOHA, and collaborate with the MOHA on the following goals targeted by MT AHEC for their 3rd grade 08-09 school year school screenings:

- Developing a method to track treatment of children identified with urgent needs.
- Combining the Community Health Partners (CHP) sealant program (the local Community Health Center), with the school oral health screening program
- Provide incentives to volunteer dentists and dental hygienists
- Improve classroom education component

OHES continues to participate in the OPI/DPHHS JCHK meetings.

An attachment is included in this section.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	4.7	4.6	4.5	4.4	4.3
Annual Indicator	4.3	5.6	6.2	6.2	3.9
Numerator	8	10	11	11	7
Denominator	186130	178212	177051	177122	177772
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	4	4	4	4	4

Notes - 2007
The numerator is from vital statistics and does not yet include deaths of MT residents 14 and younger that occurred out of state. Thus, although the 2008 objective is higher than the 2007 indicator, the objective will not be adjusted until final 2007 data are available and a moving average is calculated to account for possible single-year anomalies.

Notes - 2006
Denominator data are from the updated July 1, 2006 census estimates for the population of 0-14 year olds in Montana. Numerator data are from final vital statistics data for 2006 and include resident deaths that occurred in Montana and elsewhere that were reported to the state office of vital statistics.

Notes - 2005
Denominator were updated in 2008 to reflect the most recent census estimates for the number of children ages 0 to 14 years of age in Montana. Numerator data are from final vital statistics data for 2005 and include resident deaths that occurred in Montana and elsewhere that were reported to the state office of vital statistics.

a. Last Year's Accomplishments
FCHB supported the FCHB Bureau Chief's and Division Administrator's 2007 legislative efforts aimed at improving vehicle safety by providing information for testimony as to how primary seatbelt laws would decrease the numbers of vehicle deaths to children under the age of 14. The FCHB also supported efforts of pursuing stronger legislation regarding driving under the influence (DUI) of drugs and alcohol.

FCHB collaborated with several public and private partners, Emergency Medical Services Bureau Advisory Committee and Injury Prevention Sub-committee (EMSAD/IPS), the local and state Fetal, Infant, and Child Mortality Review (FICMR) teams, Office of Public Instruction Joint Committee for Healthy Kids (OPI/JCHK), Mothers Healthy Babies/Safe Kids/Safe Communities (HM/HB SK/SC), and the Montana Council for Maternal Child Health. All these partners focus on reducing the number of child and adolescent motor vehicle deaths. FCHB attended their meetings and shared information about efforts and strategies to reduce the number of child and adolescent motor vehicle accidents.

The 2003-2004 FICMR Report was distributed to members of the 2007 Legislative Session as well as to interested stakeholders in Montana. The report can be accessed at:

http://www.dphhs.mt.gov/PHSD/family-health/ficmr/pdf/FICMRReport2007.pdf

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. FCHB will support legislative efforts to decrease motor vehicle deaths by advocating for a primary seatbelt law for infants and children				X
2. FCHB will work with the Joint Committee for Healthy Kids, and the State Fetal, Infant and Child Mortality Review teams to research strategies for further reducing alcohol-impaired driving				X
3. The FICMR Coordinator will continue the collection, analysis, and dissemination of FICMR data relating to motor vehicle crashes to partners and the public.			X	
4. Continue FICMR reviews at the local level and encourage communities to initiate prevention activities				X
5. Continue partnership with Healthy Mothers Healthy Babies (HM/HB) to share car seat safety education and resource information.			X	
6. Transfer monitoring of this PM to the Injury Prevention Program.				X
7.				
8.				
9.				
10.				

b. Current Activities
FCHB provides information to local FICMR coordinators, State FICMR team, and the Family Health Advisory Council about seatbelt safety.

FCHB continues to collaborate with HM/HB SK/SC, the MT Council for Maternal Child Health, DPHHS Bureaus, Department of Transportation (DOT), Office of Public Instruction, and the MT Highway Patrol, to explore preventive measures for reducing motor vehicle crashes and their resulting injuries by utilizing the FICMR data.

FCHB continues to collaborate with HMHB/SKSC to distribute car safety seat educational materials to local FICMR Coordinators, PHHV/FASD Projects, and other interested entities.

FCHB continues to sustain the FICMR activities, including the twice a year training opportunities; the collection of and analysis of FICMR data for the next report which will be shared with the 2009 Legislature; providing assistance to local FICMR teams in accurately identifying preventable deaths; and serving as a resource for local public health agencies who are interested in decreasing preventable deaths in their communities.

c. Plan for the Coming Year
The FCHB and Healthy Mothers/Healthy Babies will continue with their quarterly meetings, focusing on reducing the number of motor vehicle related infant and child mortalities and the sharing of relevant information to their respective stakeholders.

FCHB plans to incorporate the Healthy Mothers/Healthy Babies' video "Safe & Alive: Disarming

Montana's Biggest Killer" as a component in their PHHV/FASD Project http://www.hmhb-mt.org/programs/multimedia/safealive.php

FCHB will continue supporting state and community FICMR prevention efforts with numerous activities that include: assuring that the local communities submit accurately completed FICMR Reports prior to entry into the state's FICMR database that tracks fetal, infant, and child deaths; coordinating the writing of the fourth statewide FICMR Report using the 2005-2006 data and developing a distribution plan for the report that includes the 2009 Legislators, local FICMR teams, and other interested parties; assisting local FICMR teams in translating their data findings into community level prevention activities; providing two FICMR Coordinator and two FICMR State Team training and technical assistance meetings based on their identified community specific program needs that are gathered through evaluations at each meeting; and promoting prevention strategies statewide through distribution of the FICMR report which includes local community prevention activities.
A new partnership is being formed with the Chronic Disease Prevention and Health Promotion Bureau which houses the State Injury Prevention Coordinator. The Injury Prevention Program Coordinator works cooperatively with organizations, agencies, health care institutions, health care providers and others to implement and evaluate injury prevention and control programs consistent with the CDPHPB data-driven, injury prevention and control plan. The FCHB will be working with the Injury Prevention Coordinator on incorporating preventable injuries, endemic to the maternal and child health population as reported by the local FICMR coordinators, into the State Injury Prevention Strategic Plan. The FCHB also plans to support the Bureau's request from the 2009 Legislature for general funds to support this position.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				26	29
Annual Indicator			25.9	49.3	53.8
Numerator			3184		
Denominator			12283		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	54	54	55	55	56

Notes - 2007
The data source for this measure is the National Immunization Survey (NIS). The breastfeeding results are reported by year of the infant's birth. In this case, the data are for infants born in 2004 (the most recent year available). The confidance interval for this indicator is +-7.4. In previous years WIC data were used to report on this measure, but the NIS were considered a better source of population-level data. The 2006 indicator was updated with NIS data for the July 15, 2008 submission. The objective for 2007 was set last year and was based on WIC data, not NIS data.

Notes - 2006
The data source for this measure is the National Immunization Survey (NIS). The breastfeeding results are reported by year of the infant's birth. In this case, the data are for infants born in

2003. The confidance interval for this indicator is +-5.8. In previous years WIC data were used to report on this measure, but the NIS were considered a better source of population-level data. The 2006 indicator was updated with NIS data for the July 15, 2008 submission. The objective still reflects the objective based on WIC data.

Notes - 2005
These data are from the WIC program, which provides the best estimate of breastfeeding rates among mothers in Montana. The denominator includes all children under two years of age enrolled in WIC during 2005. The numerator reflects all children enrolled in WIC whose mothers reported breastfeeding them at 6 months of age.

For a historical perspective on this performance measure, see state performance measure 3.

a. Last Year's Accomplishments
FCHB/WIC supported the Breastfeeding Peer Counselor Projects (BPCP) located in Ravalli, Deer Lodge, Cascade, and Custer Counties, as well as in Missoula County which also served the Salish and Kootenai Tribes, on the Flathead Reservation. The funding was calculated on 1300 pregnant and breastfeeding participants in these service areas. The Blackfeet Tribal WIC Program decided not to participate at this time.

Breastfeeding educational materials, written in English, Spanish, or other specific cultural or ethnic languages, such as American Indian, Chinese, and Vietnamese were used at the 27 local WIC
Programs. attachment.

Manual and electric breast pumps were distributed to all the local WIC programs and the clients received training on how to use them.

The Breastfeeding Coordinator (BC) continued to serve on the Statewide Breastfeeding Coalition (SBC). In response to Senate Bill 89, passed by the 2007 Legislature and which became Mont. Code Ann. SS 39-2-215, the SBC worked on developing "a breastfeeding in the workplace" webpage as a reference for state, county, city, and school and university public employers and their employees.

Certified Lactation Counselor (CLC) modules were purchased and used by 12 local WIC program staff for continuing education credits.

State and local WIC staff attended the Mother/Baby National Symposium and shared the information with their peers.

A local WIC staff member attended the breastfeeding training offered at the Pediatric Nutrition Practice Group of the American Deictic Association Meeting and shared this information with other local WIC programs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue distributing manual and electric breast pumps to local WIC programs.		X		
2. Continue providing breastfeeding education to WIC parents before and after the birth of their child.			X	
3. Sustain the five (5) Peer Breastfeeding Counselor Projects.			X	
4. Support local WIC staff by continuing to offer Certified Lactation Counseling modules as well as other trainings				X

5. Continue to monitor the five (5) Peer Breastfeeding Counselor Projects				X
6. The Western States Contracting Alliances sole-source bid for purchasing breast pumps will be monitored for ongoing participation.		X		
7. Continue the work of the WIC Futures Study Group.				X
8.				
9.				
10.				

b. Current Activities
WIC continues to support the Ravalli, Deer Lodge, Cascade, and Custer County BPCPs, as well as in Missoula County that serves the Salish and Kootenai Tribes, located on the Flathead Reservation.

Deer Lodge and Custer expanded their WIC service delivery areas and are working with the State staff to increase by 72 their BPCP participants.

WIC will continue to use the standard BPCP Monitoring Tool when conducting BPCP site reviews.

Breastfeeding education materials and breast pumps are being distributed by the 27 local WIC Programs.

Additional Operational Adjustment Funds (OAF) facilitated the purchase of 11 self-study Certified Lactation Counselor modules and paid the registration fees for several local WIC staff to attend the Mother/Baby Symposium and the Montana Statewide Breastfeeding Coalition Meeting.

The BC is continuing to work on the breastfeeding in the workplace webpage and attended the 2008 U.S. Breastfeeding Committee's Conference.

Suzanne Haynes, PhD, presented the "Results of a Social Marketing Campaign for Breastfeeding: The National Breastfeeding Awareness Campaign" and "Brief Overview of the Business Case for Breastfeeding Kit" at the 2008 WIC Day of the attended by 100 local WIC Staff.

A WIC Futures Study Group, composed of lead local public health officials, local program, and state WIC Staff, was formed this year to discuss the current and future WIC allocation of funds, program direction and how to provide quality WIC services into the future.

c. Plan for the Coming Year
WIC intends to continue their financial support for the BPCPs. If redistribution funds are available from the Food Nutrition Services, WIC will apply, with the goal of using these new dollars for enhancing and sustaining the current programs.

WIC plans to evaluate the current BPCP monitoring tool, as well as research and review other states' BPCP monitoring methods. This information will assist WIC in considering revising the current tool so it is a better gauge as to the BPCPs' ability at providing the mandated services effectively and efficiently.

The BPCPs' monitoring schedule will be reviewed to ensure that each BPCP is monitored, at a minimum, once every two years.

A new partnership with the Oral Health/Food Stamp Project will allow WIC to purchase additional breast pumps for distribution to local WIC programs.

Educational materials, providing a standardized breastfeeding message, written in English and other languages, especially Spanish, will be purchased and distributed statewide.

The BC will continue to participate on the SBC by attending their quarterly meetings and working on projects aimed at increasing the numbers of low income women who initiate and continue to breastfeed.

WIC will continue to inform the local WIC Programs of breastfeeding information through memos, regional updates, or with articles in the Montana Association of WIC Agency newsletter.

WIC will ensure that local WIC Programs receive promotional materials that support World Breastfeeding Week

WIC plans to apply for OAF and use these funds to purchase additional Certified Lactation Counselor self-study modules and breastfeeding education materials.

The WIC Futures Study Group will continue to meet this coming year and provide suggestions to the state as to how to increase WIC participation despite the decrease in funding.

The WIC food dollars' budget will be periodically reviewed to determine if there are funds to purchase and distribute multiple types and brands of breast pumps to local WIC agencies.

The Western States Contracting Alliances sole-source bid for breast pumps will be monitored in the coming year to determine any cost savings that could be realized by ongoing participation.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	98	98	98	92	92
Annual Indicator	90.0	92.8	87.9	90.0	93.1
Numerator	10144	10563	10157	11107	11403
Denominator	11276	11378	11551	12339	12249
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	94	94	94	94	95

Notes - 2007
The numerator data source for this is Hi-Track. The numerator includes hearing screenings for infants born to Montana residents in Montana. The denominator is from vital stats and includes births to Montana residents that occured in Montana in 2007. It does not include births to Montana residents that occurred out of state.

Notes - 2006

The numerator data source for this is Hi-Track. The numerator includes hearing screenings for infants born to Montana residents in Montana. The denominator is from vital stats and includes births to Montana residents that occured in Montana in 2006. It does not include births to Montana residents that occurred out of state. The denominator was updated with final vital statistics data for the September submission of the block grant.

Notes - 2005
Preliminary birth cohort for Montana in calendar year 2005 is 11,551.

Reset the objectives for 2006 to 2010 to address the issue of early discharge which impacts testing.

a. Last Year's Accomplishments
Montana's Universal Newborn Hearing Screening and Intervention (UNHSI) program is based on the national "1-3-6" program standard: newborn screening completed by one month of age; needed audiological assessment completed by no later than three months of age; and, appropriate intervention before six months of age. The UNHSI program is housed within the CSHS and includes monitoring and provision of technical assistance for: hospitals providing birthing services and newborn hearing screening in the state; and, for audiologists who provide audiological assessments for babies who receive a Refer result at the completion on their newborn hearing screening. By state law, the Montana School for the Deaf and Blind (MSDB) is responsible for tracking the intervention services provided to all deaf and blind children in the state.

The MSDB and the UNHSI program worked closely together to ensure that the babies identified as deaf or hard of hearing are referred to the school for monitoring and coordination of intervention services. CSHS and the MSDB use the same software to record and track services provided to children with special health care needs, including those who are deaf or hard of hearing. The UNHSI program makes electronic referrals to MSDB in the Children's Health Resources and Information System (CHRIS) software of all babies identified in HI*TRACK(c), which is approximately 12 babies per year.

During calendar year 2007, the Montana State Legislature amended the original voluntary newborn hearing screening legislation to make it mandatory for all hospitals in Montana providing obstetric services to: perform newborn hearing screening; report the screening results monthly to the state Universal Newborn Hearing Screening and Intervention (UNHSI) program via the approved software (the state currently requires HI*TRACK(c) to be used by all local reporting partners); arrange for needed outpatient screening before hospital discharge; and, notify the baby's primary care provider of Refer results at the completion of newborn hearing screening, as well as to make a recommendation that the baby have a pediatric audiologic assessment prior to three months of age.

In addition, the law now requires audiologists, who perform pediatric audiologic assessments on all babies referred for assessment due to Refer results at completion of their screening, to report their assessment to the state UNHSI program via the approved software (currently the HI*TRACK(c) software).

Births attended by licensed midwives outside of hospitals are not required to receive newborn hearing screening by the birth attendant. The Administrative Rules require health care providers attending births outside of hospitals to provide education to the parent(s) according to a state provided protocol that emphasizes the importance of newborn hearing screening, follow up with outpatient screening if needed, and audiological assessment. The licensed health care provider must also provide the state brochures that reiterate the need for hearing screening and that provide contact information for where newborn hearing screening can be obtained. The law does not have authority over home births not attended by a licensed birth attendant.

The amended law eliminated the original UNHSI Task Force advisory group, which had completed its legislated task. The amended law required the department to promulgate Administrative Rules to implement the law.

The UNHSI program provided monthly feedback to the local screening partners about the match of birth certificates with screening records to identify babies whose screening had not been yet recorded in HI*TRACK(c) or whose screening had been missed. In 2008, the 2007 calendar year screening data will be finalized and summarized according to 5 groups of hospitals based on the size of the birth cohort in 2008 and shared with the local partners and the CEO's of their facilities to reinforce completeness of screening and reporting for the last year screening was voluntary instead of mandatory.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Link newborn hearing screening data with matched newborn bloodspot testing data and birth certificate data				X
2. Continue to contract for Help Desk technical assistance for use of the tracking software by birthing facilities and audiologists				X
3. Track newborn hearing screening and audiological assessment results from the tracking software and communicate the results to screening and assessment partners statewide			X	
4. Electronically refer infants diagnosed as deaf or hard of hearing to the Montana School for the Deaf and Blind within six months of each child's birth.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The UNHSI manager has been providing e-mail and telephone technical assistance to hospitals, audiologists, midwives, and the program's advisory group to implement the amended law and new Administrative Rules, which were adopted in February 2008. On-site ARM training by CSHS will be combined with other funded travel to local partners.

The UNHSI manager continues to provide monthly feedback to the local screening partners about the matching of birth certificates with screening records, babies whose outpatient screenings have not been reported to the state, and compliance with the monthly reporting law.

The UNHSI manager ensures that primary care physicians are aware of the contact information for the seven audiologists who are qualified to perform a complete pediatric audiological assessment.

All babies diagnosed as deaf or hard of hearing were referred to the Montana School for the Deaf and Blind by the UNHSI manager.

The manager issued a Request for Proposal through the state's procurement process to obtain ad agency services to develop and implement a statewide advertising campaign for the 1-3-6 Program including: posters about newborn hearing screening and about delayed onset or progressive hearing loss to be sent to Montana's 670 pediatricians and family practice doctors; a

30-second TV spot; a health fair flyer; and continued mailings of existing program brochures to local partners. The TV spot will run during the summer and early fall of 2008.

c. Plan for the Coming Year

The primary focus for calendar year 2009 will be to continue the technical and programmatic support of the local screening and assessment partners in the statewide UNHSI program to ensure the achievement of the 1-3-6 program standard.

The UNHSI manager will continue to provide monthly feedback to the local screening partners about the matching of birth certificates with screening records, babies whose outpatient screenings have not been reported to the state, and compliance with the monthly reporting law. The UNHSI manager will continue to contact primary care professionals to provide the contact information for the seven audiologists who are qualified to perform a complete pediatric audiological assessment to assist the provider in reaching the state UNHSI program goal to secure a needed assessment by the time the baby is no older than three months of age. The UNHSI manager will continue to make electronic referrals of all babies diagnosed as deaf or hard of hearing to the Montana School for the Deaf and Blind as required in state law.

Special focus will be placed on reviewing the state's Lost to Follow Up (LTFU) rates with the local hospitals, midwives, and audiologists stakeholder group in order to select specific interventions to pilot, evaluate, and potentially implement statewide after review and input from the CSHS Advisory Subcommittee.

Additional funding is being sought from the CDC Early Hearing Detection and Intervention (EHDI) program to support: more intensive quality assurance on-site contact over a three-year period with all local partners who screen, assess, and provide parental education about newborn hearing screening and assessment. The funding will also enable conversion of the Children's Health Information and Referral (CHRIS) software used by the state to track diagnoses, continuing assessments and intervention services into a system providing web-based, role-defined access to mutual client records by professionals serving deaf or hard of hearing children.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	16	16	9	16	16
Annual Indicator	17.0	17.0	17.0	16.2	14
Numerator	38755	38755	38755	37000	
Denominator	227972	227972	227972	228000	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	14	14	14	14	14

Notes - 2007

The numbers reflect the estimated percent of children under 18 years of age who were not covered by any public or private health insurance at some point during the reporting year. An estimated 14% of children were without health insurance in 2007, which is approximately 34,000 children in Montana. These are the data used by the state's CHIP program.

Notes - 2006
The numbers reflect the number of children under 18 years of age who were not covered by any public or private health insurance at some point during the reporting year. Montana Kids Count is the source of these data, which is the same source used by MT CHIP. Discussions about the most appropriate way to estimate uninsured children are underway in MT DPHHS. This data source will be reviewed and may be revised for the 2009 MCHBG application.

Notes - 2005
The numerator for this performance measure is based on the 2003 Montana Household Survey, which asked about insurance among youth ages 18 years and younger. The survey results indicated that 17% of Montana's children were uninsured. Montana's CHIP program uses this survey as its estimate of uninsured children in the state. The denominator is the 2003 census estimate for children 18 years of age and younger.

The Current Population Survey, conducted by the US Census Bureau, is an alternative source of information for this performance measure. In 2005, it estimated that 19.5% of children 0-17 in Montana were without health insurance coverage. However, the number of households surveyed (78,000 nationwide) is small and so this survey is used only as a comparison.

The target of 9 for 2005 was unrealistic and was reset prior to MCHBG initial submission.

a. Last Year's Accomplishments
CHIP continued to provide quality, comprehensive insurance coverage for Montana children. Effective July 1, 2007 the CHIP income guidelines changed from 150% to 175% FPL ($36,138 for a family of four). CHIP also received funding to establish a program for CHIP children with high cost dental needs and initiated the Extended Dental Plan on October 1, 2007.

At the end of FFY 2008 there were 16,576 children enrolled in CHIP and no waiting list. This represented a 25% increase in enrollment from the same time period in FFY 2007. The program continued to receive solid support from the Governor's Office, the legislature, families with CHIP coverage and the general public.

CHIP screens all applications for Medicaid eligibility and forwards all applicants who appear potentially eligible for Medicaid to local public assistance offices. The program refers to and coordinates with Children's Special Health Services and Children's Mental Health Services. The program sends information about the Primary Care Association members (Community Health Centers, National Health Service Corps sites, and Migrant and Indian Health clinics) to all families who apply for CHIP.

CHIP also provides 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.

CHIP continues to develop its statewide network of health care associations, individual health care providers, schools, and other community agencies to increase CHIP awareness by distributing CHIP materials in their communities. The program also conducted the train-the-trainer workshops in communities throughout the state. CHIP conducted informational meetings with all seven reservation tribal health/IHS departments and five Urban Indian Clinics. These meetings emphasized how CHIP works in conjunction with Indian Health Services/tribal health and incorporated hands-on training to help families apply for CHIP. The program also developed and

distributed a brochure insert and poster addressing advantages of Native American participation in CHIP.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Acquire state and local funds to match federal funds and continue to insure Montana children.				X
2. Refer 100% of children not eligible for CHIP to other appropriate programs or plans.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CHIP continues to provide quality, comprehensive insurance coverage for Montana children. Due to legislative action taken during the 2007 legislative session to increase CHIP eligibility to 175% FPL, CHIP expanded its community partnerships ("CHIP Champions") and outreach efforts. In June 2008 CHIP provided health coverage for 16,576 Montana children.

c. Plan for the Coming Year

CHIP will continue its efforts to increase the number of children enrolled in the program, depending upon available state and federal funding. Children with health coverage have greater access to preventive and acute health care services. The ultimate goal is to improve the health of Montana children.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				25	30
Annual Indicator			26.6	32.5	33.6
Numerator			3447	3629	3706
Denominator			12936	11169	11029
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	30	29	28	28	27

Notes - 2005
The reported denominator includes all children ages 2-5 enrolled in WIC during 2005. The numerator reflects all children with risk codes 16 and 17.

a. Last Year's Accomplishments
The State WIC staff ensured that the 27 local WIC Programs were aware of the appropriate Center for Disease Control (CDC) technique for determining a child's BMI. Local programs weighed and measured children at semi-annual certification appointments and entered their information into the WIC computer system which resulted in the child's BMI. Additional measurements may also have been taken mid-certification if appropriate for the child's nutrition care plan. The local WIC staff plotted the child's BMI and age on the appropriate CDC approved gender growth grid and interpreted the results using CDC protocols.

The BMI information was used in determining when the child (parent) was referred to the on-staff or contracted Registered Dietitian (RD) and to the child's health care provider for high-risk follow-up services. The on-staff or contracted RD also determined if a child required a referral to an outside RD for more in-depth nutrition counseling outside of the scope of WIC Policy 5-13: Designated Referrals for High-Risk Participants.

The Toddler and Preschooler Nutrition Module, in the WIC competency-based training material, provides information on discussing overweight with the child's parent or guardian. WIC provided copies of two Ellyn Satter materials, Child of Mine and How to Get Your Kids to Eat, which are referenced in this module, to each of the local WIC Programs.

Value Enhanced Nutrition Education (VENA) training was provided to 109 local program staff. Role playing incorporating examples of how to approach discussions of overweight/obesity was used along with the video, "Beyond Nutrition Counseling: Reframing the Battle Against Obesity." More segments of VENA training are planned for the next two years.

The Breastfeeding Coordinator (BC) participated in the Cardiovascular Disease/Obesity Prevention Task Force (CD/OPTF) that has as one goal to increase breastfeeding as a method of obesity prevention.

The BC participated on the Eat Right Montana (ERM) Coalition and contributed WIC related topics and content for their annual plan and also provided input on the contents of their 2007 ERM Healthy Families Newsletter. The 2007 theme was Eat Together Play Together, which focused on family meals and activities and was distributed to the local WIC Programs.

The BC also served on the Statewide Breastfeeding Coalition (SBC) that worked on developing "a breastfeeding in the workplace" webpage as a reference for state, county, city, and school and university public employers and their employees. The webpage was in response to Senate Bill 89, passed by the 2007 Legislature.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Work to achieve Goal 4 of the MT Nutrition and Physical Activity State Plan to Prevent Obesity and Other Chronic Diseases which is: To increase breastfeeding of Montana infants.				X
2. Disseminate the ERM Healthy Families Newsletter.			X	
3. Promote and support breastfeeding.			X	
4. Review of VENA Policies and Procedures				X

5. Review of nutrition education materials (overweight and obesity focused)				X
6. Continue to promote and sponsor VENA trainings.				X
7. Continue the work of the WIC Futures Study Group.				X
8.				
9.				
10.				

b. Current Activities
The BC continues to participate in the CD/OPTF. An outcome of the goal to increase breastfeeding is a new partnership with the Nutrition and Physical Activity Program to work on breastfeeding activities.
The BC is continuing to work on the breastfeeding in the workplace webpage.

The SBC became a subcommittee of Eat Right Montana Coalition (ERM) which continues to have an agenda appropriate for WIC and targets the same population. This new partnership provides a firm connection to a well known diverse group of individuals and organizations who have come together with the common goal of providing consistent, science-based nutrition and physical activity messages to Montanans. It also helped to formalize the SBC's structure allowing it to become a 501(c) 3 non-profit, thus opening up grant funding opportunities.

WIC continues to distribute the ERM Newsletter and encourages locals to incorporate the newsletter in their press releases and to use the materials as a nutrition education resource. http://www.eatrightmontana.org/index.html

A WIC Futures Study Group, composed of lead local public health officials, local program, and state WIC Staff, was formed this year to discuss the current and future WIC allocation of funds, program direction and how to provide quality WIC services into the future.

VENA training focused on cultural diversity and critical thinking, was attended by 94 local program staff.

c. Plan for the Coming Year
WIC will continue to sponsor and encourage local WIC staff to attend the upcoming VENA training which will target emotion-based nutrition messages and how these messages become incorporated into achieving health behaviors and health outcomes. The anticipated health outcomes include healthy growth and weight gain or weight maintenance.

WIC plans to review the current VENA policies and procedures and suggest modifications when necessary to provide more participant-centered nutrition education.

Local WIC staff will continue to collect children's weight and height measurements and will use this information to determine the child's BMI and a child's overweight or obesity status will be addressed on an as needed basis or when requested by the child's family at future WIC appointments.

A new partnership with the Oral Health/Food Stamp Project will allow WIC to purchase additional breast pumps for distribution to local WIC programs.

The WIC Futures Study Group will continue to meet this coming year and provide suggestions to the state as to how to increase WIC participation despite the decrease in funding.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				15	15
Annual Indicator			15.9	15.9	15.9
Numerator			1668	1668	1668
Denominator			10509	10509	10509
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	14	14	13	13	13

Notes - 2007
The numerator and denominator are from the 2002 PRAMS data collected from mothers in a Point-In-Time (PIT) state sample. This is the only source of population-level data available on maternal smoking during the last three months of pregnancy. Vital statistics currently does not collect data on maternal cigarette smoking by gestational age.

A new birth certificate will be implemented in 2008 and will include a question on smoking prior to pregnancy and by trimesters of pregnancy. This is expected to provide a new source of data for this performance measure as of the 2010 MCHBG application.

Notes - 2006
The numerator and denominator are from the 2002 PRAMS data collected from mothers in a Point In Time (PIT) state sample. This is the only source of population-level data available on maternal smoking during the last three months of pregnancy. Vital statistics currently does not collect data on maternal cigarette smoking by gestational age.

A new birth certificate will be implemented in 2008 and will include a question on smoking prior to pregnancy and by trimesters of pregnancy. This is expected to provide a new source of data for this performance measure as of the 2010 MCHBG application.

Notes - 2005
The numerator and denominator came from the 2002 PRAMS data collected from mothers in a Point In Time (PIT) state sample. This is all the data we have on mothers during the last three months of pregnancy. Vital stats data does not contain cigarette smoking by trimester of pregnancy.

a. Last Year's Accomplishments
FCHB contracted with 14 counties and one reservation to provide Public Health Home Visiting (PHHV) services to at risk pregnant women and/or women parenting a less than one year old infant and with six (6) Fetal Alcohol Spectrum Disorder (FASD) sites to provide home visitation services to approximately 1200 pregnant women at high risk for abusing alcohol, tobacco and other drugs (ATOD). PHHV and FASD home visiting services were provided by a multidisciplinary team of professionals comprised of a registered nurse, registered dietician, and social worker. PHHV sites with a FASD project added a support specialist to the team. This

multidisciplinary approach addressed the client's physical, nutritional, and mental health needs and provided the clients with care coordination and case management, health education, and referrals.

FCHB provided technical assistance and trainings to PHHV and FASD sites on these screening and assessment tools: Ages and Stages Questionnaire (ASQ); the Ages and Stages Questionnaire Social Emotional Developmental Screening Tool; Life Skill Progression (LSP); Edinburough Depression Screen (EDS), ACOG (American College of Obstetricians and Gynecologists) Domestic Violence Screen; and the Tolerance Annoyed Cut-down Eye-opener (T-ACE) Alcohol Screening Tool. The seven local FASD support specialists were trained on motivational interviewing as a technique to use during home visits with pregnant women at risk for ATOD use during pregnancy.

The FASD 2006 Program Year End Evaluation Report was submitted to the Substance Abuse and Mental Health Services Administration (SAMSHA) the project funding source, and program contractors.

The FCHB staff participated on the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) statewide steering committee. The DELTA statewide steering committee includes representatives from the Office of Public Instruction (OPI), Board of Crime Control, Department of Justice Office of Victim Services, (DOJ/OVS), clergy, university systems, Native Americans, health care providers, people with disabilities, businesses, and families and friends of intimate partner violence and sexual violence (IPV/SV) victims. The DELTA committee has developed a draft IPV/SV needs and goals document and prevention plan for the state that includes statewide and regional recommendations for the primary prevention of IPV/SV.

FCHB coordinated three meetings of the Governor appointed Fetal Alcohol Spectrum Disorder Advisory Council (FASD AC) charged with identifying activities aimed at preventing alcohol consumption during pregnancy. The FASD AC included physicians, FCHB staff, teachers, trial council appointees, family & addiction specialist, FASD site managers, director of Young Parents Program, and a parent of affected children. Due to changing federal funding requirements the FASD AC was discontinued by the governor in April 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. FCHB will serve as consultants to statewide advisory councils.			X	
2. PHHV/Perinatal Nurse consultant will act as a consultant for the PHHV/FASD Projects which promote smoking cessation during and after pregnancy.			X	X
3. Continue to fund PHHV/FASD Projects to promote smoking cessation during pregnancy.				X
4. Collaborate with Montana Tobacco Use Prevention Project (MTUPP) to plan training for the PHHV/FASD Project staff on smoking cessation.			X	
5. FCHB will promote Montana's tobacco quit line as a resource for its PHHV/ FASD Projects			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The PHHV Business Plan Analysis has been initiated. State staff and local PHHV contractors have been meeting to discuss program requirements, outcomes and data system so as to identify and select an evidenced based model and data system for the delivery of services to high risk pregnant women and their infants.

FCHB and MTUPP staffs are planning fall tobacco cessation training.

FCHB staff continues to participate on the DELTA statewide steering committee.

FCHB is participating on a Medicaid/Targeted Case Management (TCM) workgroup advocating for a rate increase for TCM services provided to high risk pregnant women.

The FCHB sponsored, Risky Beginnings training attended by 80 individuals that included PHHV and FASD home visitors, and early childhood providers.

The 2007 MT Legislature allocated state funds supporting the existing PHHV/FASD Projects and to sponsor additional PHHV Projects. FCHB consulted with the Billings Area Office of Indian Health Services and three tribal health departments and discussed their capacity to provide PHHV. The Northern Cheyenne Tribal Nation's PHHV request for proposal was approved.

FCHB continues to offer training and information such as MTUPP quit line and the March of Dimes Prematurity Prevention materials, as well as provide financial support to PHHV and FASD contractors.

Matthew Dale, DOJ/OVS presented information about a potential collaboration with FICMR and the DOJ.

c. Plan for the Coming Year
At present, the FCHB is financially supporting the 16 PHHV/FASD Projects and will make site visits to each of the Projects during this upcoming year to provide technical support pertaining to program and contractual requirements. The Northern Cheyenne Tribal Nation's PHHV Project is anticipated to begin in FY 09.

FCHB will coordinate the ongoing PHHV reassessment project meetings for this coming year.

FCHB will prepare a PHHV/FASD Project report, which includes data and outcomes, for the 2009 Legislature and other interested stakeholders.

MTUPP training is tentatively planned for September and October 2008 and will be offered in at least two of the five regions of the state.

FCHB Staff will continue participating on the DELTA statewide steering committee.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	10.2	9.5	10	10	10
Annual Indicator	16.9	17.7	26.4	13.3	8.9

Numerator	12	12	18	9	6
Denominator	71149	67913	68097	67584	67389
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	9	9	9	9	9

Notes - 2007
The numerator is not yet final, as it does not include suicide deaths to Montana residents that occured out of state. Although the indicator for 2007 is lower than the 2008 objective, the 08 objective will not be adjusted until 2007 data are final and a moving average is calculated for the indicator.

Notes - 2006
The Montana Office of Vital Statistics is the source of the numerator data. 2006 vital statistics data were finalized for the September submission and include suicide deaths to MT residents, regardless of place of occurrence. Denominator data are from the 2006 census estimates for the population of 15-19 year olds in the state (updated in 2008). df

Notes - 2005
The denominator is from 2005 Census estimates for Montana children ages 15 to 19 years of age (updated in 2008). Numerator data is from the Office of Vital Statistics and includes all reported suicides to MT residents ages 15 through 19, regardless of whether they occurred in state or not.

Despite the disparity between objective and indicator, Montana is retaining this objective. Two youth suicide projects, funded in part by federal grants, began in late 2005/2006.

a. Last Year's Accomplishments
Local Fetal Infant Child Mortality Review (FICMR) teams met twice and reviewed all suicides of youth up to the age of 18 in their community. The teams identified and shared possible prevention strategies that their communities could implement. Examples of prevention strategies that communities implemented include: gun safety education; efforts to increase access to mental health services; gatekeeper training; educating the press on suicide reporting; introducing TeenScreen, which is a depression screening tool, in the schools; and public service announcements.

The State FICMR team and the local FICMR Coordinator members received updates about the YSP Projects at the meetings.

FCHB provided funding to the twelve Garrett Lee Smith Youth Suicide Prevention (YSP) Projects. A FCHB staff member was designated as the Youth Suicide Project Director (YSP PD) coordinator and ensured that the YSP Projects received technical assistance on the cross-site evaluation, TeenScreen, and training on the Question Persuade and Refer (QPR) and Applied Suicide Intervention Skills Training (ASIST) methods. Others interested in this training were directed to the FCHB website for future QPR and ASIST training dates.

FCHB participated on the MT/WY Tribal Leader's Council Planting Seeds Of Hope (PSOH) Suicide Prevention Project Technical Advisory Board, which is also funded with GLS dollars through a grant from Substance Abuse and Mental Health Services Administration (SAMHSA) FCHB met quarterly with the Advisory Board and provided updates on the tribal training

coordinator's activities, current suicide prevention education, and information about the YSP Projects.

Montana's YSP Task Force met twice in FY 07 and was charged with making recommendations to DPHHS on methods to prevent youth and young adult suicide. At these meetings the Task Force reviewed and disseminated information on suicide prevention best practices; information from the 12 YSP Projects; and updates from other members such as the MT/WY Tribal Leadership Council Planting Seeds Of Hope (TLC/PSOH) Project Project Director.

FCHB promoted the coordinated efforts of statewide trainings, meetings, educational opportunities and public education on educating the public and interested stakeholders on youth suicide prevention. This was accomplished by partnering with public and private entities which included the Office of Public Instruction, the Joint Committee for Healthy Kids (OPI/JCHK); Children's Mental Health Bureau; Injury Prevention and Control Program (IPCP); private healthcare providers, which included physicians, mid-level providers, mental health providers, counselors, psychologists and psychiatrists; Emergency Medical Services for Children (EMSC), the Faith-Based Community (clergy from around the state) Children's Special Health Services, and MT/WY Tribal Leadership Council, (TLC), Bureau of Indian Affairs and Billings Area Indian Health Service (BAO IHS).

FCHB organized a Suicide Prevention Panel, comprised of four suicide prevention experts from around Montana, who presented information on the prevalence of suicide in Montana and local prevention efforts to attendees of the Montana Mental Health Association (MMHA) Annual Conference held in May 2007.

Montana's State Suicide Prevention Strategic Plan was distributed to the 2007 Legislature in January 2007.

The 2007 Legislature passed Senate Bill 468 which funded a Statewide Suicide Prevention Coordinator (SSPC), housed in the Addictive and Mental Disorders Division (AMDD), to organize statewide suicide prevention efforts across the age span, strategic planning and crisis hotline support.
FCHB conducted a technical assistance conference call in September 2007 with the 12 YSP Projects. The conference call agenda included: 1) evaluation update and helpful hints using the evaluation tools; 2) discussion of how to accomplish the grant activity of providing community parent presentations; and 3) discussion of incorporating Senate Bill 468 deliverables into their projects.

FCHB staff presented information on the prevalence of suicide in Montana as well as the collaboration between the Department of Public Health and Human Services and the Tribal Leaders Council Planting Seeds of Hope suicide prevention projects during the National Suicide Prevention Action Network (SPAN) conference held in July 2007

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. FCHB will serve as consultants to the State Fetal, Infant, and Child Mortality Review (FICMR) team on topics related to community action to prevent youth suicide.		X		
2. FCHB will provide technical assistance and funding to the 12 YSP Projects through 9/30/08				X
3. Work with Montana Mental Health Association to develop and distribute youth driven YSP media products		X		
4. Collaborate with Montana's tribes to decrease youth suicide				X

attempts and completions in Montana				
5. Transition YSP activities to the Statewide Suicide Prevention Coordinator				X
6. Coordinate tribal and state efforts to reduce youth suicide across the state.				X
7.				
8.				
9.				
10.				

b. Current Activities
FCHB is working with the MMHA to create and disseminate a youth driven public service announcement focusing on eliminating the stigma of mental illness and prevention of suicide.

FCHB continues to work with the MT/WY TLC PSOH Project by attending their meetings and inviting the PSOH Project Director to provide updates at the YSP Task Force Meetings. The SAMHSA federal grant officer will be attending the August 2008 joint meeting of these two groups.

FCHB is providing assistance and guidance, such as making available the DVD, A Parent's Guide to Recognizing Depression and Preventing Suicide: Know the Warning Signs, to the YSP projects as well as working with the SSPC on reapplying for continued GLS funding.

FCHB continues to coordinate ASIST training by updating the website training schedule.

The YSP Project Director became a member of the Suicide Prevention Resource Center (SPRC) Steering Committee and attended their February 2008 meeting and has participated in their monthly conference calls. http://www.sprc.org

FCHB participates in monthly conference calls with SAMSHA's YSP grant officer, the cross site evaluation contact, and the state YSP evaluator.

FCHB and the PSOH Director presented information on their tribal and state government collaboration at the annual YSP SAMHSA grantees meeting.

FCHB continues to collect and analyze FICMR data and share the findings with the YSP Projects and others.

c. Plan for the Coming Year
FCHB will continue collecting suicide data from FICMR Local Teams and provide assistance to the local communities by sharing youth suicide prevention efforts that they might consider implementing in their community.

FCHB will continue to financially support the 12 YSP Projects and provide technical assistance as needed, based on information from their monthly conference calls with the SAMSHA YSP grant officer from SAMHSA, the cross site evaluation contact, and state YSP evaluator through September 2008. The transition plan that was initiated after SB 468 was passed will continue with the Bureau's Youth Suicide Director ensuring regular contacts with and technical assistance for the Statewide Suicide Prevention Director. The plan includes the FCHB promoting the State Suicide Prevention Plan that was revised in April 2008, by posting it on the FCHB website, distributing it to the YSP Projects, YSP Task Force, local FICMR Coordinators, State FICMR Team, and the PSOH Board; as well as the SSPC promoting it through the AMDD networks and to the 2009 legislators prior to January, 2009.

FCHB will participate in future SPRC Steering Committee meetings through their telephone conferences.

FCHB will continue as a representative on the PSOH Technical Advisory Board and the YSP Task Force by attending their regularly scheduled meetings and reporting back to the Family Health Advisory Council, local FICMR Coordinators and FICMR State Team, and other interested parties.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	86.5	90	90	91	91
Annual Indicator	88.7	78.7	78.2	81.8	86.8
Numerator	102	100	97	126	138
Denominator	115	127	124	154	159
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	91	91	91	91	91

Notes - 2007
The data source for this performance measure is the MT Office of Vital Statistics. In 2007, Montana had three level 3 facilities (facilities for high-risk deliveries and neonates). The numerator and denominator include infants born in Montana, regardless of the mother's place of residence. df

Notes - 2006
The data source for this performance measure is the MT Office of Vital Statistics. 2006 data were finalized for the September submission of the Block Grant. In 2006, Montana had three level 3 facilities (facilities for high-risk deliveries and neonates). The numerator and denominator include infants born in Montana, regardless of the mother's place of residence. df

Notes - 2005
The data source for this performance measure is the MT Office of Vital Statistics. In 2005, Montana had three level 3 facilities (facilities for high-risk deliveries and neonates). The numerator and denominator include infants born in Montana, regardless of the mother's place of residence. df

a. Last Year's Accomplishments
FCHB contracted with 14 counties and one reservation to provide Public Health Home Visiting (PHHV) services to at risk pregnant women and/or women parenting a less than one year old infant and with six (6) Fetal Alcohol Spectrum Disorder/Intensive Case Management (FASD/ICM) sites to provide home visitation services to approximately 1200 pregnant women at high risk for

abusing alcohol, tobacco and other drugs (ATOD). PHHV and FASD home visiting services were provided by a multidisciplinary team of professionals comprised of a registered nurse, registered dietician, and social worker. PHHV sites with a FASD project added a support specialist to the team. This multidisciplinary approach addressed the client's physical, nutritional, and mental health needs and provided the clients with care coordination and case management, and health education, and referrals.

FCHB provided technical assistance and trainings to PHHV and FASD sites on these screening and assessment tools: Ages and Stages Questionnaire (ASQ); the Ages and Stages Questionnaire Social Emotional Developmental Screening Tool; Life Skill Progression (LSP); Edinburough Depression Screen (EDS), ACOG (American College of Obstetricians and Gynecologists) Domestic Violence Screen; and the Tolerance Annoyed Cut-down Eye-opener (T-ACE) Alcohol Screening Tool. The seven local FASD support specialists were trained on motivational interviewing as a technique to use during home visits with pregnant women at risk for ATOD use during pregnancy.

The FASD 2006 Program Year End Evaluation Report was submitted to the Substance Abuse and Mental Health Services Administration (SAMSHA) the project funding source and program contractors.

The FCHB participated on the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) statewide steering committee. The DELTA statewide steering committee includes representatives from the Office of Public Instruction (OPI), Board of Crime Control, Department of Justice Office of Victim Services, (DOJ/OVS), Adolescent and School Health Services, clergy, universities, Native Americans, health care providers, people with disabilities, businesses, and families and friends of intimate partner violence and sexual violence (IPV/SV) victims. The DELTA committee has developed a draft IPV/SV needs and goals document and prevention plan for the state that includes statewide and regional recommendations for the primary prevention of IPV/SV.

FCHB staff coordinated three meetings of the Governor appointed Fetal Alcohol Spectrum Disorder Advisory Council (FASD AC) charged with identifying activities aimed at preventing alcohol consumption during pregnancy. The FASD AC statewide steering committee includes physicians, FCHB staff, teachers, trial council appointee, family & addiction specialist, site managers for the prevention of FASD, director of young parents program, and parent of affected children. Due to changing federal funding requirements the FASD AC was discontinued by the governor in April, 2008.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Serve as statewide consultant to the PHHV/FASD Projects on prematurity prevention issues				X
2. Perinatal education, outreach and support will continue to be provided to the PHHV/FASD Projects.			X	
3. Provide support to the FASD/ PHHV Projects through site visits and training as needed.			X	
4. Continue to fund the PHHV/FASD Projects		X		X
5. Provide the current FICMR data report to stakeholders and 2009 Legislature			X	
6. Advocate with Medicaid program to continue the provision of Targeted Case Management (TCM) services to at risk pregnant				X

women				
7. Coordinate State and Tribal efforts to prevent prematurity.				X
8. Continue membership in the Montana Perinatal Association and participate in business meetings and conferences to educate and build networks with hospital staff working in high risk nurseries.				X
9.				
10.				

b. Current Activities
The PHHV Business Plan Analysis has been initiated. State staff and local PHHV contractors have been meeting to discuss program requirements, outcomes and data system so as to identify and select an evidenced based model and data system for the delivery of services to high risk pregnant women and their infants.

FCHB and MTUPP staffs are planning fall tobacco cessation training.

FCHB staff continues to participate on the DELTA statewide steering committee.

FCHB is participating on a Medicaid/Targeted Case Management (TCM) workgroup advocating for a rate increase for TCM services provided to high risk pregnant women.

The FCHB sponsored, Risky Beginnings training attended by 80 individuals that included PHHV and FASD home visitors, and early childhood providers.

The 2007 MT Legislature allocated state funds supporting the existing PHHV/FASD Projects and to sponsor additional PHHV Projects. FCHB consulted with the Billings Area Office of Indian Health Services and three tribal health departments and discussed their capacity to provide PHHV. The Northern Cheyenne Tribal Nation's PHHV request for proposal was approved.

FCHB continues to offer training and information such as MTUPP quit line and the March of Dimes Prematurity Prevention materials, as well as provide financial support to PHHV and FASD contractors.

Matthew Dale, DOJ/OVS presented information about a potential collaboration with FICMR and the DOJ.

c. Plan for the Coming Year
At present, the FCHB is financially supporting the 16 PHHV/FASD Projects and will make site visits to each of the Projects during this upcoming year to provide technical support pertaining to program and contractual requirements. The Northern Cheyenne Tribal Nation's PHHV Project is anticipated to begin in FY 09.

FCHB will coordinate the ongoing PHHV reassessment project meetings for this coming year.

FCHB will prepare a PHHV/FASD Project report, which includes data and outcomes, for the 2009 Legislature and other interested stakeholders.

MTUPP training is tentatively planned for September and October 2008 and will be offered in at least two of the five regions of the state.

FCHB Staff will continue participating on the DELTA statewide steering committee.

FCHB will attend the Montana Perinatal and the ACOG Conferences to network with doctors and

nurses working in Montana hospitals that perform deliveries.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	85	85.5	86	85.4	85.9
Annual Indicator	84.1	82.6	83.1	82.4	83.3
Numerator	9571	9513	9616	10302	10204
Denominator	11384	11514	11573	12499	12249
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	84.5	84.5	85	85	85

Notes - 2007
The data source for this performance measure is the Office of Vital Statistics, Montana DPHHS. Data reflect births to Montana residents, and are provisional, as reporting of births that occurred to MT residents out of state is not yet complete.

Notes - 2006
The data source for this performance measure is the Office of Vital Statistics, Montana DPHHS. Data reflect births to Montana residents, regardless of whether they occurred in the state or elsewhere.

Notes - 2005
The data source for this performance measure is the Office of Vital Statistics, Montana DPHHS. Data reflect births to Montana residents, regardless of whether they occurred in the state or elsewhere.

a. Last Year's Accomplishments
FCHB contracted with 14 counties and one reservation to provide Public Health Home Visiting (PHHV) services to at risk pregnant women and/or women parenting a less than one year old infant and with six (6) Fetal Alcohol Spectrum Disorder/Intensive Case Management (FASD/ICM) sites to provide home visitation services to approximately 1200 pregnant women at high risk for abusing alcohol, tobacco and other drugs (ATOD). PHHV and FASD home visiting services were provided by a multidisciplinary team of professionals comprised of a registered nurse, registered dietician, and social worker. PHHV sites with a FASD project added a support specialist to the team. This multidisciplinary approach addressed the client's physical, nutritional, and mental health needs and provided the clients with care coordination and case management, and health education, and referrals.

FCHB provided technical assistance and trainings to PHHV and FASD sites on these screening and assessment tools: Ages and Stages Questionnaire (ASQ); the Ages and Stages Questionnaire Social Emotional Developmental Screening Tool; Life Skill Progression (LSP); Edinburough Depression Screen (EDS), ACOG (American College of Obstetricians and

Gynecologists) Domestic Violence Screen; and the Tolerance Annoyed Cut-down Eye-opener (T-ACE) Alcohol Screening Tool. The seven local FASD support specialists were trained on motivational interviewing as a technique to use during home visits with pregnant women at risk for ATOD use during pregnancy.

The FASD 2006 Program Year End Evaluation Report was submitted to the Substance Abuse and Mental Health Services Administration (SAMSHA) the project funding source and program contractors.

The FCHB participated on the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) statewide steering committee. The DELTA statewide steering committee includes representatives from the Office of Public Instruction (OPI), Board of Crime Control, Department of Justice Office of Victim Services, (DOJ/OVS), clergy, university systems, Native Americans, health care providers, people with disabilities, businesses, and families and friends of intimate partner violence and sexual violence (IPV/SV) victims. The DELTA committee has developed a draft IPV/SV needs and goals document and prevention plan for the state that includes statewide and regional recommendations for the primary prevention of IPV/SV.

FCHB staff coordinated three meetings of the Governor appointed Fetal Alcohol Spectrum Disorder Advisory Council (FASD AC) charged with identifying activities aimed at preventing alcohol consumption during pregnancy. The FASD AC statewide steering committee includes physicians, FCHB staff, teachers, trial council appointee, family & addiction specialist, site managers for the prevention of FASD, director of young parents program, and parent of affected children. Due to changing federal funding requirements the FASD AC was discontinued by the governor in April, 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. FCHB participates on a state workgroup of TCM providers to address changes in Medicaid rules and to explore the possibility of a fee increase for TCM providers to high risk pregnant women.				X
2. Collaborate with statewide stakeholders to evaluate the PHHV/FASD Project.				X
3. Provide continuing education on identified needs for PHHV/FASD Project staff at a minimum of two times per contractual year.				X
4. PHHV nurse consultant, representing the needs of the prenatal population, will continue participating on the DELTA steering committee			X	
5. Continue to fund and provide technical assistance and guidance to the PHHV/FASD Projects				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The PHHV Business Plan Analysis has been initiated. State staff and local PHHV contractors have been meeting to discuss program requirements, outcomes and data system so as to identify and select an evidenced based model and data system for the delivery of services to high risk pregnant women and their infants.

FCHB and MTUPP staffs are planning fall tobacco cessation training.

FCHB staff continues to participate on the DELTA statewide steering committee.

FCHB is participating on a Medicaid/Targeted Case Management (TCM) workgroup advocating for a rate increase for TCM services provided to high risk pregnant women.

The FCHB sponsored, Risky Beginnings training attended by 80 individuals that included PHHV and FASD home visitors, and early childhood providers.

The 2007 MT Legislature allocated state funds supporting the existing PHHV/FASD Projects and to sponsor additional PHHV Projects. FCHB consulted with the Billings Area Office of Indian Health Services and three tribal health departments and discussed their capacity to provide PHHV. The Northern Cheyenne Tribal Nation's PHHV request for proposal was approved.

FCHB continues to offer training and information such as MTUPP quit line and the March of Dimes Prematurity Prevention materials, as well as provide financial support to PHHV and FASD contractors.

Matthew Dale, DOJ/OVS presented information about a potential collaboration with FICMR and the DOJ.

c. Plan for the Coming Year

At present, the FCHB is financially supporting the 16 PHHV/FASD Projects and will make site visits to each of the Projects during this upcoming year to provide technical support pertaining to program and contractual requirements. The Northern Cheyenne Tribal Nation's PHHV Project is anticipated to begin in FY 09.

FCHB will coordinate the ongoing PHHV reassessment project meetings for this coming year.

FCHB will prepare a PHHV/FASD Project report, which includes data and outcomes, for the 2009 Legislature and other interested stakeholders.

MTUPP training is tentatively planned for September and October 2008 and will be offered in at least two of the five regions of the state.

FCHB Staff will continue participating on the DELTA statewide steering committee.

D. State Performance Measures

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	54	52	63	62	62
Annual Indicator	66.1	64.6	64.0	64.0	71.5
Numerator	1189	1200	1251	1281	1188
Denominator	1799	1858	1955	2002	1661
Is the Data Provisional or Final?				Provisional	Final

	2008	2009	2010	2011	2012
Annual Performance Objective	61	61	60	60	60

Notes - 2007
The denominator is total Title X clients receiving a positive pregnancy test. The numerator is the total of these clients with unintended pregnancies.

Notes - 2006
The denominator is total Title X clients receiving a positive pregnancy test. The numerator is the total of these clients with unintended pregnancies. Due to data collection changes this is an estimate.

Notes - 2005
The denominator is total Title X clinic clients. The numerator is the total of these clients with unintended pregnancies.

a. Last Year's Accomplishments
Pregnancy prevention and birth control were identified as needs by adolescents and women, respectively, in the 2005 Maternal and Child Health Needs Assessment. The Women's and Men's Health Section (WMHS) of the Family and Community Health Bureau (FCHB) maintained contracts and provided technical assistance to 14 Delegate Agencies (DA) offering services in 27 locations serving all 56 counties in MT. These agencies assured that women and men of reproductive age, including adolescents, had access to comprehensive reproductive health care, educational information, and services that included how to prevent unintended pregnancy. The agencies' sliding fee schedules, based on family size and income, also ensured the affordability of family planning services and supplies. http://www.dphhs.mt.gov/PHSD/Women-Health/directory.shtml

The Office of Population Affair's (OPA) additional special initiative funds provided Delegate Agencies with funding for male clinic services, HIV testing and counseling, satellite clinics, and outreach services for teen pregnancy prevention, and funds to increase access to highly effective contraceptives as well as emergency contraceptives.

House Bill (HB) 2, passed in the 2007 Legislative Session, allocated additional State General Funds for delegate agencies to provide efficacious contraceptives to low-income clients. HB 2 also allowed the Public Health and Safety Division (PHSD) to pursue a 1115 Medicaid Waiver so as to expand family planning services to low income women. The Medicaid Waiver went through the public comment phase and was sent to the Governor's Office for approval.

In calendar year 2007, the Delegate Agencies served 26,899 women and men. It is estimated that family planning services prevented approximately 16,848 unintended pregnancies and 2,392 abortions during this time.

WMHS provided outreach materials and fact sheets on topics, such as the 24-hour toll-free hotline number that provides information on the nearest Family Planning Clinic, pregnancy prevention and family planning services, to county Offices of Public Assistance (OPA), Healthy Mothers Healthy Babies (HM/HB), Public Health Home Visiting Programs (PHHV), WIC offices, 14 local Breast and Cervical Health Program sites (BCP), and Indian Health Services (IHS) as well as to the Delegate Agencies.

The intra-uterine device (IUD) referral system continued to allow rural Delegate Agencies, without the capacity to provide IUD insertions, the ability to refer these clients to larger agencies. In Fiscal Year 07 (FY) 98 low income women received IUD's.

WMHS received Special Initiative funding from Department of Health and Human Services (DHHS) Office of Population Affairs (OPA). These funds were distributed to Bridger Clinic for the

Partners in Prevention Project. Bridger Clinic collaborated with several agencies to provide supplementary comprehensive sex education and family planning services to teen mothers and fathers and other at risk youth for teen pregnancy prevention.

The WMHS Health Education Specialist is a member of a Region VII Regional Training Advisory Council (RTAC) which meets once a year to help plan trainings for delegate agencies. RTAC reviewed a needs assessment, conducted bi-annually, from Region VII Title X programs to assist in the training plan. Trainings included education and clinical components.

The WMHS Health Education Specialist is a member of the State Family Planning Education Committee (SPEC). The SPEC consists of delegate agency staff which meet bi-monthly which reviewed and approved materials and identified priorities for all delegate agencies. The SPEC has identified Teen Pregnancy Prevention Month as a priority and will continue to coordinate a statewide outreach campaign.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. In SFY 2009, provide FP services to at least 29,500 clients at risk of unintended pregnancy.	X			
2. In SFY 2009, ensure that 97% of female FP clients using contraception do not experience an unintended pregnancy.	X			
3. In SFY 2009, at least 80% of family planning clinic clients will be at or below 250% of federal poverty level.	X			
4. In SFY 2009 provide funding to 14 agencies with services in 27 clinics for efficacious contraceptives for low-income clients (below 250% of poverty).				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

WMHS continues to contract with the 14 Delegate Agencies.

Outreach and education materials continue to be distributed to WMHS partners, i.e. DA, OPA, HM/HB, PHHV, and WIC who share these materials with their clients.

The 1115 Medicaid Waiver was approved by the Governor's Office and has been submitted to Centers for Medicare and Medicaid Services (CMS). PHSD will continue monitoring its status.

The IUD referral system continues to allow rural agencies to refer their clients to a larger agency, and has served 77 low income women as of 5/31/08.

The Office of Population Affairs special funds were available to DAs allowing them to continue dispensing highly effective, as well as emergency contraceptives.

WMHS Health Education Specialist continues to meet and discuss future training needs for delegate agencies with RTAC. At the Family Planning Conference in May 2008 a session was dedicated to adolescent counseling for clinicians. The SPEC continues to meet and discuss materials and family planning priorities on a bi-monthly basis.

WMHS applied for Expansion Funding in SFY 2008, if awarded in SFY 2009, it would supplement the Delegate Agency's ability to expand services in underserved communities targeting low income women and men, including adolescents.

c. Plan for the Coming Year
During the coming year, WMHS plans to address unintended pregnancy through continued contracts with its 14 Delegate Agencies who will offer ongoing comprehensive family planning services targeting low-income women and men.

WMHS Health Education Specialist will continue to meet with RTAC to evaluate training needs for delegate agencies and Region VII Title X agencies by reviewing a needs assessment conducted bi-annually by delegate agencies.

The WMHS Health Education Specialist will investigate on-line resources and other sources of current information that include unintended pregnancy prevention and share this information with the Delegate Agencies and other public health partners.

WMHS will continue to apply for Office of Population Affairs special funding that will supplement the Delegate Agency's budgets for purchasing efficacious contraceptives.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	98	98	98	98.3	98.5
Annual Indicator	97.2	97.0	97.0	96.8	97.2
Numerator	10959	11203	11122	11988	11939
Denominator	11276	11554	11468	12388	12287
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	98	98	98	98	98

Notes - 2007
Numerator and denominator data are from the Montana Office of Vital Statistics. The numerator includes the number of resident women who experienced a live birth in MT in 2007 and reported not drinking alcohol during pregnancy, plus the number of resident women who experienced a fetal death in MT in 2007 and reported not drinking alcohol during pregnancy. Denominator data includes all resident women who experienced a live birth or a fetal death in MT in 2007. Vital records data on alcohol use in pregnancy is based on self-report and therefore is probably an underestimation of the actual incidence.

Notes - 2006
Numerator and denominator data are from the Montana Office of Vital Statistics. The numerator includes the number of resident women who experienced a live birth in MT in 2006 and reported not drinking alcohol during pregnancy, plus the number of resident women who experienced a fetal death in MT in 2006 and reported not drinking alcohol during pregnancy. Denominator data includes all resident women who experienced a live birth or a fetal death in MT in 2006. Vital

records data on alcohol use in pregnancy is based on self-report and therefore is probably an underestimation of the actual incidence.

Notes - 2005
The numerator for 2004 and 2005 was generated from vital records by including the number of resident women delivering live births in MT and not drinking alcohol plus the number of resident women experiencing fetal deaths in MT and not drinking alcohol. Denominator data was all resident women either experiencing a live birth or a fetal death in MT for the years in question. Vital records data on alcohol use in pregnancy is based on self-report and therefore is probably an underestimation of the actual incidence.

a. Last Year's Accomplishments
FCHB contracted with 14 counties and one reservation to provide Public Health Home Visiting (PHHV) services to at risk pregnant women and/or women parenting a less than one year old infant and with six (6) Fetal Alcohol Spectrum Disorder/Intensive Case Management (FASD/ICM) sites to provide home visitation services to approximately 1200 pregnant women at high risk for abusing alcohol, tobacco and other drugs (ATOD). PHHV and FASD home visiting services were provided by a multidisciplinary team of professionals comprised of a registered nurse, registered dietician, and social worker. PHHV sites with a FASD project added a support specialist to the team. This multidisciplinary approach addressed the client's physical, nutritional, and mental health needs and provided the clients with care coordination and case management, health education, and referrals

FCHB provided technical assistance and trainings to PHHV and FASD sites on these screening and assessment tools: Ages and Stages Questionnaire (ASQ); the Ages and Stages Questionnaire Social Emotional Developmental Screening Tool; Life Skill Progression (LSP); Edinburough Depression Screen (EDS), ACOG (American College of Obstetricians and Gynecologists) Domestic Violence Screen; and the Tolerance Annoyed Cut-down Eye-opener (T-ACE) Alcohol Screening Tool. The seven local FASD support specialists were trained on motivational interviewing as a technique to use during home visits with pregnant women at risk for ATOD use during pregnancy.

The FASD 2006 Program Year End Evaluation Report was submitted to the Substance Abuse and Mental Health Services Administration (SAMSHA) the project funding source, and program contractors.

The FCHB staff participated on the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) statewide steering committee. The DELTA statewide steering committee includes representatives from the Office of Public Instruction (OPI), Board of Crime Control, Department of Justice Office of Victim Services, (DOJ/OVS), clergy, university systems, Native Americans, health care providers, people with disabilities, businesses, and families and friends of intimate partner violence and sexual violence (IPV/SV) victims. The DELTA committee has developed a draft IPV/SV needs and goals document and prevention plan for the state that includes statewide and regional recommendations for the primary prevention of IPV/SV.

FCHB staff coordinated three meetings of the Governor appointed Fetal Alcohol Spectrum Disorder Advisory Council (FASD AC) charged with identifying activities aimed at preventing alcohol consumption during pregnancy. The FASD AC statewide steering committee included physicians, FCHB staff, teachers, trial council appointee, family & addiction specialist, site managers for the prevention of FASD, director of young parents program, and parent of affected children. Due to changing federal funding requirements the FASD AC was discontinued by the governor in April 2008.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to support legislative efforts for funding to support the FASD projects				X
2. Provide information and technical assistance to the PHHV/FASD Projects to continue statewide efforts to reduce prenatal exposure to alcohol and prevent FASD			X	
3. Continued collection of PHHV/FASD Projects' data relating to FASD prevention.				X
4. Plan yearly training(s) for the PHHV/FASD Projects		X		
5. Continue Intensive Case Management (ICM) by support specialists at the FASD Projects			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The PHHV Business Plan Analysis has been initiated. State staff and local PHHV contractors have been meeting to discuss program requirements, outcomes and data system so as to identify and select an evidenced based model and data system for the delivery of services to high risk pregnant women and their infants. Attachment

FCHB and MTUPP staffs are planning fall tobacco cessation training.

FCHB staff continues to participate on the DELTA statewide steering committee.

FCHB is participating on a Medicaid/Targeted Case Management (TCM) workgroup advocating for a rate increase for TCM services provided to high risk pregnant women.

The FCHB sponsored, Risky Beginnings training attended by 80 individuals that included PHHV and FASD home visitors, and early childhood providers.

The 2007 MT Legislature allocated state funds supporting the existing PHHV/FASD Projects and to sponsor additional PHHV Projects. FCHB consulted with the Billings Area Office of Indian Health Services and three tribal health departments and discussed their capacity to provide PHHV. The Northern Cheyenne Tribal Nation's PHHV request for proposal was approved.

FCHB continues to offer training and information such as MTUPP quit line and the March of Dimes Prematurity Prevention materials, as well as provide financial support to PHHV and FASD contractors.

Matthew Dale, DOJ/OVS presented information about a potential collaboration with FICMR and the DOJ.

An attachment is included in this section.

c. Plan for the Coming Year

At present, the FCHB is financially supporting the 16 PHHV/FASD Projects and will make site visits to each of the Projects during this upcoming year to provide technical support pertaining to program and contractual requirements. The Northern Cheyenne Tribal Nation's PHHV Project is anticipated to begin in FY 09.

FCHB will coordinate the ongoing PHHV reassessment project meetings for this coming year.

FCHB will prepare a PHHV/FASD Project report, which includes data and outcomes, for the 2009 Legislature and other interested stakeholders.

MTUPP training is tentatively planned for September and October 2008 and will be offered in at least two of the five regions of the state.

FCHB Staff will continue participating on the DELTA statewide steering committee.

State Performance Measure 4: *Percent of state fetal/infant/child deaths reviewed for preventability by local review teams.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	95	95	95	95	96
Annual Indicator	88.0	92.8	90.2	75.8	75.8
Numerator	183	155	185	141	141
Denominator	208	167	205	186	186
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	92	92	92	92	92

Notes - 2007
The data reported here are 2006 data. Reviews of 2007 deaths are still taking place. The 2006 data are more complete. Fetal, Infant, and Child Mortality Review teams may review deaths as long as 6-12 months after the event, and in some cases completion and submission of reviews may be delayed even longer by other circumstances relating to the death. The denominator reflects fetal, infant and child deaths (through age 17 years) that occured in MT to MT residents, as reported to the MT Office of Vital Statistics.

Notes - 2006
The numerator does not represent the final number of reviews for 2006. Fetal, Infant, and Child Mortality Review teams may review deaths as long as 6-12 months after the event, and in some cases completion and submission of reviews may be delayed even longer by other circumstances relating to the death. The denominator reflects fetal, infant and child deaths (through age 17 years) that occured in MT to MT residents, as reported to the MT Office of Vital Statistics.

Notes - 2005
The numerator for this objective was updated for the July 15, 2008 submission. The denominator reflects fetal, infant and child deaths (through age 17 years) that occured in MT to MT residents, as reported to the MT Office of Vital Statistics. Fetal, Infant, and Child Mortality Review teams may review deaths as long as 6-12 months after the event, and in some cases completion and submission of reviews may be delayed even longer by other circumstances relating to the death.

a. Last Year's Accomplishments
The FCHB, in collaboration with Healthy Mothers Healthy Babies (HMHB), developed and coordinated the "Safe Sleep for Baby" program. The "Safe Sleep for Baby" program provides safe sleep environments (cribs) to high risk babies and their families as well as educates these families on Sudden Infant Death Syndrome (SIDS) prevention and safe sleep practices. Public health nurses delivered the "Safe Sleep-Pack ‘n Play Playard" crib package and educated

families on SIDS prevention while explaining the crib package which consists of two fitted playard sheets and a baby safe sleep sack (sleeper). Eight of the sixteen Public Health Home Visiting/Fetal Alcohol Spectrum Disorder (PHHV/FASD) Programs referred clients to the program.

The "Safe Sleep for Baby" program also included FCHB educating the state WIC staff on "Safe Sleep for Breastfeeding Mothers" which was then shared with local WIC Programs and culturally sensitive informational materials from the Healthy Native Babies Workshop on SIDS, was distributed to local FICMR Coordinators, WIC, and other partners.

FCHB offered two training opportunities for the 29 local Fetal, Infant Child Mortality Review (FICMR) and the state FICMR Review teams. Information on bereavement resources for families of deceased children and how to use the 2003-04 FICMR Report when determining local prevention activities were discussed. The trainings also allowed the FICMR teams to share their success and challenges and brainstorm possible solutions for the challenges based on their own experiences.

The FICMR data collection tool was revised with input from the local FICMR coordinators and FCHB staff resulting in a more user friendly format for data entry into an ACCESS database that was created in collaboration between FCHB and the Public Health and Safety Division's Information Technology Section.

The database tracks fetal, infant, and child deaths and was used for the Fetal, Infant, Child and Death in Montana: Summary of 2003-04 Mortality Reviews published in December 2006. This third FICMR report was made available to the 2007 Legislators and statewide stakeholders and can be accessed at:
http://www.dphhs.mt.gov/PHSD/family-health/ficmr/pdf/FICMRReport2007.pdf

FCHB worked with Dr. Gary Dale and Dr. Willy Kemp, the State Medical Examiners (SME) and the state FICMR Team Members and gathered information on the CDC's SUID (Sudden, Unexplained Infant Death) Reporting Form and Guidelines for the scene investigation. This information will be used as the basis for educating and disseminating training materials on infant death scene investigations to coroners with the goal to improve inaccurate SUID classifications in Montana.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to support legislation to prevent fetal, infant and child deaths in communities in Montana				X
2. Develop and distribute the 2005-06 FICMR report to local FICMR Coordinators, the 2009 Legislators, and interested stakeholders			X	
3. Coordinate statewide Sudden Unexplained Infant Death death scene investigation training, by a team of MT medical examiners and coroners who are trained in CDC's train the trainer model			X	X
4. 3.Support and encourage FICMR prevention efforts, identified in the FICMR reports, at the state and local levels			X	X
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
FCHB continues to sustain the FICMR activities, including the twice a year training opportunities for coordinators. The collection of and analysis of FICMR data for the 2008 report will be available for the 2009 Legislative session. The goal for FICMR continues to be to assist communities to accurately identify preventable deaths and to develop community based mechanisms to decrease the incidence of preventable deaths in the target population.

FCHB and HMHB continue to collaborate on their "Safe Sleep Program" by sharing information with WIC, local public health agencies, and the PHHV/FASD Projects, with eight of the sixteen sites as of 6/30/08, referring clients for services.

c. Plan for the Coming Year
FCHB will continue supporting state and community FICMR prevention efforts by: assuring that the local communities submit accurately completed FICMR Reports prior to entry into the state's FICMR database that tracks fetal, infant, and child deaths; coordinating the writing of the fourth statewide FICMR Report using the 2005-2006 data and developing a distribution plan for the report that includes the 2009 Legislators, local FICMR teams, and other interested parties; assisting local FICMR teams in translating their data findings into community level prevention activities; providing two FICMR Coordinator and two FICMR State Team training and technical assistance meetings based on their identified community specific program needs that are gathered through evaluations at each meeting; and promoting prevention strategies statewide through distribution of the FICMR report which includes local community prevention activities.

FCHB will coordinate a statewide Sudden Unexplained Infant Death Scene Investigation Training by a team of medical examiners and coroners in MT who are trained in the CDC's Train the Trainer Model for SME's, Law Enforcement and local coroners

FCHB and Healthy Mothers Healthy Babies will continue their joint coordination of the Safe Sleep Project with FCHB ensuring that the PHHV/FASD Projects continue to refer their clients.

State Performance Measure 5: *Percent of Medicaid eligible children who receive dental services as part of their comprehensive services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	32	33	23	20.4	19.5
Annual Indicator	23.4	22.6	23.3	24.5	26.0
Numerator	14649	14707	15374	15066	16793
Denominator	62629	65079	66078	61369	64620
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	26	27	28	29	30

Notes - 2007
The source for this data is EPSDT. It is run on the FFY 2007.

Notes - 2006
The source for this data is EPSDT. It is run on the FFY 2006. CZ

Notes - 2005
This data came from the Early Periodic Screening Diagnostic Treatment (EPSDT) report from the Montana Medicaid Program. It is an annual report for FY 2005.

a. Last Year's Accomplishments
Jan Paulsen remained as the Medicaid Dental Consultant (MDC), a position she has held since April 2007, and participated on the Montana Oral Health Alliance (MOHA), specifically on the Community Based Prevention Work Group.

The Covered Services Section of the Medicaid Dental Provider Manual continues to be updated.

The Basic Dental Emergency Form was modified with the current CDT codes and can be found at:
http://medicaidprovider.hhs.mt.gov/pdf/emergencydentalform0404.pdf

The Medicaid fee schedule was updated to include the new October 1, 2007 CDT 5 codes and the increased reimbursement rates. This information can be found at:
http://medicaidprovider.hhs.mt.gov/pdf/provider18Jan08

The Oral Health Education Specialist (OHES) led the 18 members of the Community Based Prevention Work Group (CBPWG) in developing a 5 Year Strategic Plan. An essential component of this Plan is the initiation of the State of Washington Access to Baby and Child Dentistry (ABCD) Program in Montana. This is a collaborative effort of the Montana Office of Medicaid, the Montana Dental Association (MDA), and the MOHA. The ABCD program is designed to increase access to dental care for Medicaid-eligible infants, toddlers, and preschoolers. ABCD focuses on prevention and restorative dental care with an emphasis on enrollment and the first dental visit by age one. The Washington ABCD website is located at: http://222.abcd-dental.org/prog.html

The OHES and MDC attended the 2007 National Oral Health Conference (NOHC) and gained essential knowledge on the latest evidence-based best practice prevention strategies, and current oral health statistics. This information was shared with the 70 plus volunteer members of the MOHA, MDA, Community Health Center (CHC) Dental Clinics, 150 School Fluoride Mouthrinse Coordinators, WIC, County Health Nurses, and 200 plus participants who attended one of the 18 Community School Readiness Team's (CSRT) oral health events.

The 2007 Legislature approved House Bill 2 (HB 2) which raised Medicaid provider rates to 85 percent of charges in the aggregate replacing the previous provider rates of 58 percent for adults and 64 percent for children. The fee schedule was updated to include the new October 1, 2007 increased reimbursement rates. The HB 2 information is included on the Montana Medicaid Health Care Provider Notices and is posted on the Web Portal that all providers subscribe to as part of the claims system. Additional HB 2 funds were included to contract with CHC's to establish or expand dental services in their communities.

From October of 2006 to September of 2007 the MDC traveled to Great Falls and Missoula and conducted personal meetings with individual and area provider groups, as well as MDA members, regarding Medicaid concerns and program ideas and to problem solve specific regional provider issues.

The Human and Community Service Division (HCSD) received a Food Stamp Incentive award and with this money allocated one-time funding to the FCHB to specifically address the oral health care needs of pregnant women and children. In collaboration with the HCSD, an Oral Health/Food Stamp Project (OH/FSP), complimenting the MOHA's Strategic Plan, was developed

focusing on oral health education and dental services for families of Medicaid children in Early Head Start (EHS), Head Start (HS), and child care programs. The OH/FSP began new collaborations with the CHC, EHS and HS Health Coordinators, the CSRT, the 12 Child Care Resource and Referral Agencies (CCRR), WIC and the MDA.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MDC and OHES are participating on the 2007 Legislature sanctioned HJR 22 Dental Study Working Group.		X		X
2. MDC and OHES attendance at the 2007 & 2008 National Oral Health Conference to gain knowledge and participate in networking opportunities.				X
3. Ongoing participation as a member of the Montana Oral Health Alliance. This year's focus will be implementation of the ABCD program.				X
4. Ongoing collaboration with the MDA, FCHB, EHS/HS, CHC, CCRR, and the CSRT to promote evidence-based best practice prevention programs, with an emphasize on early intervention strategies as outlined in the OH/FSP and the MOHA 5 Year Strategic Plan.		X		X
5. Pursue avenues to increase participation of dental providers in Medicaid: 1. Utilize best practice models to address "Medicaid patient behaviors" frustrations. 2. Increase provider knowledge of Medicaid administrative procedures.		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Medicaid Dental Provider Manual continues to be updated.

MDC and OHES participate on the HJR 22 Dental Study Working Group, sanctioned by the 2007 Legislature, and are exploring incentive programs to increase access to dental care in rural areas. The Study final reports are at:
http://leg.mt.gov/css/fiscal/PEPB_Subcommittee.asp

The OH/FS Project is promoting early intervention strategies such as: educational materials distributed to over 200 people at a CSRT parent meetings; the creation of a DPHHS approved, MOHA/CBPWG oral health message aimed at disease transmission between child and caregiver and see your dentist by age 1; and access to web-based Open Wide training with a new partner, the Training Communication Center (TCC), allowing 17 EHS/HS and 22 child care providers completing it. https://montanapublichealthtcc.org/kc/main/kc_frame.asp

The MDC and OHES participated in the 2008 NOHC and June 2008 HRSA/OPR Strategic Partnership Session (SPS). At the SPS, the OHES facilitated a discussion on strategies the CHC Dental Clinics can utilize to increase education and services to pregnant women and children age 0-3.

The MDC is working with the MOHA CMPWG, to research the ABCD fiscal impact and program specifics and facilitated a panel discussion at the 2008 MDA State Convention, attended by 70

members, allowing for dialogue of Medicaid program concerns.

The 2007 Legislature approved a rate increase effective July 2008 which also expanded coverage for crowns for children.

c. Plan for the Coming Year

The OHES will continue facilitating the ongoing meetings of the MOHA, as well as overseeing the implementation of the Montana Oral Health Alliance 5 Year Strategic Plan. New MOHA partners identified at the June 2008 HRSA OPA Strategic Partnership Session will be invited to participate. The MDC will continue to serve as a member on the MOHA.

The MDC will finalize the research determining the fiscal impact and program details of implementing the ABCD program and an implementation plan will be created. The ABCD Consultant Group, which includes Washington State Medicaid, the University of Washington, School of Dentistry, and the Washington Dental foundation have agreed to assist the State of MT, which includes partnerships with the MT Dental Association, Medicaid and FCHB, in implementing ABCD,

The MDC and OHES will incorporate, as appropriate, recommendations from the 2008 CMS EPSDT Dental Review the and ABCD Consultant Group into the OH/FSP and MOHA 5 Year Strategic Plan.

The MDC will facilitate meetings with individual and health care provider groups that will assist them to utilize best practice concepts to formulate policies for no show, broken appointments, and Medicaid patient behaviors. Useful information will be provided to minimize the administrative hassles of doing business with Medicaid such as; filing clean claims, reconciling denials, and proper documentation for special cases. The current reimbursement rates and strategies to check eligibility, check limits, and check fee schedules, will be addressed as well.

The OHES and the MDC will represent the State of Montana at the 2009 National Oral Health Conference, pending available funding.

The OHES will continue to implement the OH/FSP by promoting early oral health intervention strategies, such as: enrolling an additional 90 child care providers in the Open Wide training offered through the TCC and exploring the potential of expanding Open Wide to local health departments; continued communication and sharing of information with the 18 Community School Readiness Teams; and developing a Request for Proposal, requiring the CHC Dental Clinics to increase education and services to pregnant women and children age 0-3, that will issued and funds allocated.

The OHES will continue working on a statewide distribution plan for the approved, MOHA/CBPWG message aimed at oral disease transmission between child and caregiver, and see your dentist by age 1. The distribution plan includes recruiting additional new partners, as identified at the June 2008 HRSA/OPR Strategic Partnership Session so as to blend their resources with the minimal funds allocated by the Oral Health/Food Stamp Program.

State Performance Measure 6: *Percent of pregnant women who abstain from cigarette smoking.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	81	82	83	81.6	81.6

Annual Indicator	80.5	80.6	81.0	80.6	81.8
Numerator	9204	9308	9284	9980	10048
Denominator	11439	11554	11468	12388	12287
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	82	82	83	83	83

Notes - 2007
Numerator and denominator data are from the Montana Office of Vital Statistics. The numerator includes the number of resident women who experienced a live birth in MT in 2007 and reported not smoking during pregnancy, plus the number of resident women who experienced a fetal death in MT in 2007 and reported not smoking during pregnancy. Denominator data includes all resident women who experienced a live birth or a fetal death in MT in 2007. Only events that occurred in the state to MT residents are included, as reporting of stillbirths or fetal deaths and smoking data from other states may not be consistent with Montana's pregnancy surveillance. Vital records data on smoking in pregnancy is based on self-report and therefore is probably an underestimation of the actual incidence.

Notes - 2006
Numerator and denominator data are from the Montana Office of Vital Statistics. The numerator includes the number of resident women who experienced a live birth in MT in 2006 and reported not smoking during pregnancy, plus the number of resident women who experienced a fetal death in MT in 2006 and reported not smoking during pregnancy. Denominator data includes all resident women who experienced a live birth or a fetal death in MT in 2006. Only events that occurred in the state to MT residents are included, as reporting of stillbirths or fetal deaths and smoking data from other states may not be consistent with Montana's pregnancy surveillance. Vital records data on smoking in pregnancy is based on self-report and therefore is probably an underestimation of the actual incidence. This indicator was updated for the July 15, 2008 submission. df

Notes - 2005
The numerator is from the MT Office of Vital Statistics and includes Montana residents who delivered a live birth or experienced a fetal death in MT and did not smoke during pregnancy. The denominator includes resident women who experienced a live birth or fetal death in Montana. Only events that occurred in the state to MT residents are included, as reporting of stillbirths or fetal deaths and smoking data from other states may not be consistent with Montana's pregnancy surveillance. Data were updated for the July 15, 2008 submission.

a. Last Year's Accomplishments
FCHB contracted with 14 counties and one reservation to provide Public Health Home Visiting (PHHV) services to at risk pregnant women and/or women parenting a less than one year old infant and with six (6) Fetal Alcohol Spectrum Disorder (FASD) sites to provide home visitation services to approximately 1200 pregnant women at high risk for abusing alcohol, tobacco and other drugs (ATOD). PHHV and FASD home visiting services were provided by a multidisciplinary team of professionals comprised of a registered nurse, registered dietician, and social worker. PHHV sites with a FASD project added a support specialist to the team. This multidisciplinary approach addressed the client's physical, nutritional, and mental health needs and provided the clients with care coordination and case management, health education, and referrals.

FCHB provided technical assistance and trainings to PHHV and FASD sites on these screening and assessment tools: Ages and Stages Questionnaire (ASQ); the Ages and Stages Questionnaire Social Emotional Developmental Screening Tool; Life Skill Progression (LSP); Edinburough Depression Screen (EDS), ACOG (American College of Obstetricians and Gynecologists) Domestic Violence Screen; and the Tolerance Annoyed Cut-down Eye-opener (T-ACE) Alcohol Screening Tool. The seven local FASD support specialists were trained on

motivational interviewing as a technique to use during home visits with pregnant women at risk for ATOD use during pregnancy.

The FASD 2006 Program Year End Evaluation Report was submitted to the Substance Abuse and Mental Health Services Administration (SAMSHA) the project funding source, and program contractors.

The FCHB staff participated on the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) statewide steering committee. The DELTA statewide steering committee includes representatives from the Office of Public Instruction (OPI), Board of Crime Control, Department of Justice Office of Victim Services, (DOJ/OVS), Adolescent and School Health Services, clergy, universities, Native Americans, health care providers, people with disabilities, businesses, and families and friends of intimate partner violence and sexual violence (IPV/SV) victims. The DELTA committee has developed a draft IPV/SV needs and goals document and prevention plan for the state that includes statewide and regional recommendations for the primary prevention of IPV/SV.

FCHB staff coordinated three meetings of the Governor appointed Fetal Alcohol Spectrum Disorder Advisory Council (FASD AC) charged with identifying activities aimed at preventing alcohol consumption during pregnancy. The FASD AC statewide steering committee included physicians, FCHB staff, teachers, trial council appointee, family & addiction specialist, site managers for the prevention of FASD, director of young parents program, and parent of affected children. Due to changing federal funding requirements the FASD AC was discontinued by the governor in April 2008.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. FCHB will serve on statewide advisory councils and steering committees, i.e. DELTA			X	
2. FCHB will act as a consultant for the PHHV/FASD Projects				X
3. Continue to fund and support the PHHV/FASD Projects				X
4. Coordinate with MTUPP to provide smoking cessation training to PHHV/FASD Projects			X	
5. Continue to develop and sustain partnerships with tobacco use prevention and cessation organizations.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The PHHV Business Plan Analysis has been initiated. State staff and local PHHV contractors have been meeting to discuss program requirements, outcomes and data system so as to identify and select an evidenced based model and data system for the delivery of services to high risk pregnant women and their infants. Attachment

FCHB and MTUPP are planning a fall tobacco cessation training for PHHV and FASD contractors.

FCHB continues to participate on the DELTA statewide steering committee.

FCHB is participating on a Medicaid/Targeted Case Management (TCM) workgroup advocating

for a rate increase for TCM services provided to high risk pregnant women.

The FCHB sponsored, Risky Beginnings training attended by 80 individuals that included PHHV and FASD home visitors, and early childhood providers.

The 2007 MT Legislature allocated state funds supporting the existing PHHV/FASD Projects and to sponsor additional PHHV Projects. FCHB consulted with the Billings Area Office of Indian Health Services and three tribal health departments and discussed their capacity to provide PHHV. The Northern Cheyenne Tribal Nation's PHHV request for proposal was approved.

FCHB continues to offer training and information such as MTUPP quit line and the March of Dimes Prematurity Prevention materials, as well as provide financial support to PHHV and FASD contractors.

Matthew Dale, DOJ/OVS presented information about a potential collaboration with FICMR and the DOJ.

An attachment is included in this section.

c. Plan for the Coming Year

At present, the FCHB is financially supporting the 16 PHHV/FASD Projects and will make site visits to each of the Projects during this upcoming year to provide technical support pertaining to program and contractual requirements. The Northern Cheyenne Tribal Nation's PHHV Project is anticipated to begin in FY 09.

FCHB will coordinate the ongoing PHHV reassessment project meetings for this coming year.

FCHB will prepare a PHHV/FASD Project report, which includes data and outcomes, for the 2009 Legislature and other interested stakeholders.

MTUPP training is tentatively planned for September and October 2008 and will be offered in at least two of the five regions of the state.

FCHB Staff will continue participating on the DELTA statewide steering committee.

FCHB will prepare a Legislative report for the 2009 session that will report on PHHV and FASD services provided and data collected to show outcomes as a result of the services.

State Performance Measure 7: *Rate of firearm deaths among youth aged 5-19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	7.4	7.2	7	8	8
Annual Indicator	10.0	6.3	8.5	6.4	5.3
Numerator	19	12	16	12	10
Denominator	189774	189830	189318	188336	187074
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	6	6	5	5	5

Notes - 2007

As of the 2005 data, this indicator is calculated using 3-year moving averages. The numerator is the average number of deaths due to a firearm for Montana resident youth ages 5 through 19 in 2005-2007. The denominator is the estimated average number of youth aged 5 through 19 years in Montana in 2005-2007, based on mid-year census estimates.
The numerator does not yet include deaths to MT residents that occurred outside of Montana in 2007.

Notes - 2006
As of the 2005 data, this indicator is calculated using 3-year moving averages. The numerator is the average number of deaths due to a firearm for Montana resident youth ages 5 through 19 in 2004-2006. The denominator is the estimated average number of youth aged 5 through 19 years in Montana in 2004-2006, based on mid-year census estimates.

Please note that data were corrected with updated census data in 2008.

Notes - 2005
As of the 2005 data, this indicator is calculated using 3-year moving averages. The numerator is the average number of deaths due to a firearm for Montana resident youth ages 5 through 19 in 2003-2005. The denominator is the estimated average number of youth aged 5 through 19 years in Montana in 2003-2005, based on mid-year census estimates.

Please note that data were corrected with updated census data in 2008.

a. Last Year's Accomplishments
FCHB worked with the State Fetal Infant Child Mortality (FICMR) Review team and the Local FICMR Coordinators who gathered community level child mortality data related to firearms to identify strategies for promoting gun safety practices at the community level. Their suggested activities included gun safety information distributed in communities, gun locks distributed at hunter safety courses, and gun safety Public Service Announcements (PSA).

FCHB coordinated and convened the State Fetal Infant Child Mortality (FICMR) Review team and the local FICMR Coordinators meetings. Gun lock education was provided to both groups by Fish Wildlife and Parks (FWP) staff. The 29 FICMR coordinators disseminated firearm safety education materials (firearm storage and gun locks) to gun merchants and media within their communities.

FCHB continued its support for youth gun safety and awareness classes provided by FWP, 4-H Clubs, local public health departments and schools through sharing of information at state FICMR team meetings and local FICMR coordinator meetings.

Gun safety and safe storage of firearms educational materials were routinely included and reviewed during the Public Health Home Visiting Program's (PHHV) home visits in 15 communities to high-risk pregnant women and families of high-risk children. PHHV projects provided services to approximately 1200 families a year.

FCHB provided funding to the twelve Garrett Lee Smith Youth Suicide Prevention (YSP) Projects, as well as site specific technical assistance and guidance, based on the community's unique needs, with regular phone contact and conference calls. Firearm death prevention materials and gun locks were distributed at several community health fairs sponsored by one of the Youth Suicide Prevention Projects.

FCHB arranged for FWP staff to provide a presentation on gun lock usage and educational information at the September 2007 FICMR Coordinators' meeting attended by 28 local coordinators.
An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to identify areas of preventability, through local FICMR team reviews, to direct public education and community interventions related to firearm deaths.			X	X
2. Provide educational material to health providers, including emergency room and first responder professional staff, promoting means restriction relating to firearms.			X	
3. Coordinate youth suicide prevention efforts with the Fetal, Infant and Child Mortality Review (FICMR) Team to recommend and implement prevention strategies related to youth homicide and suicide completion rates attributed to firearms.				X
4. Provide technical assistance related to firearm related deaths to the 12 communities implementing suicide prevention activities.				X
5. Gather firearm related data collected by the local FICMR team reviews sent and enter the data into the fetal, infant and child deaths data repository.				X
6. Develop and distribute the 2005-06 FICMR report to local FICMR Coordinators, the 2009 Legislators, and interested stakeholders			X	
7.				
8.				
9.				
10.				

b. Current Activities

FCHB continues to supply gun safety information to the local FICMR Coordinators and schools for their own distribution in their communities.

FCHB shares the State FICMR Team's prevention strategies, such as gun safety education and using gun locks, with the local FICMR Coordinators.

A new partnership is being developed with the State Injury Prevention Coordinator, of the EMS and Trauma System Section Bureau to incorporate gun safety information, i.e. state statistics; prevention tips for kids, adults, and parents; locations for free or low-cost trigger locks; and links to downloadable educational games on the state's Emergency Medical System /Trauma webpage: http://www.dphhs.mt.gov/ems/emsother/linkspages/links.html

FCHB continues to provide gun safety and safe firearm storage educational materials during PHHV/FASD home visits.

The Statewide Suicide Prevention Plan recommends increasing firearm safety measures by providing gun locks and hunter safety education. FCHB continues to share this message with the 12 YSP Projects and ensured that each project had information promoting awareness of proper and safe storage of firearms for their communities.
Through 9/30/08, the 12 YSP Projects will continue to receive financial and technical assistance from the FCHB as well as be involved with the transitioning of the YSP to the Statewide Suicide Prevention Coordinator.

c. Plan for the Coming Year

FCHB will continue to coordinate the regular meetings of the Fetal, Infant, Child, and Mortality Review teams, both at the community and state levels; collect the FICMR data; and develop a FICMR report using the 2005-2007 data for the 2009 Legislature.

Recent federal funding cuts resulted in the FCHB being unable to replace staff members who were responsible for coordinating the Statewide Youth and Young Adult Suicide Prevention Project currently in 12 communities and injury prevention activities. Therefore, new partnerships are being formed.

One partnership is with the Chronic Disease Prevention and Health Promotion Bureau which houses the State Injury Prevention Coordinator. The Injury Prevention Program Coordinator works cooperatively with organizations, agencies, health care institutions, health care providers and others to implement and evaluate injury prevention and control programs consistent with the CDPHPB data-driven, injury prevention and control plan. The FCHB will be working with the Injury Prevention Coordinator on incorporating preventable injuries, endemic to the maternal and child health population as reported by the local FICMR coordinators, into the State Injury Prevention Strategic Plan. The FCHB also plans to support the Bureau's request from the 2009 Legislature for general funds to support this position.

A second partnership is with Karl Rosston, from the Addictive Mental Disorder Division, who was hired in December 2007 as the statewide Suicide Prevention Coordinator. FCHB has worked with Mr. Rosston on transitioning the 12 Garrett Lee Smith Youth Suicide Prevention projects and will finalize the transition this coming year. In the coming year, FCHB will remain involved with reviewing and providing recommendations to the Statewide Suicide Prevention as well as providing technical assistance and guidance to Mr. Rosston.

State Performance Measure 8: *Percent of low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				6	6
Annual Indicator	6.7	7.7	6.7	7.3	7.2
Numerator	767	881	772	911	880
Denominator	11384	11514	11573	12499	12249
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	6	6	6	6	6

Notes - 2007
The Montana Office of Vital Statistics is the data source for this performance measure. The numerator includes low birth weight births to Montana residents that occured in Montana. The denominator includes the number of births to Montana residents that occured in Montana. The 2007 data are preliminary and will be updated when reporting for births to MT residents that occured out of state is complete.

Notes - 2006
The Montana Office of Vital Statistics is the data source for this performance measure. The numerator includes low birth weight births to Montana residents (regardless of place of occurrence). The denominator includes the number of births to Montana residents (regardless of place of occurrence). The data for this indicator were updated with final vital statistics data in 2008.

Notes - 2005

The Montana Office of Vital Statistics is the data source for this performance measure. The numerator includes low birth weight births to Montana residents (regardless of place of occurrence). The denominator includes the number of births to Montana residents (regardless of place of occurrence). The data for this indicator were updated with final vital statistics data in 2008.

a. Last Year's Accomplishments

FCHB contracted with 14 counties and one reservation to provide Public Health Home Visiting (PHHV) services to at risk pregnant women and/or women parenting a less than one year old infant and with six (6) Fetal Alcohol Spectrum Disorder/Intensive Case Management (FASD/ICM) sites to provide home visitation services to approximately 1200 pregnant women at high risk for abusing alcohol, tobacco and other drugs (ATOD). PHHV and FASD home visiting services were provided by a multidisciplinary team of professionals comprised of a registered nurse, registered dietician, and social worker. PHHV sites with a FASD project added a support specialist to the team. This multidisciplinary approach addressed the client's physical, nutritional, and mental health needs and provided the clients with care coordination and case management, and health education, and referrals.

FCHB provided technical assistance and trainings to PHHV and FASD sites on these screening and assessment tools: Ages and Stages Questionnaire (ASQ); the Ages and Stages Questionnaire Social Emotional Developmental Screening Tool; Life Skill Progression (LSP); Edinburough Depression Screen (EDS), ACOG (American College of Obstetricians and Gynecologists) Domestic Violence Screen; and the Tolerance Annoyed Cut-down Eye-opener (T-ACE) Alcohol Screening Tool. The seven local FASD support specialists were trained on motivational interviewing as a technique to use during home visits with pregnant women at risk for ATOD use during pregnancy.

The FASD 2006 Program Year End Evaluation Report was submitted to the Substance Abuse and Mental Health Services Administration (SAMSHA) the project funding source and program contractors.

The FCHB staff participated on the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) statewide steering committee. The DELTA statewide steering committee includes representatives from the Office of Public Instruction (OPI), Board of Crime Control, Department of Justice Office of Victim Services, (DOJ/OVS), Adolescent and School Health Services, clergy, universities, Native Americans, health care providers, people with disabilities, businesses, and families and friends of intimate partner violence and sexual violence (IPV/SV) victims. The DELTA committee has developed a draft IPV/SV needs and goals document and prevention plan for the state that includes statewide and regional recommendations for the primary prevention of IPV/SV.

FCHB staff coordinated three meetings of the Governor appointed Fetal Alcohol Spectrum Disorder Advisory Council (FASD AC) charged with identifying activities aimed at preventing alcohol consumption during pregnancy. The FASD AC statewide steering committee includes physicians, FCHB staff, teachers, trial council appointee, family & addiction specialist, site managers for the prevention of FASD, director of young parents program, and parent of affected children. Due to changing federal funding requirements the FASD AC was discontinued by the governor in April, 2008.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue collection and review of Fetal, Infant, and Child Mortality Review (FICMR) and Public Health Home Visiting				X

(PHHV) data related to low birthweight.				
2. Promote good prenatal care and prevention of preterm birth through PHHV/FASD Projects.		X		
3. Promote good prenatal care and prevention of low birthweight infants through the work of the FICMR state team and FICMR coordinators.				X
4. Provide education and training to the public health home visitors and FASD/ICM support specialists on prevention of low birth weight.				X
5. Continue to fund the PHHV/FASD Projects that provide services to prevent preterm and low birth weight babies.				X
6. Distribute informational materials and provide training related to risk of smoking during pregnancy to local FICMR coordinators and PHHV/FASD Projects			X	X
7. The FICMR coordinator will partner with MOD to provide education and outreach on prevention of prematurity.			X	
8.				
9.				
10.				

b. Current Activities

The PHHV Business Plan Analysis has been initiated. State staff and local PHHV contractors have been meeting to discuss program requirements, outcomes and data system so as to identify and select an evidenced based model and data system for the delivery of services to high risk pregnant women and their infants. FCHB and MTUPP staffs are planning fall tobacco cessation training.

FCHB staff continues to participate on the DELTA statewide steering committee.

FCHB is participating on a Medicaid/Targeted Case Management (TCM) workgroup advocating for a rate increase for TCM services provided to high risk pregnant women.

The FCHB sponsored, Risky Beginnings training attended by 80 individuals that included PHHV and FASD home visitors, and early childhood providers.

The 2007 MT Legislature allocated state funds supporting the existing PHHV/FASD Projects and to sponsor additional PHHV Projects. FCHB consulted with the Billings Area Office of Indian Health Services and three tribal health departments and discussed their capacity to provide PHHV. The Northern Cheyenne Tribal Nation's PHHV request for proposal was approved.

FCHB continues to offer training and information such as MTUPP quit line and the March of Dimes Prematurity Prevention materials to PHHV, FASD, and FICMR contacts, as well as provide financial support to PHHV and FASD contractors.

Matthew Dale, DOJ/OVS presented information about a potential collaboration with FICMR and the DOJ.

c. Plan for the Coming Year

At present, the FCHB is financially supporting the 16 PHHV/FASD Projects and will make site visits to each of the Projects during this upcoming year to provide technical support pertaining to program and contractual requirements. The Northern Cheyenne Tribal Nation's PHHV Project is anticipated to begin in FY 09.

FCHB will coordinate the ongoing PHHV reassessment project meetings for this coming year.

FCHB will prepare a PHHV/FASD Project report, which includes data and outcomes, for the 2009 Legislature and other interested stakeholders.

MTUPP training is tentatively planned for September and October 2008 and will be offered in at least two of the five regions of the state.

FCHB Staff will continue participating on the DELTA statewide steering committee.

State Performance Measure 9: *Percent of Montana public middle and secondary schools that include comprehensive sexuality education as part of their health curriculum.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective					63
Annual Indicator				62.6	62.6
Numerator				107	107
Denominator				171	171
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	63	70	70	70	70

Notes - 2007
The source of these data are the 2002-2003 Sex Education Telephone Questionnaire conducted by Planned Parenthood. The survey included only high schools, therefore middle schools are not included in this first year of data reporting, although the intent is to include them in future surveys. 20 (11.7%) of the 171 high schools did not repsond to the survey.

The data used for this indicator suggest that 25% of the schools reporting comprehensive sexuality education as a part of their curriculum actually only teach about contraceptive failure rates. The definition of comprehensive sexuality education used for this performance measure will be reviewed. As a result, schools that only teach about contraceptive failure rates may not be included in the numerator in the future, which would result in a lower indicator. ahb df

Notes - 2006
New SPM for the MCH BG 08 Application. The source of these data are the 2002-2003 Sex Education Telephone Questionnaire conducted by Planned Parenthood. The survey included only high schools, therefore middle schools are not included in this first year of data reporting, although the intent is to include them in future surveys. 20 (11.7%) of the 171 high schools did not repsond to the survey.

The data used for this indicator suggest that 25% of the schools reporting comprehensive sexuality education as a part of their curriculum actually only teach about contraceptive failure rates. The definition of comprehensive sexuality education used for this performance measure will be reviewed over the coming year. As a result, schools that only teach about contraceptive failure rates may not be included in the numerator in the future, which would result in a lower indicator. ahb df

a. Last Year's Accomplishments
This was a new performance measure beginning in FY 2008. Previously established partnerships aided in expediting the work by the Women's and Men's Health Section Health

Education Specialist (WMH/ES): These partnerships included: the Joint Committee for Healthy Kids (JCHK) comprised of state employees from the Department of Public Health and Human Services (DPHHS) and the Office of Public Instruction (OPI); the 14 Delegate Agencies that provide family planning and education services to all 56 counties; the Missoula Adolescent Pregnancy, Parenting, and Prevention Services (MAPPS); the Montana Partnership for Sex Education; and several partnerships within DPHHS including, the HIV/STD Section Supervisor.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide Teen Pregnancy Prevention Training at the 08 Fall MT Public Health Association Conference			X	X
2. Develop new partnership with Parent Teacher Association and provide educational materials for their use and distribution			X	X
3. Continue to coordinate and provide information, using an electronic tool kit, to interested stakeholders in October for Let's Talk/Family Involvement Month and in May National Teen Pregnancy Prevention Month		X	X	X
4. Evaluate the electronic tool kit's use amongst stakeholders				X
5. Maintain involvement on the Joint Committee for Health Kids				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The WMH/ES continued to attend the JCHK quarterly meetings and presented information about teen pregnancy rates, best practices, and comprehensive sexuality education at the spring 2008 meeting.

In March 2008, Bill Traverner presented the workshop Sex Ed 101 attended by over 100 participants who were teachers, school administrators, counselors, health educators and nurses.

Additional training opportunities for public health and family planning staffs included: What is Abstinence-only-until- Marriage?" in March 2008 and "Field Guide to Sex Ed." at the May 2008 Spring Public Health Conference; and "A Snapshot of Montana Youth" at the Annual Family Planning Conference.

The WMH/ES facilitated the October 2007 "Let's Talk/ Family Involvement Month" and the May 2008 National Teen Pregnancy Prevention Month activities incorporating a prevention message encouraging comprehensive sexuality education.

The WMH/ES assisted with writing Teen Pregnancy Prevention Month: Adolescent Health Viewed Through Teen Pregnancy featured in the May 2008 Montana Public Health: Prevention Opportunities Under the Big Sky. www.dphhs.mt.gov/PHSD

The ES also assisted with distributing the report, May 2008: Trends in Teen Pregnancies and Their Outcomes in Montana to over 200 stakeholders.
http://www.dphhs.mt.gov/PHSD/Women-Health/documents/teenpregnancyreport.pdf

c. Plan for the Coming Year

The WMH/ES will provide training on Teen Pregnancy Prevention at the Fall 2008 Montana Public Health Association Conference. The presentation will include an overview of the state data released in May 2008, risk and protective factors, statewide indicators, best practices, and skills building for communities.

The WMH/ES is developing a new partnership with the Parent Teacher Association and will offer educational materials on teen pregnancy prevention, protective and risk factors, best practices, and comprehensive sexuality education at the 2008 Fall Parent Teacher Association conference in Great Falls, MT.

WMH/ES will continue to coordinate and provide electronic tool kits for Let's Talk/ Family Involvement Month in October and National Teen Pregnancy Prevention Month in May to the Delegate Agencies.

WMH plans to create to query the Delegate Agencies, using an online survey tool, so as to determine if the electronic tool kit is meeting their needs as well as to gather information as to how to improve future tool kits.

WMHS will continue to participate in the quarterly Joint Committee on Healthy Kids meetings.

E. Health Status Indicators

The Health Status Indicators (HSIs) are a useful source of multi-year data on the measures. Montana's relatively small population can result in a low number of cases for some outcomes, particularly for uncommon health events. Alternatively, an increase or decrease of one or two cases from one year to the next can result in the appearance of drastic increases or decreases in the rates of some outcomes. Major increases in the frequency of a particular event from one year to the next do not necessarily demonstrate a significant increase, and while small numbers of events or outcomes present particular opportunities and challenges in analysis, they are not necessarily an indication of a lack of need. Therefore, annual frequencies, rates or calculations may vary widely and be less descriptive than the multi-year perspective captured in the HSIs.

Collecting the health status indicators in one location, at one time is a useful overview on Montana's residents. The data reported in the HSIs are used often in grant applications, reports and programmatic activities, but they are often only on more specific topics. For example, data on motor vehicle crashes and sexually-transmitted diseases are discussed and used within those programs, but rarely are data on such programmatically disparate topics brought together and used to create a broader perspective of the health status of the state's population.

Some health status indicators are more useful than others in serving as surveillance and monitoring tools or acting as evaluative measures. Montana encounters challenges in reporting on some of the health status indicators, specifically those for which something other than vital records is the expected data source. Those health status indicators currently offer less helpful information on the state's residents, although some of them provide a data collection goal to strive for.

For those health status indicators for which Montana does not have an ongoing, stable source of data, such as the rate of nonfatal injuries among children (HSI04A), investigating possible data sources can result in new connections with programs outside of the state Title V program and increased knowledge within the Title V program of activities elsewhere in the health department. While this is useful programmatically, it does often mean that the indicator itself is not comparable from year to year and does not offer an accurate perspective on the health status being measured.

Some information collected in the HSIs may be more useful in directing public health efforts with additional narrative information to provide perspective or background on the measure. For instance, in the 2007 MCH Block Grant Application, Montana added low birth weight as a new state performance measure. Although birth weight under 2,500 grams is already captured in Health Status Indicator 01A, prevention of low birth weight and premature birth are priorities of the Family and Community Health Bureau (FCHB), and the narrative section of the performance measures allows the state to track the data as well as related initiatives, programs and interventions.

/2009/ Except for slight increases and decreases, Montana's health status indicators have remained fairly stable over the past several years. Even using 3-year moving averages, the indicator does not suggest an upward or downward trend in most of the measures, even over the 5-year time period reflected in the block grant. Additional years of data may be necessary to identify whether there is actually a trend in the health status indicators. In some cases, data sources for the HSIs have changed over the past 5 years, and consistent enough data are not available to look at trends over time.

The one exception is the rate of nonfatal injuries due to motor vehicle crashes (MVCs) among children aged 14 and younger (HSI 04B). The data source for this indicator has been the same for many years and reporting has been fairly consistent. Looking at 3-year moving averages for this measure, the incidence of nonfatal injuries due to MVCs has steadily decreased since 2003. While the incidence of death due to MVCs among children 14 and younger has not decreased, it has also not increased, indicating that there may be fewer MVCs involving children, or the MVCs that do occur are less likely to cause injuries or death.

Since its inception two years ago, the MCH Epidemiology Unit has been reviewing the MCHBG data sources to standardize and enhance the use of data in MCH Block Grant reporting and program planning. The Unit's workplan for 2009 includes a more in-depth review of the measures included in the Health Status Indicators and a longer term look at trends using standardized population definitions (i.e. resident vs. occurrent incidents) and sources of data that may not have been available for analysis in previous years. //2009//

F. Other Program Activities

Although mentioned elsewhere in this document, the importance of continuing to develop and refine the public health system and its capacity to support the delivery of the core functions and essential services of public health is worth emphasizing. Due to the rural/frontier nature of much of the state, we depend upon a public health workforce that is overburdened and under funded. In order to maximize the health of the public, and specifically the health of the MCH population, it is important that state level efforts continue to focus on supporting linkages and encouraging efficient delivery of services. A focus on population-based services is also key, with MCH continuing to struggle with its perceived role as a safety net provider of services otherwise not available or funded. The efforts of the Public Health Improvement Bureau and the public health informatics section will continue to help educate and support the workforce, and to improve and streamline reporting in order to decrease the burden on local contractors.

Reviewer questions asked for an examination of the low birth weight (LBW) incidence in Montana. A review of the existing data revealed that the appears to be a trend in the incidence of LBW births in Montana. Low birth weight, defined as births less than 2500 grams, is a standard indicator of perinatal health at both the state and federal levels. In response to this concern, a low birth weight trend analysis was performed on aggregate state data for the years 1995 to 2004, stratified by year and race. Using the Cochran-Armitage test for trend for the years in question regardless of race, there appeared to be a significant positive linear trend for the occurrence of low birth weight events in the state. Further investigation into the trend revealed

though Native American populations were 16% more likely to have a low birth weight baby than Caucasian populations, however, they were not the cause of the positive linear trend, with noticeable highs and lows apparent for multiple years. The Caucasian population's variability over time was the significant cause of the positive linear trend seen in the analysis, rising approximately 30% since 1995.

In addition, strategic planing will be a focus during the remainder of 2005 and 2006. Further prioritization of health needs will occur using the priorities identified by stakeholders throughout the state and the involvement of FCHB Advisory Council Members and staff.

/2008/ The FCHB five sections continued their work on developing their respective work plans which in turn have been incorporated into the Bureau's strategic plan which is attached to this application. The Montana Oral Health Alliance resumed their meetings and completed Montana's Oral Health 5 Year Strategic Plan which formed the basis for the Targeted State MCH Oral Health Service Systems Grant Program 2007 application. The Oral Health Alliance will continue to meet and refine the Strategic Plan this coming year.

The FCHB Advisory Council continued to be involved with identifying priorities. As noted elsewhere, the Governor's Office has replaced the FCHB Advisory Council with the Family Health Committee, with Governor Appointments expected to be made in the Fall of 2007

A portion of the State Systems Development Initiative (SSDI) grant supported an assessment of the Public Health and Safety Division's information systems and data reporting requirements, which includes Maternal Child Health (MCH) data collection. This assessment was completed by Pete Kitch of KIPHS Inc. and the recommendation is that the Bureau uses the Business Process Analysis (BPA) to analyze how MCH currently works with their stakeholders (i.e. local health department officials). This process will include examining how work is currently being completed and "rethinking" on how things should work in determining the information needed to meet federal grant requirements. A committee, consisting of Bureau members and stakeholders will use this methodology as a way to determine the best solution for selecting a proper information system. It is anticipated that completing the BPA will help increase the state's and local's data collection capacity and decrease the burden on local contractors. SSDI funding will also be used to improve and develop data collection and analysis systems for MCH data based on the BPA recommendations. //2008//

/2009/

Montana's maternal and child health population continues to depend on the local public health workforce for addressing their health care needs, of which the MCHBG provides significant funding to many of the state's 56 local public health departments. As noted throughout the application, the FCHB continues to review and revise the Blueprint for Maternal and Child Health in Montana that is the foundation for the Bureau's activities related to the performance measures.

The Public Health Home Visiting Business Process Analysis, more commonly referred to as the PHHV Reassessment Process, and the WIC Futures Study Group began meeting in FY 2008 and will continue through 2009. These two work groups are composed of state and local stakeholders and are charged with submitting suggestions and/or recommendations to the Bureau as to how to be more efficient in administering and collecting data related to the PHHV and WIC Programs. The lessons learned by these two groups provide a basis to learn from and incorporate into future Bureau work groups. //2009//

G. Technical Assistance

Technical assistance needs identified to date include:

1. Staffing has remained fairly constant since the creation of the FCHB's Strategic Plan, Blueprint for Maternal and Child Health in Montana. However, logic model training would benefit the entire FCHB staff as we continue to explore methods of increasing staff capacity while addressing the national and state performance measures with our partners and collaborations. Michael Fagen, PhD. MPH, from the School of Public Health, University of Chicago has been identified as the trainer.

V. Budget Narrative

A. Expenditures

Montana depends upon its local partners for provision of MCH services to the population. 42% of the MCHBG is distributed to local county contractors under MCH services contract. Local match continues to be well beyond the reuired level, with local match of about $3.6 million, instead of the approximately $825,000 which would be required under the present contract. Montana does not have enough state general fund to pull down the federal funding, with a total of slightly over $1 million, instead of the $1.9 million needed.

Local match continues 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. For the first time in 2004, we were able to capture and report the program income.

Please see attachment for charts depicting trends.

Form 3 - Federal funding stayed about the same from 2001 through 2004 - federal decreases in 2005 and potentially 2006 will result in a drop in the federal level. The state funding also continues to go down slightly. Efforts to increase funding are anticipated for the 2007 session, depending upon fiscal picture. Local funding has had the most increase, albeit variable.

Form 4 - Children continue to be the primary target of services in the state. 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.The increase in infant and pregnant women expenditures may be in part attributed to the program income, much of which is for targeted case management for high risk pregnant women and infants. Variations between budgeted and expended amounts continue to vary by as much as 40% in some categories (pregnant women and others).

Form 5 - Direct expenditures reported by the counties continue to be high. This is in part due to definition and reporting issues. Large variations in expenditures by level of the pyramid continue. While definition issues continue to confound, a large percent of funding continues to support direct health care.

/2007/ Montana continues to experience decreases in MCHBG funding due to federal decreases and population shifts. Montana's block grant allocation has decreased by over $180,000 since 2001. County contracts, accounting for approximately 42% of the overall budget have decreased, as have state level program budgets. Cost allocation, or administrative costs, have increased. Counties have continued to overmatch the MCHBG, providing far more match than is required by contract.

Form 4 - Children's services continue to account for the largest portion of the federal/state/local MCH partnership. Counties commit over $2 million annually to services for children aged 1 - 22. Children with special health care needs have also received more resources from counties over the last year.//2007//

/2008/
Montana's block grant allocation was decreased in FFY 06 by $85,000. For FY 08, the federal funding is estimated to remain the same as for FFY 06 and 07, $2,462,222. The county contracts continue to reflect approximately 42% of the total budget. The cost allocation or administrative costs increased, but are within the 10% threshold. Children's services continue to receive the greatest portion of the federal/state/local MCH partnership. //2008//

/2009/

Montana's block grant allocation was decreased by $38,000 in Fiscal Year 2008, resulting in the decision not to rehire the Child Health Coordinator housed in the CACH Section. Montana was able to maintain 42% of the total block grant allocation being distributed to 53 of the 56 local public health departments. Children's services continue to receive the greatest share of the MCH Partnership. //2009//

B. Budget

The proposed budget for FFY 2006 as outlined on Form 2 includes the following:

Primary and Preventive Services for Children $ 1,008,269

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 $829,709
Primary and Preventive Services for Children $ 1,008,269

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 $829,709

Budget includes the CSHS budget of $764,000 plus $65,000 of cunty MCHBG which they report expending on the CSHCN population.

Title V Administrative Costs $224,404

Includes state indirects of $176,633 plus anticipated local of $47,777. Administrative rule allows counties to use up to 10% of their award for administrative costs. The state admin costs are increased by approximately $40,000, due in part to conversion of the BC position for "direct pay" to cost allocation.

Unobligated balance $0

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

State MCH Funds $1,085,637

Budget includes public health home visiting general funds ($550,000) and funds to support the voluntary genetics program (apprximately $530,00).

Local MCH Funds $3,598,977

Local contractors continue to overmatch their contracted $1.1 million.

Program Income $791,235

County contractors are required to establish a sliding fee schedule which "adjust the charges to the income, resources, and family size of each such individual, and publish the fee schedule if the Cotnractor imposes any charges for services" under Section 1 of the MCH Services Task Order

for Montana County Contracts.

Federal-State Block Grant Partnership $8,023,781

Other Federal Funds $18,334,262

/2007/

The proposed budget for FFY 2007 as outlined on Form 2 includes the following:

Primary and Preventive Services for Children $ 955,473

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. Decreased from last year due to decreased federal funding available.

Children with special health care needs $838,666

Slightly increased from last year due to county efforts.

Title V Administrative Costs $194,083

Includes state indirects and local administrative costs. Administrative rule allows counties to use up to 10% of their award for administrative costs.

Unobligated balance $0

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

State MCH Funds $1,440,467

Budget includes public health home visiting general funds ($550,000), small amount of general funds to support MCH Administrative activities, and funds to support the voluntary genetics program (increased to approximately $850,000).

Local MCH Funds $3,165,000

Local contractors continue to overmatch their contracted receipts.

Program Income $743,094

County contractors are required to establish a sliding fee schedule which "adjust the charges to the income, resources, and family size of each such individual, and publish the fee schedule if the Cotnractor imposes any charges for services" under Section 1 of the MCH Services Task Order for Montana County Contracts.

Federal-State Block Grant Partnership $7,810,783

Other Federal Funds $19,458,492

Tables depicting the changes in Montana's Title V funding are attached. //2007//

/2008/

The proposed budget for FFY 2008 as outlined on Form 2 includes the following:

Primary and Preventive Services for Children $ 873,000

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 $838,666

Title V Administrative Costs $212,658

Includes state indirects and local administrative costs. Administrative rule allows counties to use up to 10% of their award for administrative costs.

Unobligated balance $0

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

State MCH Funds $2,173,902

Budget includes public health home visiting general funds ($550,013), small amount of general funds to support MCH Administrative activities, and funds to support the voluntary genetics program (increased to approximately $1,045,000 per 2007 Legislative action).

Local MCH Funds $3,500,746

Local contractors continue to overmatch their contracted receipts.

Program Income $914,508

Program Income shows an increase due to CSHS' clinic billing. Also county contractors are required to establish a sliding fee schedule which "adjust the charges to the income, resources, and family size of each such individual, and publish the fee schedule if the Contractor imposes any charges for services under Section 1 of the MCH Services Task Order for Montana County Contracts.

Federal-State Block Grant Partnership $9,051,378

Other Federal Funds $19,104,399

//2008//

/2009/

The proposed budget for FFY 2009, as outlined on Form 2, reflects a decrease from the amount received in FFY 2008. Form 2 includes the following:

Primary and Preventive Services for Children: $818,763 ($ 873,000 in 2008)

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. Decreased from last year due to decreased federal funding available.

Children with special health care needs: $823,666 ($838,666 in 2008)

Title V Administrative Costs: $225,325 ($212,658 in 2008)

Includes state indirects and local administrative costs. Administrative rule allows counties to use up to 10% of their award for administrative costs.

Unobligated balance $0 ($0 in 2008)

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

State MCH Funds $2,352,554 ($2,173,902 in 2008)

Budget includes public health home visiting general funds ($550,013), small amount of general funds to support MCH Administrative activities, and funds to support the voluntary genetics program (increased to approximately $1,045,000 per 2007 Legislative action).

Local MCH Funds $3,510,000 ($3,500,746 in 2008)

Local contractors continue to overmatch their contracted receipts.

Program Income $1,025,000 ($914,508 in 2008)

Program Income shows an increase due to CSHS' clinic billing. Also county contractors are required to establish a sliding fee schedule which "adjust the charges to the income, resources, and family size of each such individual, and publish the fee schedule if the Contractor imposes any charges for services under Section 1 of the MCH Services Task Order for Montana County Contracts.

Federal-State Block Grant Partnership $9,349,776 ($9,051,378 in 2008)

Other Federal Funds $20,268,575 ($19,104,399 in 2008)

//2009//

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.