

Maternal, Infant, and Early Childhood Home Visiting Statewide Needs Assessment Update



Rural Institute



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Executive Summary

Introduction

Home visiting has been shown to prevent adverse perinatal outcomes, improve child development, prevent child abuse and neglect, support positive parenting, and improve maternal and child health for low-income and other at-risk children and families. Home visiting provides information, resources, and support to expectant parents and families with young children. Montana's home visiting program, Healthy Montana Families (HMF), is administered by the Family and Community Health Bureau (FCHB) at the Montana Department of Public Health and Human Services (DPHHS). HMF is supported by the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program and State General Funds. Since 2011, HMF has supported community-based efforts to promote life-course development for families in at-risk communities across Montana, with a primary focus on improving the health and wellbeing of the maternal and child health (MCH) population. This report updates the findings from the 2010 Affordable Care Act, Maternal, Infant, and Early Childhood Home Visiting Program Montana Needs Assessment to provide a picture of the needs for and capacity to provide home visiting services in the state.

Primary Objectives

This update has four key objectives:

1. Identify communities with concentrations of risk;
2. Understand the needs of families and population trends;
3. Assess services available in early childhood systems and outline resources available to families in need; and,
4. Identify opportunities for collaboration to strengthen and expand services for at-risk families.

Purpose

The needs assessment results will inform strategic decision making among Montana's MIECHV awardees and stakeholders and ensure that awardees have a current understanding of home visiting service needs across Montana.

Key Findings

Key findings from this statewide need assessment update (SNAU) include:

- Thirty-eight (38) counties in Montana were identified as at-risk. In agreement with findings from the Title V Maternal and Child Health Services Block Grant Needs Assessment, the Child Abuse and Neglect Prevention Strategic Plan, and other recent statewide needs assessments, the most significant risk factors Montana families experience include substance use disorders (SUD), mental health concerns, a lack of mental health providers, and increasing rates of child maltreatment. Rural and tribal communities have the largest concentration of risk factors.
- SUD and child maltreatment are growing problems for Montana families evidenced by higher rates of SUD for alcohol use (57.3%), marijuana use (19.8%), methamphetamine use (0.97%), and opioid misuse (4.03%) compared to national rates (51.2% alcohol use, 15% marijuana use, 0.7% methamphetamine, and 3.6% opioid misuse) and the

increasing number of children taken into foster care due in part to parent SUD. In 2018, 65% of cases where children were taken into care were SUD-related.

- Seventy-two (72) agencies and organizations provide home visiting services in 36 counties across the state, including 23 MIECHV-funded agencies (Lead Implementing Agencies) serving 19 counties. In 2018-2019, MIECHV-funded agencies served 1,444 households and reached 32.9% of the population estimated to need home visiting services in the counties served.
- MIECHV-funded agencies support rural and tribal communities. Of the four smaller counties (populations of less than 10,000 residents) served by MIECHV-funded agencies, 61% of the estimated population in need received home visiting services. Additionally, 14% of MIECHV home visiting clients are American Indian (American Indians comprise 6.6% of the state's population). Sustained service to rural and tribal communities will provide needed support for these populations.
- Mirroring national trends in the characteristics of the home visiting workforce and state demographics, home visitors in Montana tend to be non-Hispanic, White and female. Increasing the gender and racial diversity of home visiting staff may help to reach subgroups with unique cultural and language needs such as single fathers, American Indians, migrant workers, and Spanish-speakers.
- Home visitors reported feeling motivated by working with families and having supportive teams/colleagues. Notable barriers to providing services include client retention and lack of knowledge of home visiting services. Continuing or increasing outreach and other efforts to destigmatize home visiting may serve to reduce these barriers.
- Substance use disorder treatment capacity in the state is limited by a lack of mental health providers and limited outpatient and residential services. Additional barriers are faced by those in rural/frontier areas as many services are primarily available in urban centers. Various local and state initiatives are striving to remove barriers that previously blocked people from getting needed help.
- There is a lack of infrastructure in Montana to support new mothers, particularly those with current or past substance use. Home visitors report not being fully prepared to recognize or address SUD issues. Home visitors may benefit from professional development around recognizing the signs of SUD and using trauma-informed, destigmatizing approaches to reduce staff burnout and turnover.

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Introduction

Decades of scientific research confirm that home visits by a nurse, social worker, early childhood educator, or other trained professional during pregnancy and the first years of a child's life can improve the lives of children and families.^{i,ii} Home visiting has been shown to prevent adverse perinatal outcomes, improve child development, prevent child abuse and neglect, support positive parenting, and improve maternal and child health.ⁱⁱⁱ Home visiting refers to programs or initiatives in which visits to a client's home is a primary service delivery strategy offered on a voluntary basis to pregnant women, expectant fathers, and parents and caregivers of children from birth to kindergarten entry. Montana's home visiting program, Healthy Montana Families (HMF), is administered within the Family and Community Health Bureau (FCHB) at the Montana Department of Public Health and Human Services (DPHHS). HMF is supported by the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program and State General Funds. MIECHV programs are administered by the U.S. Health Resources and Services Administration (HRSA) in partnership with the U.S. Administration for Children and Families (ACF). Since 2011, HMF has supported community-based efforts to promote life-course development for families in at-risk communities across Montana, with a primary focus on improving the health and wellbeing of the maternal and child health (MCH) population.

Consistent with the statutory requirement of the Social Security Act, Title V, 511(c9) (42 U.S.C. 711 (c)), Montana is updating the statewide home visiting needs assessment. The key objectives of this update are:

1. Identify communities with concentrations of risk;
2. Understand the needs of families and population trends;
3. Assess services available in early childhood systems and outline resources available to families in need; and,
4. Identify opportunities for collaboration to strengthen and expand services for at-risk families.

The needs assessment results will inform strategic decision making among Montana's MIECHV awardees and stakeholders. The first statewide needs assessment was conducted in 2010. This

update will ensure that awardees have a current understanding of home visiting service needs across Montana.

Montana Overview

Montana is the fourth largest state in the U.S. with 145,545 square miles of land area and has the third lowest population density in the US with 6.8 people per square mile.^{iv} Montana's 2019 population estimate was 1,068,778, reaching over one million people for the first time in 2018. The population increased by 8.0% since 2018 and is projected to grow. U.S. Census Bureau estimates for 2019 show Montana's population is predominantly White (89% of the population).^v

American Indians and Alaska Natives are the second largest racial group, comprising 6.6% of the population. Montana is home to seven American Indian reservations (Blackfeet, Rocky Boy's, Flathead, Crow, Fort Belknap, Fort Peck, Northern Cheyenne reservations) and 12 federally-recognized tribes (Blackfeet, Chippewa-Cree, Salish, Kootenai, Crow, Assiniboine or Nakoda, Gros Ventre, Sioux, Northern Cheyenne, Little Shell Chippewa, and Pend d'Oreille/Kalispell). The population also includes Hispanics (4%), Asian (0.9%), and Black or African American (0.6%). Just over twenty-one percent (21.4%) of the population is under the age of 18 (see Table 1).

Between 2010 and 2018, Montana had an average of 12,122 births per year and a crude birth rate of 11.8 per 1,000 persons, which represents a decline the average birth rate in 2000-2010 of 13.0 per 1,000 persons.^{vi} In 2018, the highest birth rates were in non-core counties (11.3 per 1,000 persons), compared to small metropolitan areas (10.8 per 1,000) and micropolitan counties (10.4 per 1,000 persons).^{vii} In 2017, the adolescent birth rate, ages 15 to 19, in Montana was 21.2 per 1,000 persons. The teen birth rate has continuously declined since 2013 when this rate was 28 per 1,000 persons.^{viii} The number of very young children in Montana, age 0 to 5, has increased slightly since 2008, from 60,678 to 62,536 in 2018,^{ix} though as a percent of the population, this represents a decline from 6.2% in 2008 to 5.9% in 2018.

Other unique factors affecting Montana's population include mental health concerns and an increasing rate of child maltreatment. From 2014 to 2018, Montana has had the third highest age-adjusted suicide rate in the country at 24.9 deaths per 100,000 residents.^x The national suicide rate in 2018 was 14.5 per 100,000 persons.^{xi} In 2018, Montana's rate of child maltreatment victims was 16.4 per 1,000 children, compared to a national rate of 9.2 per 1,000 children. Montana has the second highest rate of foster care entry in the U.S. with a rate of 16.8 per 1,000 children compared to the national rate of 5.8 per 1,000 children.^{xii}

Table 1. Montana Population Demographics, 2019 Population Estimate, U.S. Census Bureau

2019 Estimate	2019 Montana Estimate	2019 U.S. Estimate
Population	1,068,778	328,239,523
Percent Change (2010-2019)	8.0%	6.3%
Persons under 5 years (%)	5.7%	6.0%
Persons under 18 years (%)	21.4%	22.3%
Female persons (%)	49.7%	50.8%
Women of Childbearing Age	18.2%	19.6%
White	89.0%	76.5%
Black or African American	0.6%	13.4%
American Indian and Alaska Native	6.6%	1.3%
Asian	0.9%	5.9%
Native Hawaiian/Pacific Islander	0.1%	0.2%
Hispanic or Latino	4.0%	18.3%
Two or more Races	2.8%	2.7%

The population distribution over the state’s large geographic area is uneven, creating barriers to the availability and accessibility of services, particularly in remote areas of the state. Population centers are in western and south-central Montana. According to federal Office of Management and Budget definitions,^{xiii} Montana has four small metropolitan counties with urbanized areas of 50,000 or more inhabitants and five micropolitan counties with at least one urban cluster of 10,000, but less than 50,000. Population and services tend to be clustered in these areas. Montana’s other 52 counties are rural or frontier counties. Montana’s most populous county, Yellowstone County, has fewer people than many medium sized cities in other states with an estimated 2018 population of 160,137. The county with the smallest population, Treasure County, has 679 residents. Bozeman and Kalispell, located in Gallatin and Flathead counties, respectively, are the fastest growing cities in Montana with an average annual growth rate of more than 2.8%. See Figures 1 and 2 below.

Figure 1. Montana 2018 Population by County

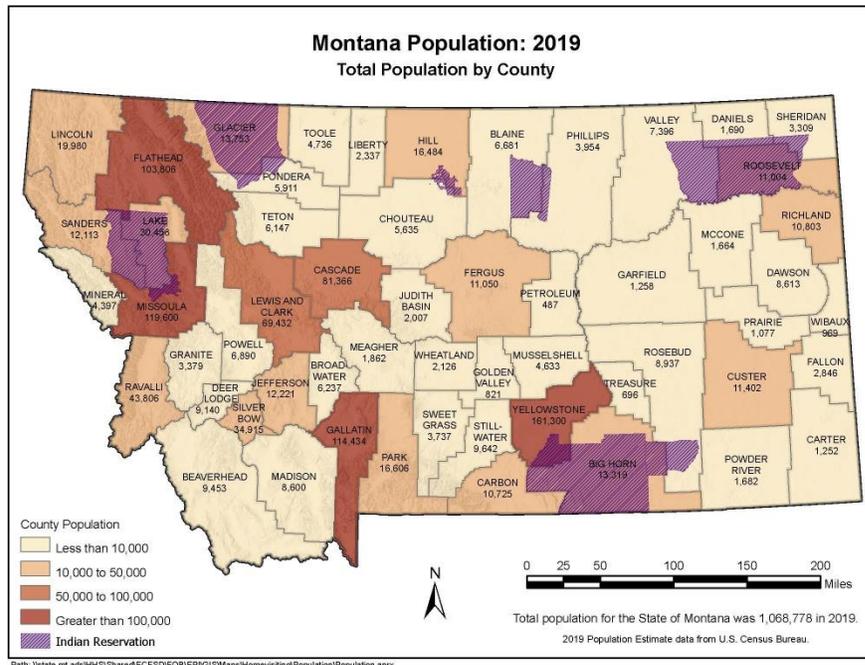
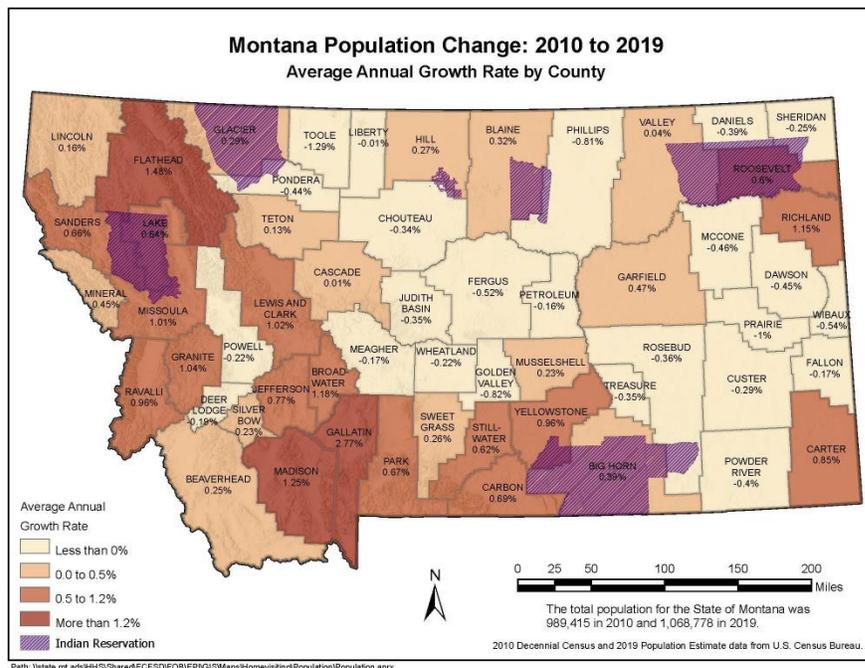


Figure 2. Montana Population Change by County, 2010 to 2018



Montana's Home Visiting History

Montana has a long history of home visiting for MCH populations. Frontier nurses provided home visits to women in mining and agricultural communities in the late 1800s and early 1900s. Early accounts described services that included prenatal and infant care as well as counseling and support. Throughout the last century, home visiting services in Montana were provided by many different agencies and individuals, including public health nurses, social workers, nutritionists, and other health care workers. Home visiting programs targeted a variety of different issues, including health promotion, child abuse prevention, and environmental assessment.

With the implementation of the Affordable Care Act (ACA), the MIECHV funding, and the creation of the Healthy Montana Families Section in 2011, MIECHV-funded services began in one county and expanded to six counties in 2012. In 2014, Montana received one-time only funding (MIECHV Expansion) from HRSA to be used to expand evidence-based home visiting services. Additionally, in 2014, HMF received state general funds to supplement 8 local public health departments already implementing with MIECHV funds. With the Expansion funding, an additional 19 sites were awarded MIECHV funds. In 2018, HMF awarded additional MIECHV funding to expand FTE in 12 existing sites. These additional FTE are dedicated to strengthening the coordinated intake and referral system between Child Protective Services and MIECHV-funded services in local counties. HMF refers to this partnership as the First Years Initiative or FYI. Montana's MIECHV programs prioritize services to eligible families residing in at-risk areas of the state.

Process for Conducting the Home Visiting Statewide Needs Assessment Update

In January 2020, HMF contracted with the University of Montana Rural Institute for Inclusive Communities (UM-RI) to conduct the statewide needs assessment update (SNAU). The UM-RI Team worked with HMF epidemiologists and the HMF program director throughout the process to determine sources of data, clarify information, and learn more about initiatives, strategies, and partnerships relevant to home visiting services in Montana. HMF, with federal HRSA guidance and assisted by UM-RI, made decisions regarding key indicators and other factors to consider in the SNAU.

Many organizations and programs across the state have an interest in promoting child health, early learning, and strengthening families. Recognizing this, additional stakeholders were invited to review and contextualize SNAU processes and preliminary results. In addition to stakeholder input, UM-RI included information from Head Start needs assessments, Child Abuse Prevention Needs Assessment, and the Early Childhood Systems Statewide Needs Assessment. UM-RI was contracted to work on the Title V MCH Block Grant Program Needs Assessment and considered data and findings from that assessment as well.

In early 2025, the HMF epidemiologist updated and researched additional data points to identify additional at-risk counties. She contacted prior sources such as Part C, the Head Start Collaboration Office, and Maternal Child Health for updated information regarding the home visiting landscape in Montana.



Identification of At-Risk Counties

Methods

MIECHV Supplemental Information Request (SIR) guidance requires the identification of communities with concentrations of risk in the SNAU. Identifying at-risk communities supports a targeted approach for providing limited resources to communities in need and prioritizing families in greatest need of home visiting services. For the purposes of this update, we follow the SIR guidance to interpret the term “community” as county.

At-risk communities refer to those for which certain indicators demonstrate more risk in comparison to statewide indicators. Indicators considered in assessing risk include adverse perinatal outcomes, poverty, crime, domestic violence, substance abuse, high school dropout rates, unemployment, child maltreatment, and drug and alcohol use.

We followed the HRSA-developed methodology, Simplified Method (see Appendix A, Data Summary Table 1). Using this method, we started with the pre-populated data for risk in five domains: socioeconomic status, adverse perinatal outcomes, child maltreatment, crime, and substance use disorder. We updated the raw data for the existing risk indicators as it became available. The evaluation team worked with numerous organizations and agencies to obtain appropriate data, the majority of which are county-level. The exception is substance use disorder data which is reported regionally.

Drawing on findings from the Title V MCH Block Grant Program Needs Assessment and the Child Abuse and Prevention Strategic Plan, additional risk indicators were added and grouped into new domains to identify concentrations of population in need (i.e., birth rates, single-parent households), mental health risk (i.e., suicide rates and mental health care provider rates), and child maltreatment risk related to parental drug use (i.e. child taken into care due in part to parental drug use). Risk associated with a lack of prenatal care, a known concern particularly in rural Montana, was added to the adverse perinatal outcomes domain.

To update the needs assessment in 2025, the 2025 Title V MCHBG Needs Assessment was assessed for additional risk indicators. According to the needs assessment’s parent survey, families’ biggest concerns included affording and accessing necessities such as food and housing. In rural counties, transportation and childcare were also high concerns. These topics were not considered in the previous MIECHV Statewide Needs Assessment Update (SNAU).

Previous data from the FY2020 SNAU were updated where possible as well. The 18 additional at-risk counties were compared to state estimates for these indicators and were designated as at-risk communities when they demonstrated more risk than state estimates. Indicators considered in assessing risk include single parent households, population growth, poverty and unemployment, cost of living expenses, adverse perinatal outcomes, substance use, crime, child maltreatment, domestic violence, and mental health.

Indicator Domains: At-risk Data

The following sections provide an overview of Montana's status related to the data included in tables 1 to 9. Each section provides a description of how the identified counties reflect the level of risk in Montana.

In addition to community risk factors, we reviewed data looking at population risk factors based on race. Race/ethnicity is a social construction that is can be used as a measure for social, economic, and political factors that can impact health outcomes.^{xiv} Presenting data by race and ethnicity helps with understanding the magnitude of the disparities and can assist with developing or supporting interventions to decrease these gaps. Racial disparities in risk factors are discussed below.

Population in Need Domain

Due to Montana's vast size and dispersed population, it is important to consider areas where populations are concentrated. Montana's more populated counties with low health or socioeconomic risk factors may have more individuals who are at risk due to the concentrated number of people. The population factors that were considered are birth rates (number of births per 1,000 people) and percent of single parent households with children under the age of six among all families with children under the age of six. These two population indicators were included in the risk assessment as they served to identify target populations for home visiting.

Birth Rate

Birth rates from 2014 to 2018 were aggregated to obtain reliable estimates for counties with lower populations and number of birth events. The Montana birth rate for those years was 11.6 per 1,000 residents, ranging from 6 to 20.7 per 1,000 residents. This mirrors the national birth rate for 2018 of 11.6 per 1,000 population. Adolescent birth rates in Montana have declined 19%^{xv} in recent years and were not included as a risk factor for this indicator. It is important to note, however, that American Indian adolescent birth rates (25.6 per 1,000 persons) remain high, compared to white adolescents (6.2 per 1,000 persons) in the state.^{xvi} The Montana birth rate for 2019-2023 was 10.0 per 1,000 residents, ranging from 6.8 to 15.9 per 1,000 residents.

Percent of Single Parent Households with Children Under the Age of 6

Using 2018 5-year estimate data from the American Community Survey (ACS), 24% of households with children under six are led by a single parent in Montana, compared to 26.5% nationally.^{xvii} The percent of households with children under six living with a single parent ranged from 0% to 56.6%. Using 2023 5-year estimate data from ACS, 25.0% of households with children under six are led by a single parent in Montana, ranging from 0% to 99.7%.

Percent Population Change of Children Under the Age of 6

Many counties in Montana have felt the effects of population growth over the past few years. Using 2020 and 2023 5-year estimate data from ACS, Montana experienced an overall population change of -1.8% of children under the age of 6. Counties' population change ranged from -67.7% to 52.2% for children under the age of 6. For this indicator, counties were considered at risk if they experienced positive population growth of children under the age of 6.

Socioeconomic Status Domain

The socioeconomic status indicator includes reported poverty rates, unemployment, high school dropout rates, and income inequality.

Poverty

Data for poverty rates includes the percentage of residents living below 100% of the federal poverty line (FPL) for all counties in 2018. County rates were between 7.7% and 27%; the state average is 12.9% of the population living below the FPL, compared to 13.1% nationally.^{xxiii} Rural Montana, however, has a higher poverty rate of 13.4%, compared with 12.1% in urban areas. The USDA Economic Research Service shows that the average per capita income of Montanans in 2018 was \$47,538, although rural per capita income was lower at \$46,089 (urban per capita income was \$50,225).^{xix}

In 2018, 16.4% of children ages zero to 17 lived in poverty, compared to 18% nationally.^{xx} Child poverty rates are higher in rural Montana compared to urban areas (13.4% and 12.1% respectively).^{xxi} Significant differences in poverty rates exist between counties. Glacier, Blaine, Big Horn, Lincoln, and Roosevelt counties have poverty rates above 20%. Jefferson, Richland, Fallon, Stillwater, Gallatin, and Madison counties have poverty rates under 10%.^{xxii}

In 2023, the state average was 11.8% of the population living below the FPL, with counties ranging between 8.3% and 28.0%.

Unemployment

2019 unemployment rates ranged from 1.8 to 7.5%, with a state average of 3.4% overall.^{xxiii} Unemployment rates are geographically and racially uneven across the state as unemployment on American Indian reservations are 2 to 3 times as high.^{xxiv} The 2018 American Community Survey (ACS) estimates that unemployment rates for this population are 11%.^{xxv} The higher unemployment rate among American Indians is partially due to populations being concentrated in rural areas on reservations. However, even American Indians living off reservations face higher unemployment rates than other Montana workers.

It is important to note that these figures are likely to change dramatically with the economic impact of COVID-19 and related business closures. In May 2020, The Bureau of Business and Economic Research estimated that Montana will face a loss of 75,000 jobs, on average, over the year 2020 reflecting worsening prospects for health care, transportation, and agriculture industries.^{xxvi} Job losses come from payroll positions as well as self-employed, business proprietors, and non-employee contractor jobs. Compared to estimates prior to March 2020, there is a projected shortfall in state personal income of \$6.4 billion, or 11.7% in 2020. As of June 2020, the Montana Department of Labor and Industry reported an overall 7.1% unemployment rate, with unemployment on American Indian reservations ranging between 7.6% to 16%.^{xxvii}

In 2023, unemployment rates ranged from 1.7% to 5.4%, with a state estimate of 2.9% overall.

High School Dropout Rate and Income Inequality

Using a 5-year estimate from 2013 to 2017, the percent of 16 to 19 year-olds not enrolled in school with no high school diploma ranged from zero to 19.5%, with an overall state estimate of 5%. Using 5-year estimates from 2023, the percent of 16-19-year-olds not enrolled in school with no high school diploma ranged from 0% to 31.1%, with an overall state estimate of 6.2%.

Gini coefficients measure the concentration of income and wealth in each region using a score from zero (equal distribution) to 100 (income concentrated in hands of 1 person). For 2014 to 2018, Montana's Gini Coefficient was 45%, with county scores ranging from 36% to 57%. For 2019-2023, Montana's Gini Coefficient was 46%, with county scores ranging from 38% to 52%.

Cost of Living

Housing

Housing availability is an issue in many regions of the state. In 2014 to 2018, median rent prices in the state were \$661/month, and an average of 29.6% of the renter households spend 35% or more of their income toward monthly housing costs. Over the same period, median monthly mortgage costs for homeowners was \$1,191/month, and an average of 23.9% of households with a mortgage pay 35% or more of their income towards housing costs. Affordable housing is increasingly an issue where housing prices increase at rates outpacing income growth.^{xxviii} Home prices in Ravalli and Lake counties, for example, are six times higher than the median household incomes in those counties.

According to the [Montana Department of Commerce](#), the 2023 median gross rent price in the state was \$1,083/month after adjusting for inflation, and an average of 47% of the renter households spend more than 30% of their income on monthly housing costs. Median sale prices of Montana homes started outpacing national median sale prices in June 2020, when they were approximately \$310,000. The median sale price of a home was \$499,000 in 2023 at an interest rate of 6.81%. The income needed to purchase a home in 2023 was \$122,987. In addition to the rising costs, Montana has experienced a decline in housing availability since 2019. The Available Housing Vacancy Rate declined from 3.4% in 2019 to 1.9% in 2023, while the US declined from 3.2% to 2.4%.

Crowded housing has been an emerging issue in Montana. From 2019-2023, the percentage of occupied housing units with more people than rooms was 1.9%. Counties ranged from 0% to 11.9%.

The Title V MCHBG 2020 Needs Assessment identified housing and homelessness as a need among families in Montana with survey respondents noting the increased price of housing, lack of affordable housing options, and limited beds at homeless shelters for families.

Using point-in-time data to offer a snapshot of homelessness—both sheltered and unsheltered—on a single night, between 2015 to 2019 the average number of the people in families with children under 18 who were homeless was 506.^{xxix} Family demographics served by MIECHV programs in the last year report that 79 households, or 5.5%, served were homeless in the last program year. This figure includes only those families who reported their housing status. Homelessness may be underreported among MIECHV families.

Transportation

Especially in rural communities, transportation is a concern among families because services are often located far away from their homes. From 2019-2023, 4.6% of households did not have a vehicle. Counties ranged from 0% to 13.3%.

Food Insecurity

USDA Economic Research Service estimates that between 2016 to 2018, 10.3% of Montanans lived in food insecure households^{xxx} compared to 11.1% nationally.^{xxxi} According to a Montana Food Bank Network survey, approximately one in nine Montanans struggle with hunger, and nearly 37,000 children live in food insecure homes.^{xxxii} Increased financial burdens for housing affects what food is affordable and many parents rely on feeding programs at schools and Head Start, which is problematic during the weekends and during COVID-19 related school closures.

In 2022, [Feeding America's Map the Meal Gap](#) estimates that the rate of food insecurity in Montana was 11.7%. The rate of food insecurity for children under the age of 18 was 16.9%. Counties rates ranged from 10.3% to 28.1%.

Childcare Capacity

Childcare Capacity is a longstanding issue in Montana. As of 2023, Montana only has the capacity to meet 44% of the demand for childcare for children under the age of 6. Counties ranged from meeting 0% to 88% of the demand for childcare for children under the age of 6.

Adverse Perinatal Outcomes Domain

According to the U.S. Centers for Disease Control and Prevention, infant death (mortality) occurring prior to a child's first birthday is a measure of both pregnancy outcome and societal health.^{xxxiii} Premature birth is defined as births occurring before 37 weeks of gestation; low birth weight birth rates identify infants born weighing less than 2500 grams. These two measures are strongly associated with infant mortality. Infant mortality rates were reviewed but ultimately excluded as an indicator due to high levels of data suppression at the county level. State-level risk for infant mortality is discussed below. The level of suppression for preterm births and low birthweight was also substantial for individual year data. Thus, 5-year aggregate data for 2014 to 2018 and 2019-2023 were obtained to get reliable estimates for smaller counties. For counties where there were fewer than 10 births, the mean of counties was used. Access to prenatal care was included as an additional indicator due to known challenges for rural and frontier areas where there are limited services or a significant burden due to distance to services. In fact, 16 out of the 18 (89%) additional at-risk counties are considered maternity care deserts by [March of Dimes](#).

Preterm Births

Montana's prematurity rate between 2014 to 2018 was 9%, compared to 10.02% nationally.^{xxxiv} Twenty-one (21) counties in Montana did not have enough birth events to be included. Of the counties with data available, preterm birth rates ranged from 6% to 13.4%. Rates of preterm births are higher among American Indian women at 13.8% in 2018, compared to 8.4% among White women for the same year. Mothers in rural areas and with lower educational attainment also have higher rates of pre-term births. See Table 2.

Montana's prematurity rate between 2019 and 2023 was 9.9%. Nine (9) counties in Montana did not have enough births to be included. Of the counties with data available, preterm birth rates ranged from 4.7% to 26.5%.

Table 2. Percent of Preterm Births in Montana, 2013 to 2018^{xxxv}

	Preterm Births						2013-2018 % Change
	2013	2014	2015	2016	2017	2018	
Montana, % (#)	9 (1110)	9.3 (1156)	8.4 (1061)	8.7 (1072)	9.5 (1118)	9.1 (1047)	1.1%
Race, % (#)							
White	8.3 (876)	8.5 (907)	8 (867)	8.2 (864)	8.7 (878)	8.4 (830)	1.2%
American Indian	13.8 (211)	13.8 (214)	12 (178)	12.6 (183)	15.2 (214)	13.8 (181)	0.0%
County of Residence							
Small County	8.9 (388)	10.4 (458)	8.8 (390)	9.8 (420)	10.7 (429)	9.7 (394)	9.0%
Large County	9 (722)	8.7 (697)	8.2 (671)	8.1 (651)	8.9 (689)	8.8 (653)	-2.2%
Maternal Education , % (#)							
Less than High School	10.6 (148)	12.8 (180)	11.1 (145)	10.8 (147)	11.3 (142)	12.2 (142)	15.1%
High School/GED	10 (380)	9.9 (367)	8.7 (326)	9.3 (322)	10 (315)	10 (313)	0.0%
Some College/Associates	8.6 (321)	8.8 (329)	9.1 (353)	8 (307)	10 (377)	9 (325)	4.7%
Bachelor's Degree or above	7.3 (244)	7.6 (267)	6.4 (231)	8.1 (290)	7.8 (279)	7.4 (263)	1.4%

Note: Percent change is only between years 2013 and 2018.

Low Birth Weight

Nationally, the percentage of infants born low birthweight (LBW) was unchanged for 2017-2018 at 8.3%. Montana's LBW rate was 7.4% in 2018. LBW rates remained the same for White women from 2013 to 2018 in Montana at 7%. American Indian women saw a 7% decline in LBW rates (from 9.9% in 2013 to 9.2% in 2018). See Table 3. Twenty-four (24) of Montana's 56 counties did not report LBW rates during the 5-year period between 2014 and 2018 due to less than 10 LBW births. Reported LBW rates for counties with available data ranged from 5.4% to 10.3%.

Montana's LBW rate was 7.8% for 2019-2023. Thirteen (13) counties did not have enough reportable births to be included. Of the counties with data available, LBW rates ranged from 4.7% to 21.4%.

Table 3. Percent of Low Birthweight Births (Births Less than 2500 grams) in Montana, 2013 to 2018^{xxxvi}

	Low-Birth Weight Births						2013-2018 % Change
	2013	2014	2015	2016	2017	2018	
Montana, % (#)	7.4 (912)	7.4 (923)	7 (887)	7.9 (966)	8 (946)	7.4 (856)	0%
Race, % (#)							
White	7 (736)	7 (746)	7 (757)	7.7 (818)	7.5 (754)	7 (699)	0%
American Indian	9.9 (151)	9.2 (143)	7.8 (116)	8.2 (120)	11.8 (166)	9.2 (120)	-7%
County of Residence							
Small County	7.2 (311)	7.7 (339)	6.7 (295)	8 (343)	8.9 (357)	7.4 (300)	2.8%
Large County	7.5 (601)	7.3 (582)	7.2 (591)	7.8 (622)	7.6 (589)	7.4 (556)	-1.3%
Maternal Education , % (#)							
Less than High School	11.2 (156)	11 (154)	9.4 (122)	10.8 (148)	10.8 (236)	10.6 (124)	-5.4%
High School/GED	8.3 (314)	8.3 (306)	7.7 (288)	8 (279)	9.4 (297)	8.6 (271)	3.6%
Some College/Associates	6.7 (250)	6.6 (249)	7 (271)	7.4 (283)	7.4 (276)	6.9 (251)	3%
Bachelor's Degree or above	5.3 (177)	5.8 (204)	5.5 (197)	7 (249)	6.4 (230)	5.8 (207)	9.4%

Note: Percent change is only between years 2013 and 2018.

Access to Prenatal Care

Research has shown a correlation between the lack of prenatal care with increased healthcare costs and adverse perinatal outcomes.^{xxxvii, xxxviii, xxxix} Due to Montana's geographic size, access to prenatal care is a known concern. This indicator was included to highlight risk specific to rural and frontier counties. The percentage of women who received prenatal care in the first trimester was used as a proxy for access to prenatal care.

The HRSA Simplified Method was modified to address this factor. Because *lack* of access to care is associated with increased risk, counties with a z-score of -1 or less were considered to be at-risk. In short, this adjustment identifies a county where a smaller percentage of the maternal population has access to prenatal as at risk. In short, this adjustment identifies an additional county as at-risk where a smaller percentage of the maternal population has access to prenatal care.

Using 2014 to 2018 aggregate data, 71.7% of Montana women received prenatal care in the first trimester,^{xl} below the national rate in 2018 of 77.5%.^{xli} Montana's rate is also below the Healthy People 2020 (HP2020) baseline of 77.1% of women receiving prenatal care in 2016, and well below the HP2020 goal of 84.8%.^{xlii} Using 2019-2023 aggregate data, 75.5% of Montana women received prenatal care in the first trimester. The target for HP2030 is 80.5%, with a 2018 baseline of 76.4%.

Prenatal care access and utilization is uneven around the state with significant patterns of disparity by geography and by race. Between 2014 and 2018, 76% of White women received early prenatal care, compared to 42.8% of American Indian women.^{xliii} In two counties, the percentage of women receiving early prenatal care is as low as 37.7% and 35.7%, respectively. There are four counties where less than half of pregnant women receive early prenatal care. These are Hill County (43.2%), Roosevelt County (45%), Rosebud County (49.7%), and Wheatland County (49.6%). The percent of births where mothers received prenatal care in the first trimester is also disparate between mothers who resided on tribal reservations (46.7%) and those that did not (74.7%) between 2014 and 2018.^{xliv}

Infant Mortality

In 2018, the infant mortality rate was 4.8 per 1,000 births, below the national average of 5.9 per 1,000 births (see Table 4). However, there are significant disparities in infant mortality rates across race. Aggregate data from 2016 to 2019 show the American Indian infant mortality rate at 12.2 per 1,000 births, compared to 4.5 for White infants (see Table 5). Leading causes of infant mortality across Montana include pre-term births, birth defects, and sudden unexpected infant deaths (SUID). Between 2013 and 2018, Montana's rate of SUID was 136.6 per 100,000 which is higher than the national rate of 93 per 100,000.

Table 4. Montana Infant Mortality Number and Rate, per 1,000 Live Births, Overall by Year, 2013 to 2018^{xlv}

Year	Number of Live Births	Number of Infant Deaths	Infant Mortality Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval
2013	12352	66	5.3	4.1	6.8
2014	12431	68	5.5	4.2	6.9
2015	12580	75	6.0	4.7	7.5

2016	12274	73	5.9	4.7	7.5
2017	11800	64	5.4	4.2	6.9
2018	11515	55	4.8	3.6	6.2

Table 5. Montana Infant Mortality Number and Rate, per 1,000 Live Births, by Race, 2016 to 2018^{xvii}

Race	Number of Live Births	Number of Infant Deaths	Infant Mortality Rate	Lower 95% CI	Upper 95% CI
American Indian/Alaska Native	4176	51	12.2	9.1	16.1
White	30598	137	4.5	3.7	5.2

Substance Use Disorder Domain

Though substance use disorders (SUD) are a rising concern nationwide, Montanans are particularly at risk, having rates higher than the national average across the lifespan. Parental SUD is a specific concern for families as it represents an adverse childhood experience (ACE) which can have significant short-term and long-term health impacts on children (Dube et al., 2003). Data identifying counties with risk concentrations for SUD come from the National Survey on Drug Use and Health (NSDUH), 2016 to 2018.^{xviii} Unfortunately, substate regional estimates have not been updated for the NSDUH. We were able to collect regional data from the 2023 Montana Behavioral Risk Factor Surveillance System (BRFSS) on marijuana, alcohol, and tobacco use.

Alcohol Use

According to the 2016 to 2018 National Survey on Drug Use and Health, Montanans age 12 and older have higher rates of alcohol use (57.31%) and binge alcohol use (27.98%) in the past month, as well as a higher rate of alcohol use disorder in the past year (7.47%) among individuals over the age of 12 compared to the national averages of 51.17%, 24.41%, and 6.1% respectively. One in 14 (7.13%) Montanans reported needing, but not receiving treatment for problematic alcohol use, the third highest rate in the U.S. According to the 2022-2023 NSDUH, Montanans age 12 and older have an alcohol usage rate of 51.75% and binge alcohol rate of 22.94% in the past month, as well as an alcohol use disorder rate of 10.97% in the past year. National averages are 48.13%, 21.68%, 10.33%, respectively. The 2023 BRFSS indicates that 19.5% of survey respondents (aged 18 and older) reported meeting the criteria for binge drinking. Regional rates ranged from 17.8% to 21.9%.

Marijuana Use

Montana has higher rates of marijuana use in the past year (19.84%) and past month (13.97%) among those age 12 and older compared to national averages of 14.96% and 9.52%, respectively. To identify counties with a risk concentration for marijuana use, the prevalence rate for 'use in the past month' using data from 2016 to 2018 was assessed. The average prevalence rate among counties was 10.8%, ranging from 9.3% to 13.9%. Overall, fewer Montanans age 12 and older perceive smoking marijuana as a great risk (19.12%) compared to the national average of 25.54%. In 2022-2023, Montanans aged 12 and older used marijuana in

the past year at a rate of 28.68% (US: 21.88%) and in the past month at a rate of 21.97% (US: 15.20%). 14.57% of Montanans aged 12 and older perceive smoking marijuana once per month as a great risk compared to the national average of 20.40%. The 2023 BRFSS indicates that 20.3% of survey respondents (aged 18 and older) reported using marijuana in the last 30 days. Regional rates ranged from 14.3% to 23.4%.

Tobacco Use

The 2023 BRFSS indicates that 12.4% of survey respondents (aged 18 and older) reported being current smokers. Regional rates ranged from 9.3% to 16.1%.

Other Drug Use

Rates of illicit drug use (not including marijuana) in the past month among individuals age 12 or older (3.6%) is similar to the national average of 3.30%. The highest rates of illicit drug use in Montana were for prescription opioid misuse (4.03%, compared to 3.6% nationally), cocaine use in the past year (1.95%, 2.0% nationally), followed by methamphetamine use (0.97%, 0.7% nationally) and heroin use (0.30%, 0.30% nationally). In 2022-2023, rates of illicit drug use other than marijuana in the past month among individuals aged 12 or older was 3.36% (US: 3.32%). The highest rates of illicit drug use in Montana were for hallucinogens (5.18%, compared to 3.06% nationally), prescription pain relievers (3.02%, 3.01% nationally), cocaine (1.92%, 1.82% nationally), followed by methamphetamine (1.37%, 0.94% nationally) and heroin (0.28%, 0.33% nationally).

Between 2016 and 2018, 11.91% of calls to emergency medical services were for methamphetamine-related problems) compared to calls related to prescription opioid overdose (3.69%) or heroin overdose (0.62%).^{xlviii} Among Montanans age 12 or older who needed treatment for illicit drug use, 8.44% needed, but did not receive treatment for substance use. This was greater than the national average (6.79%).

Crime Domain

According to a 2018 Montana crime summary, violent crimes have increased 33% since 2014, largely attributed to aggravated assaults.^{xlix} Property crimes have increase 8% since 2014, and drug reports have increased by 30% since 2014. Among substance use crimes, methamphetamine-related crimes increased 100%; opioids/heroin increased 24%. We were unable to locate this data source to provide an update.

Data to identify county crime risk concentrations included the number of reported crimes per 1,000 residents and the number of juvenile crime arrests, age zero to 17 per 1,000 residents. The estimated state crime rate was 30.9 per 1,000 residents, ranging from zero to 53.5. The number of crime arrests for juveniles age zero to 17 was 13.9 per 1,000 residents, ranging from zero to 60.4. For the FY25 Needs Assessment Update Amendment, this indicator was modified to include residents aged zero to 19 due to the data source parameters. The number of crime arrests for juveniles aged zero to 19 was 19.2 per 1,000 residents, ranging from zero to 56.7.

Child Maltreatment Domain

According to Montana law, child maltreatment includes, “actual physical or psychological harm to a child, substantial risk of physical or psychological harm to a child or abandonment.”^l Child abuse is classified into four categories: physical neglect, physical abuse, sexual abuse, psychological abuse or neglect.

Data indicators within this domain include the rate of maltreatment victims, younger than 18 per 1,000 child residents and the percent of children taken into protective custody due, in part, to parental drug use.

Rate of Child Maltreatment

Child abuse and neglect is a growing problem. The number of children in the care of the Montana Child and Family Service Division (CFSD) more than doubled in the last 10 years. During the same time period, the total child population under age 18 grew less than 3%.^{li} Of child abuse cases in Montana, neglect is the most common, comprising 93% of all child abuse and neglect cases in the 2017-2018 state fiscal year.^{lii}

Nationally, the victim rate in 2017 for substantiated child abuse and neglect, which combines all maltreatment categories, was 9.1 victims per 1,000 children in the population.^{liii} The overall child maltreatment rate in Montana 2017 was 15.4 per 1,000 child residents.^{liv}

From 2019 to 2023, the rate of maltreatment was 54.8 for children aged 0-17 per 1,000 child residents aged 0-17. Reportable county rates ranged from 16.8 to 110.7 per 1,000.

As of July 31, 2018, 3,934 children were in the child foster care system in Montana. Half (50%) are under age five; 29% of the children are American Indian, which is disproportionately high. American Indians comprise just over 6% of the overall population.^{lv}

Child Removals Due to Parental Drug Use

According to Montana's 2018 Child Abuse Prevention Strategic Plan, compared to other states, Montana has the highest percentage of children living in a home with someone with alcohol or drug problems (19%) or with a mental illness (14%). Montana has experienced an increase in substance use related cases; 65% of cases where children were taken into care in 2018 were SUD-related.^{lvi} SUD-related removals are categorized under neglect and not a separate category for removal. Generally, SUD-related removals are categorized as neglect.

To account for SUD impact on families, specifically on rates of child abuse and neglect in Montana, the percentage of children taken into state care due in part to parental drug use were reviewed. Using 10-year aggregate data from 2010 to 2019, the overall percentage of children removed due in part to parental drug use was 24.5%, ranging from 4.7% to 57%. Due to differences in data collection systems, this does not include data from tribal child protective systems. We were unable to update this indicator for this report.

Rate of Child Removal

From 2019 to 2023, the rate of child removal was 36.7 for children aged 0-17 per 1,000 child residents aged 0-17. Reportable county rates ranged from 0 to 78.9 per 1,000.

Domestic and Intimate Partner Violence Domain

The National Survey on Sexual Violence and Intimate Partner Violence 2010 to 2012 shows that Montana is in the top national quartile for lifetime prevalence of contact sexual violence victimization for women and men in the U.S.^{lvii} In the U.S., just over one in three women (36.3%) and one in six men (17.1%) experience some form of contact sexual violence during their lifetime. Montana's rates were higher than the national average with 41.4% of women and 20.7% of men having ever experienced sexual violence. Montana is in the second quartile for intimate partner violence (IPV). In Montana, 37.2% of women and 34.6% of men have experienced IPV, compared to U.S. rates of 37.3% and 30.9%, respectively.

Domestic violence incidence data is challenging because events are often unreported and reporting systems are uneven across states and jurisdictions. This report uses data from reported violations of the Partner or Family Member Assault (PFMA) statute between 2014 and 2018. Rates of child maltreatment are considered under another indicator. Including all PFMA violations result in a duplicative child maltreatment count. This report sorted violations by relationship type to exclude violence against children. Despite the data limitations, domestic violence is a significant risk factor. For example, on a single day in September 2018, 234 domestic violence victims found refuge in emergency shelters or transitional housing provided by local domestic violence programs.^{lviii}

The rate of violence against intimate partners is 3.2 per 1,000 residents. Sixteen of 56 counties have rates of domestic violence or intimate partner violence that are higher than the state average; seven counties were identified as having a significant concentration of risk. In 2023, the rate of violence against intimate partners was 2.3 per 1,000 residents in Montana. Counties ranged from 0 to 4.1 per 1,000.

Mental Health Domain

The World Health Organization (WHO) defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution in her or his community.”^{lix}

For nearly 40 years, Montana’s suicide rate has been among the highest in the nation, consistently ranking within the top five. In 2016, one in five (21%) of Montana adults reported experiencing mental distress.^{lx} In 2018, 17.7% of Montana adults reported experiencing mental distress six or more days in the past month,^{lxi} while 12.3% experienced mental distress more than 14 days in the past month.^{lxii} Prevalence of mental distress is higher among those living with a disability and among women.

Access to mental health services, post-partum depression, and substance use disorder treatment and prevention have been identified as priority needs for maternal health in Montana. The Title V MCHBG Needs Assessment identified a specific need for more specialists such as psychiatrists and more SUD treatment and prevention services in the state. Polysubstance use in pregnancy is common, as well as psychiatric comorbidities, environmental stressors, and limited and disrupted prenatal care.^{lxiii} 2016-2017 PRAMS data show that 20.5% of Montana women self-reported depression in the three months before pregnancy (12.8% nationally), 16.9% self-reported depression during pregnancy (12.0% nationally), and 15.0% self-reported postpartum depressive systems (12.5% nationally).^{lxiv}

To account for the unique mental health risk, two data indicators were added. These are (a) mental health provider ratios per 100,000 residents, and (b) suicide rates.

Mental Health Provider Ratio

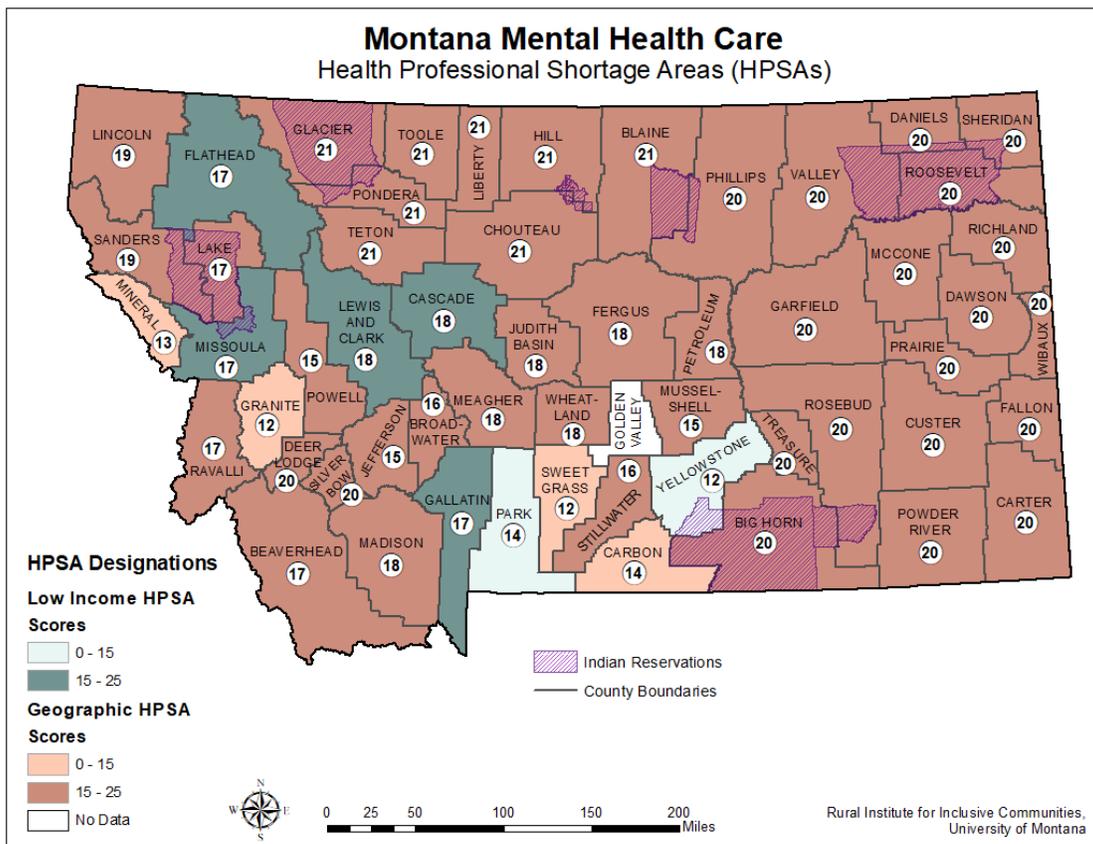
This report defines mental health providers as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and mental health providers that treat alcohol and other drug abuse as well as advanced practice nurses specializing in mental health care.

In 2019, Montana had 281 mental health providers per 100,000 residents with a range from zero to 534.7, per county. Additionally, 55 out of 56 (98%) Montana counties are designated as

health professional shortage areas (HPSA) for mental health providers.^{lxv} Counties may be designated as a shortage area due to a shortage of providers for the entire population of a given area (geographic shortage) or a shortage of providers for low-income population (population-based shortage).^{lxvi} See Figure 3. Two counties do not have any mental health providers-- Golden Valley and Petroleum.^{lxvii}

In 2023, Montana had 357.1 mental health providers per 100,000 residents with a range from 0 to 588.2 per county. Four counties do not have any mental health providers: Golden Valley, Petroleum, Treasure, and Wibaux.

Figure 3. Montana Mental Health Professional Shortage Areas 2020



The HRSA Simplified Method was modified to assess risk associated with mental health provider rates. Because a *lack* of access to care is associated with increased risk, counties with a z-score of -1 or less were considered to be at-risk. This adjustment identifies a county where a smaller percentage of the population has access to mental health services. For the FY25 Amendment, counties with less than 357.1 mental health providers per 100,000 residents were considered at risk.

Suicide Rates

From 2011 to 2015, Montana's suicide rate was nearly two times higher than the national average. Over that same period, an average of 340 suicides occurred each year in Montana

and there were 990 reported emergency department visits for suicide attempts. Suicide rates are higher among veterans and residents of rural counties, compared to micropolitan counties.^{lxviii} The proportion of American Indian high school students who reported that they had attempted suicide in the past year was nearly two times higher (18%) than youth overall in Montana (10%).^{lxix}

The suicide rate per 100,000 residents in Montana was 24.4 over 2009 to 2018 and 27.0 from 2019 to 2023; reportable county rates ranged from 13.1 to 42.5 and 15.6 to 50.1, respectively.^{lxx} The national suicide rate for 2009-2018 was 13.3.^{lxxi}

Identification of At-Risk Counties

The methods for identifying at-risk counties were updated from the 2010 needs assessment. In 2010, counties were at-risk for an indicator if the prevalence factor was higher than the state as a whole. Counties were assessed on community risk indicators and on population indicators. Counties were identified as at-risk based on community risk factor or population indicators.

For the FY20 SNAU, the HRSA Simplified Method was used to identify counties with concentrations of risk. Indicators with z-scores greater than or equal to one were determined “at-risk.” If at least half of the indicators (50%) within a domain were “at-risk,” then a county was designated at-risk for that indicator. Following this method, counties with two or more at-risk indicator domains were identified as having concentrations of risk. See Figure 4 below. See also Appendix A.. See Appendix B for maps of at-risk counties, by indicator domain.

Following HRSA guidance, additional counties may be designated “at-risk” based on high or emerging need, such as communities already served by MIECHV programs. Four counties were designated at-risk due to being currently served by existing MIECHV programs. Three have currently operating MIECHV programs and one was identified due to the higher number of eligible families and its proximity to a county with an established MIECHV program. Additionally, six counties were designated at-risk because some portion of those counties were within the boundaries of a tribal reservation. Table 6 shows each tribal reservation in Montana along with MIECHV funded programs currently serving those areas. Of the seven tribal reservations in Montana, 6 are currently served by MIECHV in some capacity. Fort Belknap tribal reservation has no known MCH home visiting services available. In Table 6, the designated counties at-risk are not currently being served by the MIECHV programs that serve other areas of the tribal reservation. Designating those counties as at-risk allows existing MIECHV programs in those tribal reservations to serve residents in those designated counties that are within reservation boundaries. Residents of Pondera county (Blackfeet), Daniels, Sheridan and Valley counties (Fort Peck), and Chouteau counties (Rocky Boy) can potentially be served by those tribal LIAs. See Appendix B for maps of at-risk counties, by indicator domain and additional counties designated as at-risk.

Table 6. MIECHV Funded Programs Serving Tribal Reservations in Montana (2018-2019)

Tribal Reservation	Counties Within Reservation Boundaries	Existing MIECHV Program
Blackfeet	Glacier, Pondera*	Blackfeet Indian Health Services
Crow	Big Horn, Yellowstone	Big Horn Valley Health Center

Flathead	Sanders, Lake, Missoula, Flathead	Lake County Health Department, Flathead City-County Health Department, Missoula City-County Health Department
Fort Belknap	Blaine, Phillips*	N/A
Fort Peck	Roosevelt, Daniels*, Sheridan*, Valley*	Fort Peck Health PDPW Program, Roosevelt County Health Department
Northern Cheyenne	Rosebud, Big Horn	Boys and Girls Club of Northern Cheyenne Nation
Rocky Boy	Hill, Chouteau*	Rocky Boy Health Center, Hill County Health Department

*Indicates counties designated at-risk

All counties within tribal reservations are considered at risk based on the economic and health disparities observed among Montana residents who reside on tribal reservations. With the exception of Yellowstone and Missoula counties, counties within tribal reservation boundaries are very rural. Five of the seven tribal reservations have population densities of less than 6 persons per square mile. See Table 7 for additional details. The remaining two, Northern Cheyenne and Rocky Boy, have higher population densities due to their comparatively small geographic area (690 and 171 square miles respectively)^{lxxii}. Flathead and Crow tribal reservations are situated closer to larger population centers, but the remaining reservations are remote, potentially making access to health services and service supports more challenging for families.

Table 7. Population and Population Density, MT Tribal Reservations^{lxxiii}

Tribal Reservation	Counties Within Reservation Boundaries	Total Population	Population Density
Blackfeet	Glacier, Pondera*	10,938	4.8/sq mi
Crow	Big Horn, Yellowstone	7,096	2/sq mi
Flathead	Sanders, Lake, Missoula, Flathead	29,218	5.8/sq mi
Fort Belknap	Blaine, Phillips*	3,182	3.1/sq mi
Fort Peck	Roosevelt, Daniels*, Sheridan*, Valley*	10,374	3.2/sq mi
Northern Cheyenne	Rosebud, Big Horn	4,939	7.2/sq mi
Rocky Boy	Hill, Chouteau*	3,794	22/sq mi

*Indicates counties designated at-risk

Table 8 demonstrates poverty, education and unemployment percentages for residents of Montana tribal reservations and for the state as a whole. All tribal reservations have poverty rates that are higher than the poverty rate for the state overall, but poverty rates for 5 of the 7

tribal reservations are at least twice that of the state rate. Similarly, unemployment rates for 6 of the 7 tribal reservations are at least twice that of the state rate.

Given the economic disparities and geographic isolation of tribal reservations in Montana, it is not unexpected that health disparities are present between tribal and non-tribal residents of Montana. Table 9 shows disparate perinatal outcomes between MT residents who resided on a tribal reservation and those that did not. Previous sections discussed disparities in perinatal outcomes between White and American Indian mothers. Table 9 shows that those disparities are greater when taking tribal residence into account, for timely prenatal care in particular. For White mothers with births between 2014 and 2018, the difference in the percent who received prenatal care in the first trimester of pregnancy between those who lived on tribal reservations and those that did not is less than 3 percentage points. In contrast 39.8% of American Indian mothers who lived on tribal reservations received prenatal care in the first trimester of pregnancy, compared to 53.2% for those that did not reside on a tribal reservation.

Table 8. Economic Indicators for MT Tribal Reservations, ACS 5 Year Estimates 2015-2019^{lxixiv}

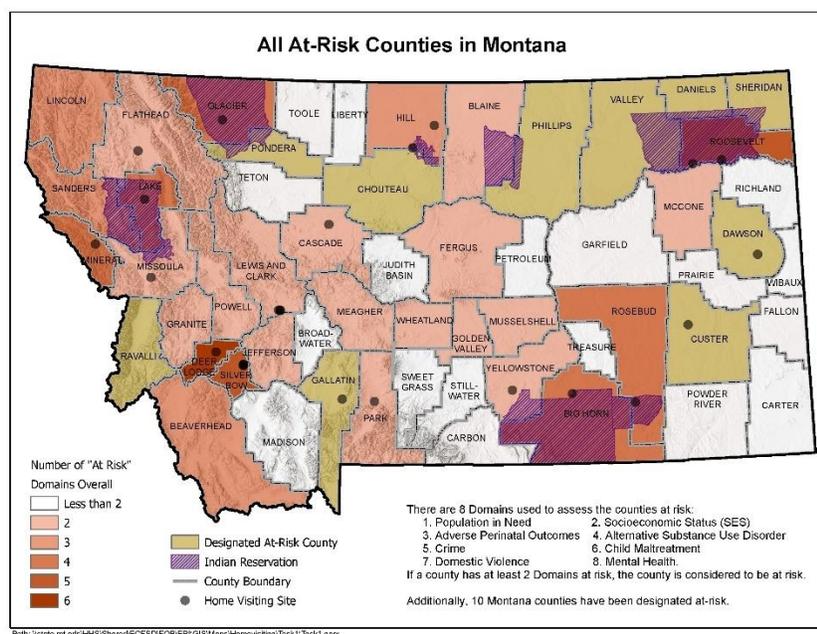
Tribal Reservation	Counties Within Reservation Boundaries	Poverty Rate	Residents 25 and Older with less than a High School Education	Unemployment Rate
Blackfeet	Glacier, Pondera*	32.8%	9.2%	9.1%
Crow	Big Horn, Treasure, Yellowstone	29.2%	10.7%	16.3%
Flathead	Sanders, Lake, Missoula, Flathead	20.9%	9.0%	7.4%
Fort Belknap	Blaine, Phillips*	43.4%	12.4%	33.2%
Fort Peck	Roosevelt, Daniels*, Sheridan*, Valley*	31.6%	13.6%	14.2%
Northern Cheyenne	Rosebud, Big Horn	25.4%	9.7%	13.7%
Rocky Boy	Hill, Chouteau*	35.6%	17.3%	9.8%
Montana		14.4%	5.8%	4.1%

*Indicates designated at-risk counties

Table 9. Perinatal Outcomes and Prenatal Care in MT Resident Births by Mother's Race and Residence, 2014-2018^{lxixv}

	Preterm Birth	Low Birth Weight Births	Prenatal Care in First Trimester
White	8.3%	7.2%	76%
Reservation Resident	8.7%	6.6%	73.8%
Non-Reservation Resident	8.2%	7.2%	76.4%
American Indian	13.3%	9.2%	45.5%
Reservation Resident	14.2%	9.1%	39.8%
Non-Reservation Resident	11.8%	9.0%	53.2%

Figure 4. All At-Risk Counties in Montana, MIECHV Needs Assessment, 2020



FY25 Identification of Additional At-Risk Counties

In 2025, counties were considered at-risk for an indicator if the prevalence factor was higher than the state estimate. If at least half of the indicators (50%) within a domain were at-risk, then a county was designated at-risk for that domain. Following this method, counties with two or more at-risk indicator domains were identified as having concentrations of risk. See also Appendix I.

Key Findings

Thirty-eight counties were identified as at-risk in this SNAU. Of those counties, the most frequently identified domains of risk were SUD (18 counties), Mental Health (12 counties), Child Maltreatment (11 counties) and Crime (13 counties). SUD, mental health concerns, and child maltreatment have been identified in other recent needs assessments as known issues in the state. The risks Montanans face are elevated in rural and frontier regions where services are limited or sparse. Except for Deer Lodge county, counties with the highest concentrations of risk (highest number of at-risk domains, see Figure 4 above) are those where tribal reservations are located. Tribal communities face significant health disparities and greater concentrations of risk.

In comparison to the 2010 MIECHV Needs Assessment, four additional counties were identified (Beaverhead, Fergus, McCone, and Park counties). Broadwater, Richland, Fallon and Carbon counties were no longer identified as at-risk. Custer, Dawson, and Gallatin counties were designated at-risk for this SNAU as they have existing MIECHV-funded agencies. Sheridan and Valley counties were identified at-risk in 2010 but were not identified in 2020. However, these counties were designated at-risk based their location within the boundaries of a tribal reservation. Four additional counties that were not identified at risk in either 2010 or 2020 (Chouteau, Daniels, Phillips and Pondera) were designated at risk for the same reason.

Key findings from the risk assessment include:

- Birth rates in Montana from 2014-2018 were 11.6 per 1,000 residents, mirroring national rate (11.6 per 1,000 residents). Adolescent birth rates declined 19% in 2018 since 2010. Birth rates are higher in frontier regions of the state where access to prenatal care and labor and delivery services may be limited.
- Montana had been experiencing economic recovery from the 2008 to 2010 recession with overall poverty and unemployment rates below the national average. Within the state, rural communities and tribal communities had higher rates of poverty and unemployment. Homelessness and food insecurity are increasing concerns in the state and may be exacerbated by the impacts of COVID-19 and related mitigation measures.
- At the state level, Montana has lower rates of low-weight births (7.4%) and preterm births (9%) compared to the national averages (8.3% and 10.02%), though fewer women in Montana receive prenatal care in the first trimester (71.7% compared to 77.5% nationally). For all adverse perinatal outcomes risk indicators, disparities exist across race and geography as American Indian and rural populations have higher risk factors.
- Montanans have higher rates of substance use compared to national rates for alcohol (57.3% compared to 51.2%), and marijuana (19.84% compared to 14.96%). Methamphetamine use and opioid misuse are increasing concerns in the state.
- Montana's increasing rates of child maltreatment are related to increased SUD in the state. 65% of children taken into foster care in 2018 were SUD-related cases. This has implications for home visiting programs in the state and the types of families served. Montana has implemented the First Years' Initiative (FYI) to respond to the growing concerns around child abuse and neglect. Launched in 2018, Montana's home visiting programs are the foundational infrastructure of FYI.
- Mental health concerns and access to mental health providers are significant challenges in the state. Along with the third highest suicide rate in the nation, Montanans have limited access to mental health providers. Post-partum depression rates are a concern among women in Montana with 15% of women self-reporting postpartum depressive symptoms compared to 12.5% nationally.
- Based on available data, which is limited, domestic violence rates in Montana are higher than the national average. If domestic violence rates in the state follow national trends, the impacts of COVID-19 and related activities may increase risk in the state.
- American Indian populations in the state, the largest minority group, have among the highest concentrations of risk factors and the highest percentage of population in need (see Appendices A and B). Adolescent birth rates, infant mortality, adverse perinatal outcomes, SUD, poverty, unemployment, child maltreatment, and domestic violence are experienced at higher rates among American Indians.

Data Limitations

Identifying counties with concentrations of risk was limited by several factors. Unavailable data and small numbers posed challenges when identifying risk among very rural and frontier low-population counties. To provide a more stable perspective, multi-year aggregate data was used. For counties with suppressed data, the state average rate was used.

Unavailable and small sample data is a further limitation with American Indian populations where aggregate data tends to reflect the outcomes of the majority population. For some factors, such as children taken into protective custody, tribal and state data reporting systems are different, making data comparison challenging. Consequently, some risk factors for American Indian populations may be underreported.

County level data might not appropriately capture risk in large heterogeneous counties. Gallatin County, for example, contains one of Montana's largest and more affluent cities, Bozeman. While Gallatin County has the highest median household income in the state,^{lxxvi} not all areas of this county share that affluence. Consequently, county-level data does not reflect needs in other areas within the county limits. Counties with lower overall risk, like Gallatin County, may also have greater numbers of at-risk families due to a higher population.

Several indicator domains did not have full data for all counties. Variations in rates for counties with low population numbers mean even aggregated data is not a reliable estimate. For example, nearly half (46%) of the counties did not have complete suicide data from year to year. Just over 14% of counties did not have mental health provider rate data and over one-third (37.5%) of counties did not have consistent preterm birth rate or low weight birth rate data (42.8%). Domestic violence rates and child maltreatment rates were absent for some counties. It is unknown if there were no occurrences of these events, or if inadequate reporting capacity resulted in no reported data.

Finally, using calculated z-scores is a means of identifying concentrations of risk. This approach has limitations in that it captures only those that are *most* at risk. Using the HRSA Simplified Method, eight counties (14%) were identified as having a concentration of risk for child maltreatment. However, 31 of 56 counties are above the national rate of 9.1 child maltreatment victims per 1,000 child residents; 19 counties have child maltreatment rates above the state average of 13.7 victims per 1,000 child residents.



Home Visiting in Montana

The federal MIECHV Program Supplemental Information Request (SIR) states that the SNAU must include information about the quality and capacity of existing programs or initiatives for early childhood home visitation in the State, including the:

- Number and types of individuals and families receiving services;
- Gaps in early childhood home visitation in the State; and,

- Extent to which programs and initiatives are meeting the needs of eligible families.

Montana has several home visiting programs and initiatives. Programs are provided by different agencies, including county public health departments (CPHD), state and federal programs, non-profit organizations and other private entities. Programs are supported by a variety of funding streams: federal, state, local, tribal, and private.

The UM-RI Team gathered information from a variety of home visiting service providers. Though MIECHV focuses on evidence-based home visiting models, an understanding of all home visiting options aids in planning statewide strategies to strengthen and support at-risk communities.

For the purposes of the SNAU, “home visiting programs” are those that use home visiting as a primary intervention strategy for families with children under six years old. “Home visiting services” are those with few or infrequent visiting or where home visiting is a supplement to other services. Following SIR guidance, home visiting services that were infrequent or provided on “as needed basis” are noted but were not fully investigated for capacity assessment in this SNAU.

Capacity and Quality Assessment Methods

UM-RI collected administrative data from relevant state programs and qualitative data from local implementing agencies (LIA). LIAs are current MIECHV-funded, evidence-based home visiting agencies that are sub-recipients of MIECHV funds through HMF. LIAs may have subcontractors which are subrecipients of the LIAs awarded funding. HMF considers these subcontractors a “home visiting site” and not an LIA. Qualitative data collection included a questionnaire sent to LIAs, focus groups consisting of MIECHV-funded home visiting staff, and home visiting programs within county public health departments not funded with MIECHV. See Appendix C for a summary of measures considered and data sources.

Alternative Estimate of Families in Need

To obtain a more accurate estimate of the number of families in need, the HMF Epidemiologist followed the methodology used by the HRSA estimates of potentially eligible families but replaced the Public Use Microdata Area (PUMA) geographic units and American Community Survey (ACS) data with data from birth records and Child Protective Services. A three-step process was used to calculate the estimates.

Step 1: To determine the number of families with children under six, all births that occurred in the State of Montana and all births that occurred out of state to Montana residents between 2015 and 2019 were analyzed. That provided a dataset with all children under six in Montana (excluding those children under six who may have migrated into the state). The mother’s social security number from the birth record was counted distinctly to estimate the number of families with children under six. The insurance payment type from the birth record was used as a proxy to determine whether a family was categorized as low-income. Two additional parameters were applied to the dataset to estimate at-risk sub populations. These parameters were (a) mother’s age less than 21 and (b) mother’s education less than high school.

Step 2: To determine the number of pregnancies to low-income families per county we calculated the average number of mothers who had a Medicaid paid birth per county from the birth records and added it to the calculation for each county from Step 1.

Step 3: Analyzed the number of families per county with allegations of child maltreatment reported to CPS. Children who had allegations of maltreatment were matched to the dataset from Step 1 using their names and dates of birth. The number of families per county with allegations of maltreatment were added to the Step 2 calculations, excluding those families whose births were paid by Medicaid as those families were already included in the Step 1 calculations.

See Appendix F for a complete list of the alternative estimated number of families in need of home visiting services by county. The alternative estimated number of families in need of home visiting services was used to identify and assess underserved areas and populations.

Home Visiting Questionnaire

Questionnaires were sent to representatives in all 56 Montana counties. Each was categorized into one of three groups:

- Group One: Counties with existing MIECHV-funded home visiting programs
- Group Two: County Public Health Departments in counties identified or designated as at-risk (as of May 2020). This group is not currently funded by MIECHV.
- Group Three: County Public Health Departments in all other counties

Questions were modified depending on which group the respondent represented. Existing MIECHV-funded agencies (group one) were asked specific questions about current activities, program and staffing capacity, strengths and challenges, resources, referrals, and public support/collaborations with other early childhood programs. Group two respondents were asked about their organizational capacity and services, home visiting services in the county, and other early childhood organizations or key stakeholders. This group was invited to participate in a community readiness assessment as part of the focus group process. Group three respondents were asked to identify any home visiting programs in their county. See Table 10 for group participation rates.

Table 10. County Participation in Home Visiting Questionnaire, by Group

Group	Number of Counties in Each Group	Responses Received	No Response
1	24	*24	2
2	15	**13	1
3	17	11	6
Total	56	48	10

*Cascade County Home Visiting has 3 subcontractors all of which responded separately to the questionnaire.

**3 counties in Group 2 are part of the Central Montana Health District; one joint response was submitted.

Focus Groups

In June 2020, UM-RI hosted six focus groups with 32 MIECHV program home visitors. Due to COVID19 related travel restrictions, the focus groups were held in online forums, each was attended by 2 to 6 participants. Twelve counties, including two American Indian reservations, were represented. Participants represented the four different MIECHV-funded home visiting models in Montana: Nurse-Family Partnerships, Parents as Teachers, Family Spirit, and SafeCare Augmented.

Participants were asked to reflect on the needs in their communities, specifically any cultural and language needs, as well barriers faced by the families they serve. Participants discussed the barriers they face as home visitors and the presence of support for home visiting programs among local early childhood systems and the broader community.

Readiness Assessments

CPHD and local early childhood program and council representatives in Group 2 counties (17 total) were invited to participate in readiness assessments. Readiness assessments are designed to assess staffing, community resources, and other requirements for operating an evidence-based home visiting service model. Interviews were scheduled with at-risk counties in July 2020. Four counties elected to participate. Unfortunately, a sharp increase in COVID-19 cases resulted in only one county participating. Given the significant limitation of this response rate, readiness assessment data was excluded from analysis. HMF administrators will continue to assess the available infrastructure, workforce, and public support.

The Montana Home Visiting Landscape

Information collected from the questionnaire was triangulated with results of the 2020 FCHB pre-contract survey sent to 54 counties that contract with Montana Department of Public Health and Human Services for Title V Maternal and Child Health Services Block Grant funding. This resulted in the identification of 67 home visiting organizations, including MIECHV-funded agencies, Early Head Start (EHS) home-based programs, CPHD programs, non-profit programs, and others. See Table 11. There are slightly fewer home visiting service providers in Montana than in 2010, when 80 organizations or agencies were identified in 29 counties.^{lxxvii}

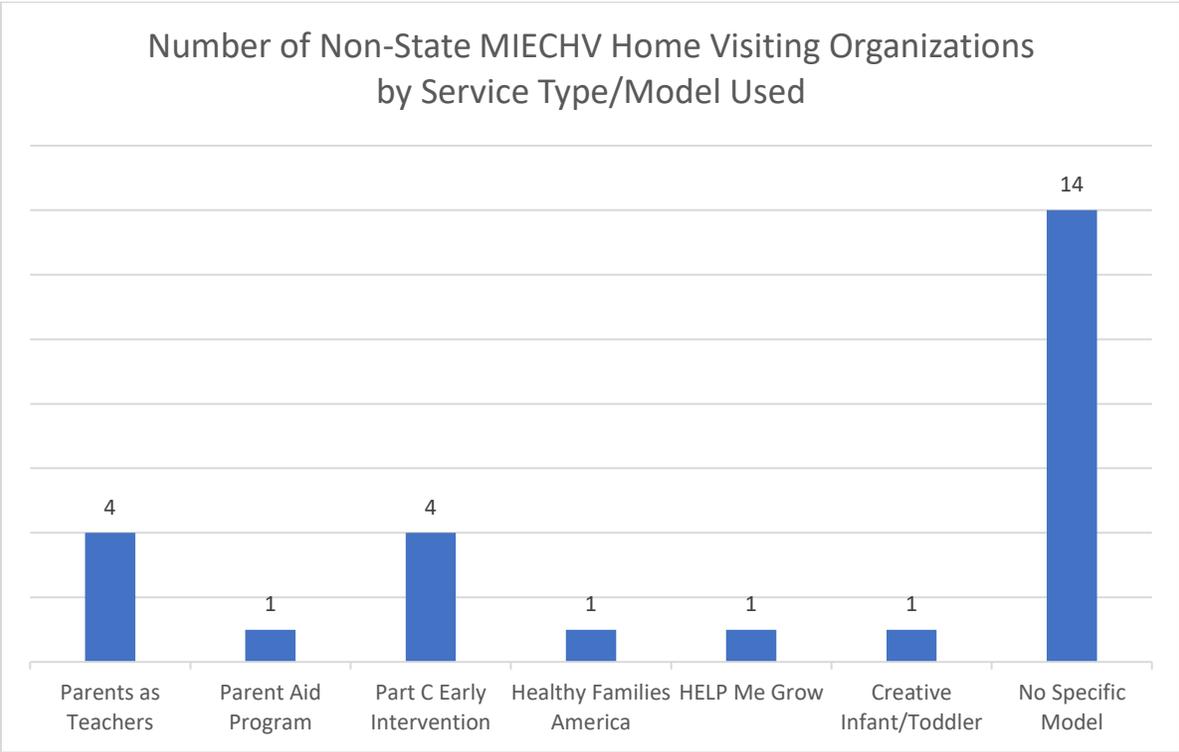
Table 11. Home Visiting Services by Organization Type in Montana, 2020 and 2025

Type of Organizations	Organizations 2020	Organizations 2025
MIECHV–funded Agencies (LIAs)	23	18
Tribal MIECHV Program	1	1
Early Head Start Home-based Option	4	4
Non-MIECHV funded County Public Health Departments	15	15
Non-Profit Agencies (Excluding Part C Early Intervention Providers)	12	2
Part C Early Intervention Providers	4	4
Other Providers	8	Unknown
Total	67	44

Non-MIECHV-funded Home Visiting Organizations

The HMF Team identified 26 organizations not funded by MIECHV that provide home visiting programs or services. Fifteen County Public Health Departments provide some public health home visiting services that may be infrequent or provided on an as-needed basis. These organizations use a variety of home visiting models. See Figure 5.

Figure 5. Number of Non-State MIECHV Home Visiting Models in Montana by Service Type/Model Used



Non-Profit Organizations

Specific information regarding the individuals served by the 12 non-profit home visiting programs (not including the 4 Part C Early Intervention Providers) was obtained by reviewing mission statements and service descriptions on their websites. In general, these organizations serve children ages zero to 18, families in need of additional support due to SUD or interactions with welfare services, people with disabilities, children and youth with special health care needs, foster children, youth with behavioral health concerns, and parents with children of all ages. Non-profit organizations (excluding Part C Early Intervention programs) provide home visiting services in nine counties, most of which are in Montana’s more populated counties such as Missoula, Yellowstone, Gallatin, and Cascade counties. Services include early intervention, developmental milestone awareness, home-based services, parent training, speech therapy, behavior health support/therapy, caregiver support, school-based services, and case management. These types of organizations were not found in the additional at-risk counties.

Early Head Start

Early Head Start (EHS) is a federal initiative providing child development and parent support services to low-income pregnant women and families with children birth to three years old. EHS home-based services offer home visits and group socialization activities for parents and their children.^{lxxviii} EHS programs operate in 12 counties, including: Lincoln, Glacier, Hill, Lake, Missoula, Ravalli, Silver Bow, Lewis and Clark, Cascade, Gallatin, Yellowstone, and Pondera. American Indian Head Start/EHS programs are located on the Flathead, Blackfeet, Rocky

Boy's, and Fort Belknap Reservations. Of the EHS programs across the state, four offer a home-based option.

The Head Start Collaboration Director provided enrollment information for EHS and EHS home-based options. In 2019, EHS enrolled 1,386 children; 171 children were enrolled in the home-based option. Three EHS programs use the Parents as Teachers model; two programs use Creative Curriculum for Infants and Toddlers and HELP Me Grow models, respectively.

In 2024, Early Head Start enrolled 1,130 children; 102 children were enrolled in the home-based option. Eight of ten Early Head Start center-based programs use Creative Curriculum, with the other two programs using Frog Street Infant/Toddler and HELP Me Grow. Two of the four home-based programs use Parents as Teachers (Born to Learn), with the other two using Creative Curriculum for Infants and Toddlers and HELP Me Grow.

PART C of IDEA Early Intervention Program

The Program for Infants and Toddlers with Disabilities (PART C of IDEA) is a federal grant program that provides a comprehensive statewide program of early intervention services. Montana Milestones/Part C of the IDEA Early Intervention Program is Montana's system of early intervention services and support for families who have infants or toddlers, from birth through three, who have significant developmental delays or disabilities or have been diagnosed with an established condition associated with significant delays in development.

Montana's eligibility criteria:

- Type I Established Condition diagnosed by a physician or psychologist that is likely to result in a developmental delay or disability; or
- Type II Measured Delay: Two or more 25% developmental delays in the five developmental domains or one 50% developmental delay in the five developmental domains.

Montana Milestones is funded through an annual federal grant under Part C of the Individuals with Disabilities Education Act (IDEA) and legislatively appropriated State General Fund dollars.

Part C Early Intervention services are administered through four school and non-profit organizations that serve all counties in the state.^{lxxix} Part C Early Intervention programs are headquartered in Custer, Cascade, Lewis and Clark, and Yellowstone counties. In the 2022-2023 program year, 1,371 infants and toddlers received early intervention services in the home or community.^{lxxx}

County Public Health Department Home Visiting Services

Based on the results of the 2019 FCHB pre-contract survey with 54 CPHDs, 10 local health departments without MIECHV-funded home visiting programs counties^{lxxxi} provide home visiting services for mothers, infants, and young children in 15 counties. In 2024, the pre-contract survey identified 15 local health departments without MIECHV-funded home visiting programs. In 2019, two counties used Learn the Signs and Circle of Security curriculum. In 2024, one county used Parents as Teachers and one used Parents as Teachers and Safe Care to inform their home visiting practices. Other health departments do not follow specific curriculums or models. Respondents noted that their home visiting services focus on pre- and post-natal follow-up, infant weight checks, breastfeeding support, and follow-up for children with special needs, typically including 1-2 visits. These home visiting services are provided on a referral-only

and as-needed basis when the need for home visiting has been identified. The number of individuals served by CPHD services was not obtained.

Tribal Home Visiting

The Tribal Home Visiting Program, sometimes referred to as Tribal MIECHV, brings critical services to the nation's most vulnerable American Indian and Alaska Native (AIAN) children and families. The program is funded through the Administration for Children and Families' Office of Child Care within the US DHHS and maintains a strong partnership with HRSA and its MIECHV program. Tribal communities disproportionately experience poor health outcomes associated with poverty, unemployment, substance abuse, and barriers to education and services.^{lxxxii} AIAN children often fall behind their peers developmentally, entering kindergarten with gaps that persist through elementary school.^{lxxxiii} However, tribal communities have significant strengths as well,^{lxxxiv} and the Tribal MIECHV program builds on those strengths while working to reduce disparities.

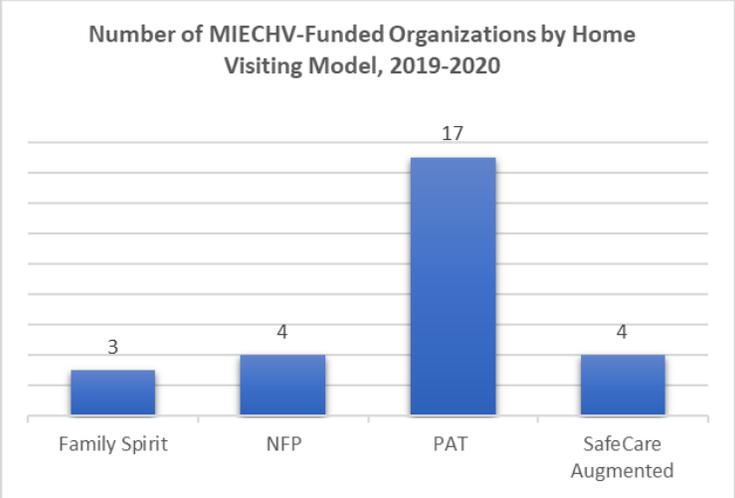
In Montana, the Confederated Salish and Kootenai Tribes have been implementing a Tribal MIECHV program, Early Foundations Home Visiting Program since 2011.^{lxxxv} The Confederated Salish and Kootenai Tribes (CSKT) is a federally recognized union of three tribes—Bitterroot Salish, Pend d'Oreille, and Kootenai—located on the 1.317 million acre Flathead Reservation in Northwestern Montana. The program uses the Parents as Teachers model to serve pregnant women, expecting fathers, primary caregivers of children (including grandparents, other relatives, foster parents, and noncustodial parents who sometimes provide physical care) residing on the Flathead Reservation and are either enrolled tribal members, descendants, or members of other Indian tribes. The PAT home visiting model is used with cultural enhancements that include involving elders at monthly group meetings and holding seasonal and special cultural activities that incorporate tribal language and traditions.^{lxxxvi} CSKT is also implementing a leadership-training enhancement for PAT participants. In 2019, the CSKT Tribal MIECHV program had the capacity to serve up to 56 families.^{lxxxvii}

MIECHV Home Visiting Programs

Montana currently supports 18 MIECHV-funded LIAs based in 16 counties, including three tribal reservations. MIECHV programs are implemented by CPHD, federally qualified health centers, and non-profit organizations. See Figure 8. Home visiting models include Family Spirit, Nurse-Family Partnership, Parents as Teachers, and SafeCare Augmented. Figures 6a, 6b, and 7 demonstrate the number of programs using each model and the number of families served by each model. See Appendix D.

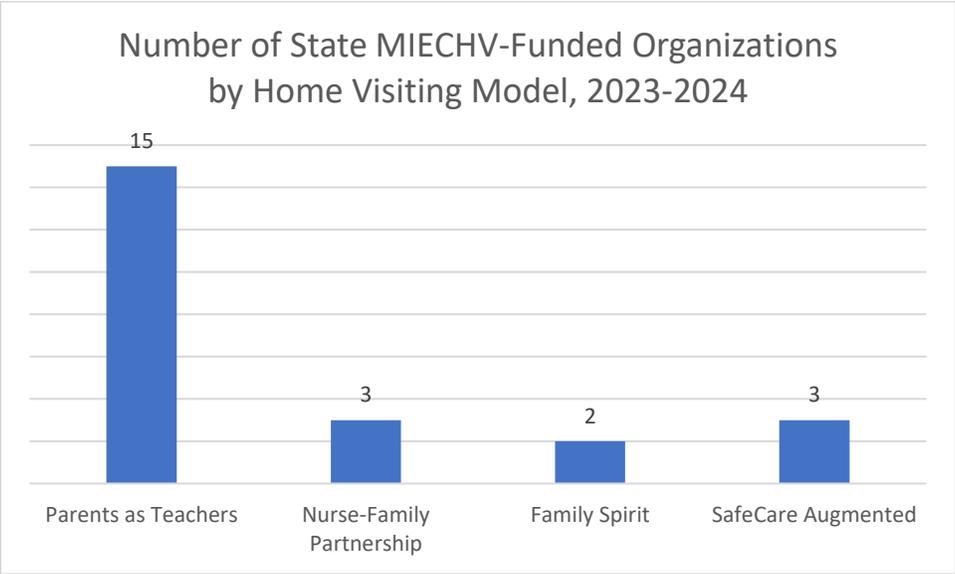
Specific information about the intended recipients, goals, services provided, and average cost for each Home Visiting model used by MIECHV Programs is outlined in Appendix D.

Figure 6a. Number of MIECHV-Funded Organizations by Home Visiting Model, 2019-2020



Note: MIECHV-Funded Organizations are duplicated in this figure because several LIAs implement more than one model through subcontracts. For example, Flathead County has one organization implementing two home visiting models with MIECHV funds, under one contract.

Figure 7b. Number of MIECHV-Funded Organizations by Home Visiting Model, 2023-2024



Note: MIECHV-Funded Organizations are duplicated in this figure because several LIAs implement more than one model through subcontracts. For example, Flathead County has one organization implementing two home visiting models with MIECHV funds, under one contract.

Figure 8 Home Visiting Sites in Montana, 2018-2019

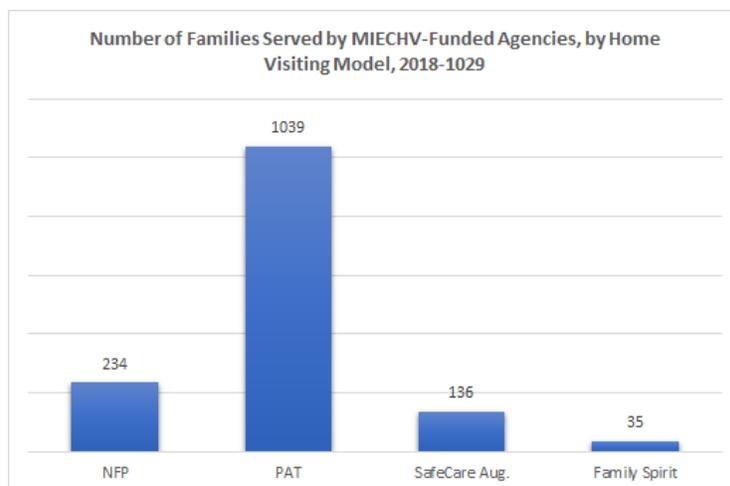
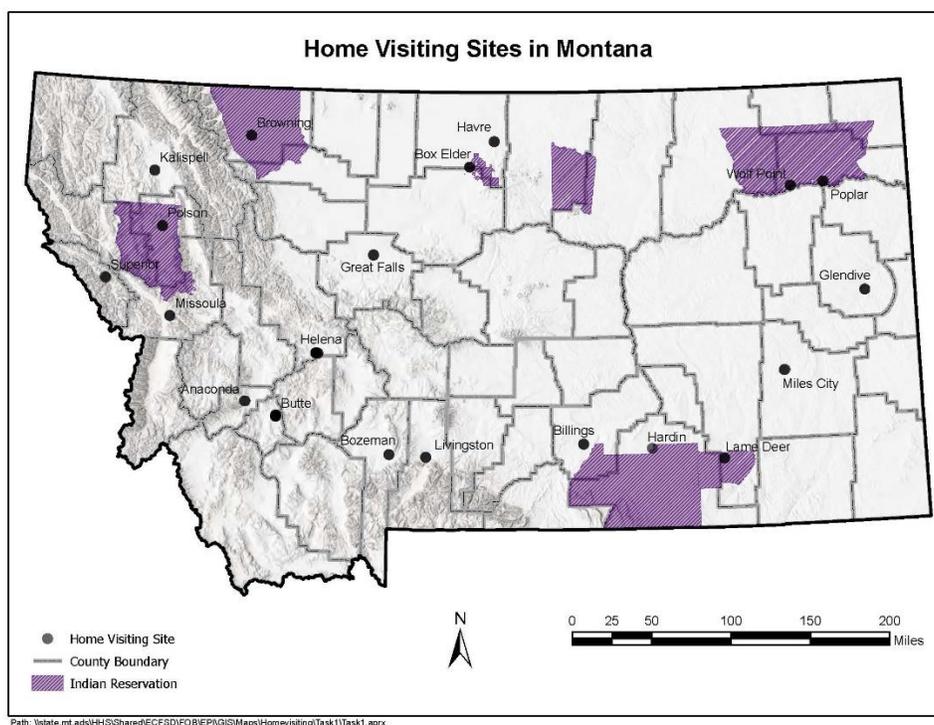


Figure 9. MIECHV-Funded Home Visiting Sites in Montana



Capacity of Current MIECHV-Funded Agencies

The SNAU includes information about gaps in early childhood home visiting, staffing, and available community resources. To demonstrate this, the following information was collected:

- Priority population characteristics of families served by MIECHV-funded agencies;
- Attrition and retention rates among families served by MIECHV-funded agencies;
- Program resources;

- Work force demographics, professional development opportunities, and staff qualifications; and
- Staff Attrition and Workforce Challenges

Priority Population Characteristics of Families Served

In 2018-2019, Montana’s MIECHV-funded agencies served 1,367 children and 1,444 caregivers.^{lxxxviii} In the most recently completed program year (2024-2025), Montana’s MIECHV-funded agencies served 947 children and 948 caregivers. Montana families are eligible for MIECHV services if they self-identify as a member of at least one of eight priority populations. See Table 12.

Table 12. Households Served by MIECHV By Priority Population Characteristics, Number and Percent of Total Served, 2018 to 2019 and 2023 to 2024

Priority Population Characteristics*	Number of Households	Total Households Served (%)	Number of Households	Total Households Served (%)
	2018-2019		2023-2024	
low-income households	750	51.9	516	54.4
households containing a pregnant woman under the age of 21	132	9.1	21	2.2
households with a history of child abuse or neglect or interactions with child welfare services	679	47.0	428	45.1
households with history of substance abuse or needs substance abuse treatment	467	32.3	281	29.6
households where someone uses tobacco products in the home	627	43.4	346	36.5
households with someone who has attained low student achievement, including a child	491	34.0	297	31.3
households with a child with developmental delays or disabilities	287	19.9	213	22.5
households with someone currently or formerly serving in the US armed forces	156	10.8	102	10.8

*Households may identify with more than one priority characteristic.

Families served by MIECHV programs include those in low-income households (51.9%, FY19; 54.4%, FY 24), those with a history of interactions with child welfare services (47%, FY19; 45.1%, FY24), those with a history of substance abuse (32.3%, FY19; 29.6%, FY24), and tobacco users (43.4%, FY19; 36.5%, FY24). Priority population characteristics of eligible families reflect Montana needs. SUD, child maltreatment, and poverty were identified as significant issues faced by Montana families.

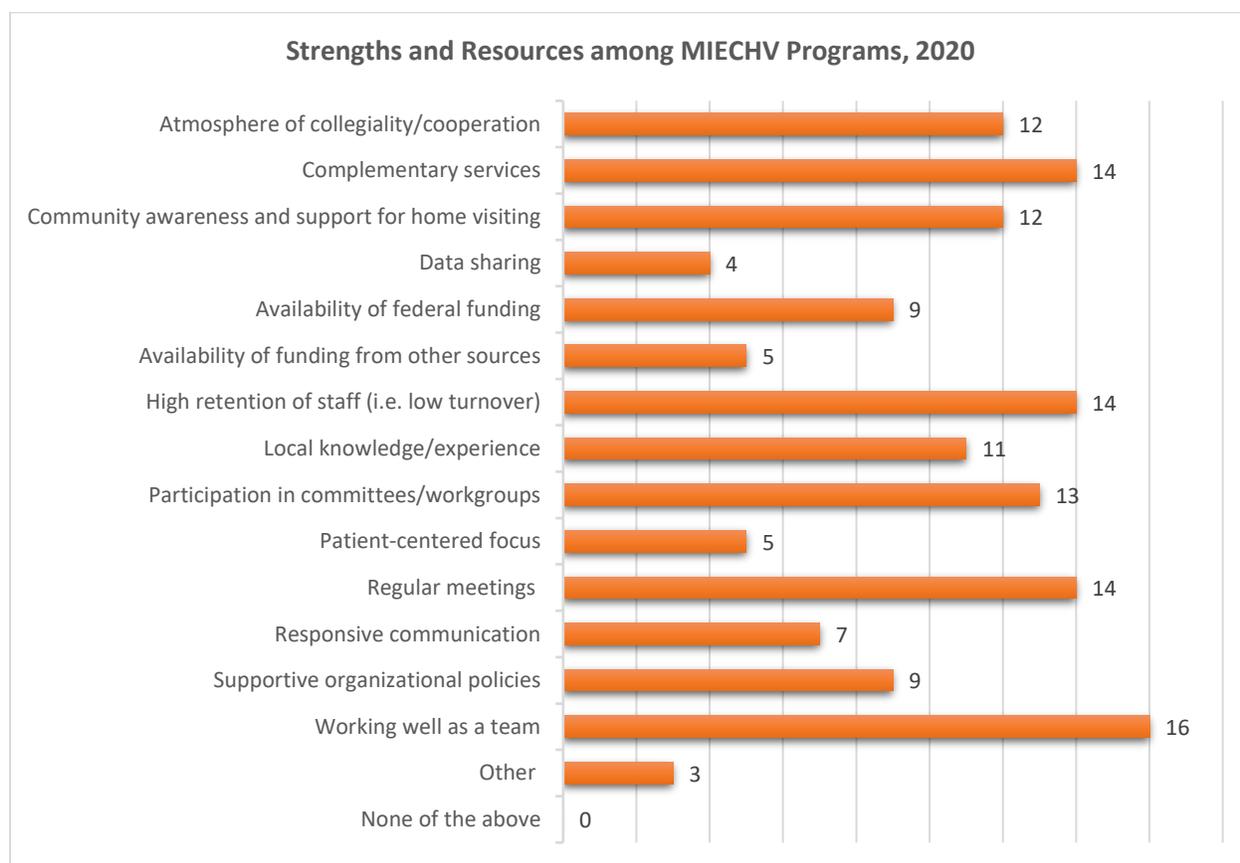
Other issues families enrolled in MIECHV-funded agencies face include low educational attainment and homelessness. In the 2018-2019 program year, 31.5% of households were at or under 100% FPL, and 58% had a high school diploma or less. In the 2018-2019 program year, 5.4% of households reported experiencing homelessness, though this number may not fully capture the number of families struggling with adequate housing.

American Indian populations are more likely to face issues of poverty, SUD, suicide, domestic violence, child abuse, and mental health concerns due to structural racism and discrimination.^{lxxxix, xc} Given the significant risk factors faced in American Indian communities, they are a priority population for home visiting services. Existing MIECHV programs (including the Tribal MIECHV program) in Montana currently serve four tribal reservation communities. Of the 1,444 households served by MIECHV programs in the 2018-2019 program year, 14% of families were American Indian (American Indians represent 6.6% of the population in Montana).

Program Resources

The questionnaire asked respondents to select the strengths and resources of their home visiting services. Respondents could select all that applied. See Figure 9. Respondents also provided a brief comment on the resources they identified.

Figure 10. Strengths and Resources among MIECHV Programs, 2020



While connecting with local communities and ensuring referrals among other local programs is a challenge for home visiting programs, many identified Working Well as a Team, Complementary Services with Other Organizations, High Retention of Staff, and Regular Meetings as key

strengths within each program. These are quotes from the focus groups with MIECHV-funded home visitors:

We have a great retention of staff. Everyone has been here for at least a year or more. We work hard to provide a warm and supportive work environment to maintain the staff members we employ.

We work closely with other organizations to ensure families are getting all the assistance they need and we are not duplicating services and overwhelming them.

Program Partnerships

Healthy Montana Families currently works in close partnership with CFSD and ECFSD on the First Years Initiative (FYI) to support and implement a coordinated intake and referral system for evidence-based home visiting services funded through MIECHV. As noted, the FYI program aims to reduce child abuse, neglect, and child deaths in Montana by providing home visiting services to families referred by CPS. All, local, MIECHV-funded home visiting programs receive referrals through their local CPS offices, however, 13 counties have one home visitor dedicated to receiving and following up on these referrals. This intentional partnership has led to coordinated intake and referral systems necessary for the support of families and the function of MIECHV-funded services. Additionally, this partnership extends beyond the local communities to the state agencies overseeing the programs and has resulted in deeper communication, collaboration, and systems-level partnerships.

Home Visiting Workforce

Information about Montana's Home Visiting Workforce, Professional Development, and Staff Qualifications come from three sources: Children's Trust Fund Workforce Project Survey of 57 Montana home visitors in 2019, focus groups with MIECHV-funded home visitors, and the Home Visiting Questionnaire.

Demographic information about the home visiting workforce for MIECHV-funded agencies in Montana was obtained for 32 home visitors, out of a total of 75. This sample of the home visiting workforce reflects national trends^{xci} in that home visitors tend to be predominantly non-Hispanic white (63% nationally) and female (99% female). In Montana, 31 of 32 (96.9%) home visitors were women, two home visitors were from tribal communities, and one home visitor self-identified as a Spanish-speaker. Increasing the gender, racial, and linguistic diversity of home visitors may serve to better reflect the diversity of families in need of home visiting services in Montana including single-fathers, Spanish-speaking communities, and American-Indian families living off reservations.

Home visitors ranged in their years of home visiting work experience from less than one year to 15 years of experience. Forty-seven percent had three or more years of experience.

Staff Qualifications

The Home Visiting Questionnaire assessed academic or educational requirements for home visitors. The responses demonstrated that there is significant variability in requirements and expectations for home visitors from program to program as well as years of experience. Staff qualifications for MIECHV-funded home visitors included high school diploma with years of experience, early childhood training or certification, Associates Degree in education/early childhood education or other related field, Bachelor's of Nursing degree or license, Bachelor's degree in education, early childhood education, social work or other related degree, and

Master's of Social Work or license. Because the survey question was open-ended, a variety of responses were received that identified the qualifications of current staff or the required qualifications for the position which prevented quantification of the results. HMF will begin to collect educational attainment for newly hired home visitors in 2021.

Professional Development Opportunities

Mirroring national trends,^{xcii} home visitors in Montana receive extensive in-service training but point to other areas where they could use further in-depth training to better serve families' needs. During focus groups, several respondents identified a need for trainings to serve families from different cultural backgrounds. This need is echoed by findings from the Children's Trust Fund Workforce Project Survey, where 41 respondents reported a need for professional development on supporting families with different values (see Figure). Other areas where home visitors identified a need for professional development include recognizing signs of use and how to respond (47), and how to cultivate resiliency/protective factors in parents (43) and children (42).

Opportunities for professional development among home visitors in the previous 12 months included local and national conferences such as the Great Beginnings, Great Families annual conference organized by the Early Childhood and Family Support Division of Montana's Department of Public Health and Human Services. Certification trainings included lactation certification, doula training, and Certificate of Public Health from University of Montana. All MIECHV-funded home visitors in Mineral County, for example, have completed doula training and certification. Webinar trainings included topics such as mental health, SUD, family engagement, breast feeding, prenatal health, and child abuse. Respondents reported trainings related to screening tools for depression, intimate partner violence, and general child development.

Staff Attrition and Workforce Challenges

Staff retention is a well-justified concern among home visiting programs. Training new staff is a significant investment (financially and otherwise) and takes a significant amount of time (up to six months). Additionally, staff transition can impact program delivery: enrolled families are less likely to forge a new relationship with a different home visitor and often decide to exit the program. Providing needed supports to home visitors is necessary to minimize staff attrition and reduce the impact on vulnerable families.

Using information collected from the Home Visiting Questionnaire, 70% (17 of 24) programs did not have staff attrition or turnover in the last year. Seven (7) MIECHV-funded agencies did report staff turnover in the last year; four programs reported one currently vacant home visiting position.

During focus groups with home visitors in Montana, they reported enthusiasm towards working directly with families and building relationships with them over time, and as discussed above (see Program Resources), home visitors are generally satisfied with relationships among their colleagues. This information about home visitors in Montana reflects findings from a national study of home visitors.^{xciii}

Home visitors who work with the FYI (partnership between local CPS and home visiting programs), however, reported feeling stress about working with families that were more likely to leave the program when their CPS cases were closed. Home visitors also reported stress

related to helping clients with issues that were outside the scope of home visiting, such as case management. Others identified challenges of working in small communities where privacy can be difficult to maintain. Limited mental health resources for staff and the increased challenges of work/ life balance during COVID-19 restrictions were also mentioned. The following quotes exemplify these concerns.

We need a lot more social support for the families we're serving. I would say, if we talk about personal stress, over the years, you know, obviously, dealing with some of the clients that we deal with that causes stress and you feel really bad for some of the situations that you've seen and not being able to help the way you would hope that you could help. Not, not being able to refer them to a decent place for housing for, you know, all of that for mental health...that's, that's hard.

There's the vicarious trauma that affects visiting you know when your families are experiencing trauma and I mean just being in a small community, you know everybody. And so it's really hard to separate yourself in your personal life and your work life.

I think one of the barriers that I see both as a home visitor and primarily as a supervisor role is the lack of mental support for our home visitors. I think we all know that the work we do can be really difficult, and it can be very emotionally taxing...we don't really take the time to be mindful of how it might actually be affecting us...And I feel like that's something that has increased since the COVID stuff has happened because we're not able to check in on the families that we might be more concerned about in such a direct way.

An example of an initiative designed to support mental health for home visiting staff is the Montana Project LAUNCH Initiative (MPLI). In 2014, Gallatin County City County Health Department (a current MIECHV-funded site) served as a pilot for MPLI to assess strategies for supporting home visiting staff in Montana. This initiative was funded by the Substance Abuse and Mental Health Services Administration (SAMSHA) to engage Montana's early childhood partners to improve systems and access to mental health services for young children and their families.^{xciiv} LAUNCH funding helped create a system of mental health consultation that was accessible to home visitors and child care programs. Mental Health Consultants provided case consultation and ongoing support to home visitors in Gallatin and Park Counties. Results from the survey of 18 home visitors showed that emotional exhaustion decreased from moderate to low burnout risk range, the depersonalization parameter remained low, and the personal accomplishment parameter improved from moderate to low burnout risk.

A national study of the home visiting workforce found that strong relationships with supportive supervisors are critical for reducing burnout and retaining qualified staff.^{xcv} Other strategies to support home visiting staff retention include offering flexibility such as teleworking and limiting caseloads to help with work-life balance. Job satisfaction is lower in instances where staff feel micromanaged, undervalued, and misunderstood in the work they do.

Gaps in Home Visiting Services

The SNAU includes information about gaps in home visiting services to identify where there may be underserved or unserved populations and how MIECHV-funded agencies are meeting the needs of families. To demonstrate this, we used data from the Home Visiting Questionnaire, focus groups with Home Visitor, and the alternative number of families in need to describe:

- Unserved or underserved populations in the state;
- Home visiting program waiting lists;
- Meeting Needs of Eligible Families;

- Barrier to providing home visiting services;
- Costs of home visiting services and reductions in funding for home visiting services; and,

Unserved or Underserved Populations

Gaps in home visiting services were assessed by considering the estimated number of families in need of home visiting services and the number of families currently served by MIECHV-funded agencies.

Fourteen counties (of 38 total) originally identified as at-risk in this SNAU do not have MIECHV-funded agencies. Of those counties, 13 do not have home visiting services. These counties are primarily rural and frontier areas. Nine of the 14 at-risk counties have populations of less than 10,000 residents. Using the alternative estimate of families in need of home visiting services, 646 families in these counties may be eligible for MIECHV services. Of the 18 additional at-risk counties, 11 do not have home visiting services and none have MIECHV-funded services.

Nineteen counties (of 38 total) identified as at-risk in this SNAU are currently served by MIECHV-funded agencies. MIECHV programs in those counties served 32.9% of the population in need of services (1,444 received services and an estimated 4,392 families were in need). This represents a difference of 2,948 families.

Of those 19 counties served by MIECHV-funded agencies in 2018-2019, seven counties provided home visiting services to 50% or more of the population in need. In 11 counties, MIECHV-funded agencies met the needs of less than 50% of the estimated families in need.

Existing MIECHV-funded agencies support families in both larger (more than 10,000 residents) and smaller (less than 10,000 residents) counties in the state. MIECHV-funded agencies served 61.2% of the estimated families in need in smaller counties (n=4) of Montana (128 families served out of an estimated 309 families in need). In larger counties (n=14), 31.6% of estimated families in need were served by MIECHV-funded agencies (1,326 families served out of 4,183 in need).

Four counties with the highest numbers of families in need of home visiting services—Yellowstone, Missoula, Cascade, and Flathead—are also among the most populated regions in the state. Counties in the state with higher populations correlate to where there is the greatest number of families in need. Looking at the difference between current funded caseloads and the estimated families in need for these counties, more than 70% of the families in need of home visiting services may be underserved (80.4% in Yellowstone, 76.2% in Missoula, 72.2% in Cascade, and 71.29% in Flathead).

Waitlists

Home visiting program waitlists help to identify areas where demand for home visiting services might be greater than the current capacity. Among the MIECHV programs, five programs reported having waitlists for services in the 2018-2019 program year. Flathead reported 72 families on their program waitlist, Yellowstone reported 30 families, Silver Bow reported two families, Park reported seven families, and Gallatin reported 15 families, for a total of 126 families. The estimated wait time varied from one to two weeks in Silver Bow to more than six months in Flathead.

Client Attrition and Retention

Home visiting programs are long-term intervention and prevention services, and most evidence-based models have a preferred length of enrollment for families to achieve the highest outcomes (see Appendix E for recommended length of service for each model). Given the importance of a termed commitment by families to the effectiveness of home visiting interventions, attrition and retention rates of are significant metrics for program achievement. Attrition of families served refers to the percent of families that did not complete a program. Retention rates identify the percent of families that graduated from the home visiting program or stayed in the program for six months or longer. For Montana MIECHV-funded agencies, the average family attrition rate for 2018-2019 was 35.5%. Rates ranged from 11.1% to 75%. The state average for family retention in the same period was 61%. Six programs had family retention rates above 70%. Retention rates ranged from 29% in Big Horn County to 79% in Deer Lodge County. See Table 13.

Table 13. Families Served, Attrition Rates, and Retention Rates for MIECHV Programs in Montana, by County 2018-2019

County	Families Served (2018-2019)	Attrition Rates (2018-2019)	Retention Rates (2018-2019)
Big Horn	35	11.1%	29%
Cascade	127	35.7%	58%
Custer	55	20.0%	72%
Dawson	22	30.4%	73%
Deer Lodge	27	35.7%	79%
Flathead	147	45.3%	66%
Gallatin	219	35.1%	62%
Hill	20	28.6%	45%
Lake	35	29.4%	57%
Lewis and Clark	110	40.5%	46%
Mineral	53	13.2%	74%
Missoula	103	50.9%	52%
Park	93	19.1%	77%
Richland	8	75.0%	71%
Roosevelt	54	43.1%	63%
Rosebud	26	34.6%	64%
Silver Bow	140	34.7%	59%
Yellowstone	170	39.7%	61%

Attrition and retention rates among families may be influenced by some households' involvement with child protective services (CPS). Montana's First Years Initiative (FYI) program, a program that aims to reduce child abuse, neglect, and child death in Montana through early education, prevention, and home visiting services, serves families who have open CPS cases.^{xvii} Though all MIECHV home visiting programs are voluntary, families or households that

interact with CPS may be referred to any MIECHV-funded home visiting program. Many home visitors reported that families enrolled in home visiting services due to CPS referral often choose to leave when the case is closed, thus potentially contributing to higher attrition rates. Further analysis of CPS involved families in MIECHV-funded programs will be conducted.

Meeting the Needs of Eligible Families

Cultural and Language Needs of Families

As part of the assessment of gaps in early childhood home visiting in the state, the federal MIECHV Program SIR states that the SNAU may include information about the cultural and language needs of families to ensure that programs are provided in a relevant and appropriate way. This section draws on information collected from focus group and the Home Visiting Questionnaire to consider how MIECHV-funded agencies are meeting the cultural and language needs of families in Montana.

Home visitors noted that resources for home visiting curricula were available in different languages, including interpretation services. Overall, home visitors felt that the need for resources in languages other than English were low or infrequent. However, when home visiting services are needed for families who speak other languages, providing services was identified as a challenge. One home visitor noted, “There is a really big difference between having Spanish language materials and trying to do home visiting through an interpreter.”

Some home visitors suggested that there may be subgroups that are not being reached with home visiting services. Such groups include single fathers, refugees, migrants, Spanish-speakers, international students, and individuals who identify as LGBT.

We get a lot of workers from different countries. Some of them have kids, sometimes it's just one family...they don't always know English and so we may have a population that kind of runs under the radar where they may struggle with getting a social security number or something. They're very quiet but they're out there.

Thinking about single dads, fathers...We were talking about dads as a culture and how when they walk into our agency, which is the [name], there's tons of moms and babies and moms and dads and babies, but there's not just dads and kids. It's not something you see a lot of, and so a lot of dads spoke to that and that it made them feel uncomfortable.

One home visitor described the potential for unserved populations as “latent demand,” suggesting that until these populations can identify with home visiting programs, the extent of need among some communities may be unknown.

You know the idea of latent demand. Like right now I'm the first person who speaks Spanish, and I am inundated with referrals, whereas before we used to get none...There is something to having people that look like you, and people that know your experiences from firsthand or at least know a little bit more about it so they don't have to explain it to a person over and over again...Sometimes you don't see that demand. Meeting Families' Basic Needs

Home visitors from both urban and rural counties are increasingly asked to help families meet basic needs such as housing, food insecurity, or other material needs. Home visitors described taking on the role of case managers to help families enroll in the necessary assistance programs or navigate state systems. This can impact home visiting programs in different ways: families may not be able to commit to home visiting programs while struggling to find housing or other basic needs, the home visitor may spend a significant amount of time helping clients to address basic needs rather than attending to home visiting curriculum, and in other cases the

home visitor is able to help the client meet their needs while also completing the home visiting curriculum. Home visitors generally suggested that enrolling and retaining families struggling to meet basic needs is a challenge:

It can be difficult to get families to enroll. Families have a difficult time committing and following through if their life is chaotic and full of crisis. They have difficulty prioritizing home visiting.

One of the most significant basic needs among families is access to affordable and safe housing. Housing is a particular challenge due to long waiting lists, inadequate supply, affordability, and availability. Waitlists for housing were reported to be longer than six months in some counties, and a lack of housing availability often means families live in other temporary housing for extended periods of time. Similar to the statement above, families struggling with housing needs may face additional barriers to services.

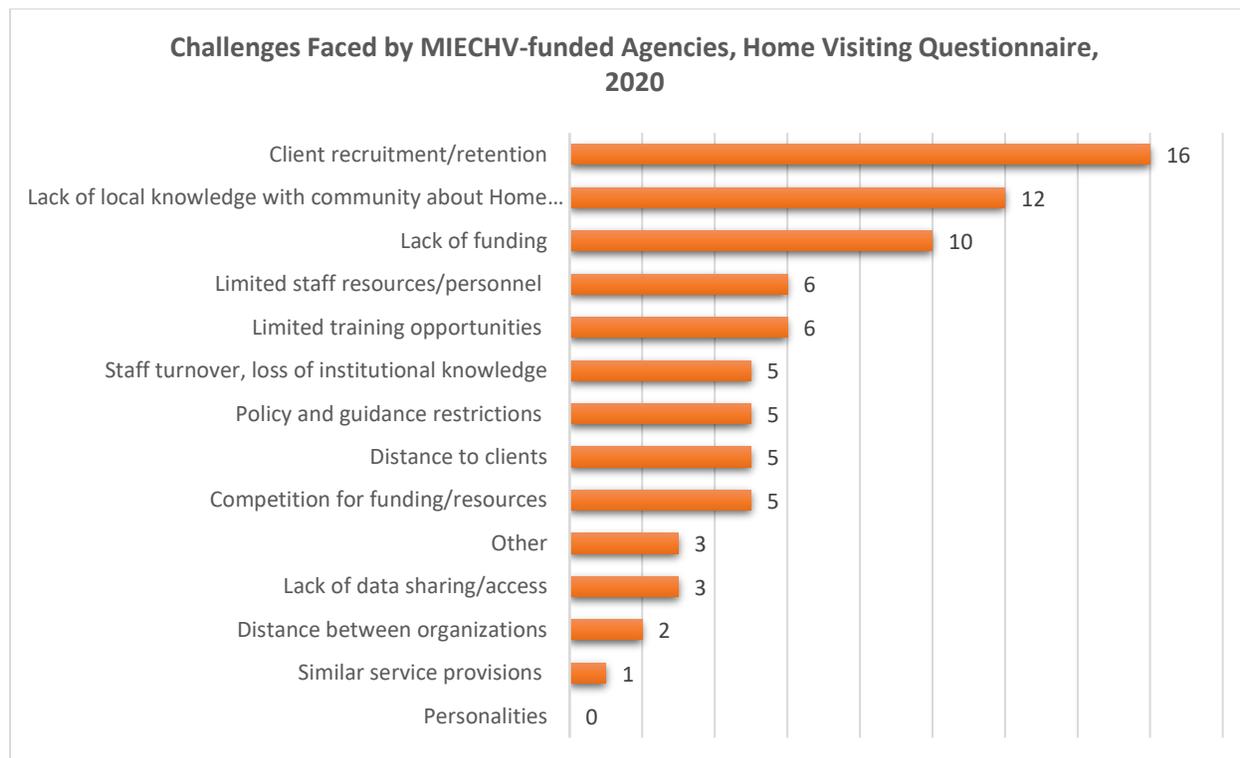
It is hard sometimes to enroll clients or keep clients enrolled due to many barriers. But the main barrier would be lack of housing. Some clients are living with family or friends and they do not want us coming into their home. We have to honor the homeowners' wishes.

Home visitors also noted that flexibility with funding to help families with emergency needs such as food, gas cards, phone cards, and diapers would be beneficial, particularly due to COVID-19-related concerns and mitigation efforts.

Barriers to Providing Services

The MIECHV program SIR also suggests the identification of barriers to providing home visiting services through programs in at-risk counties. To address this measure, the Home Visiting Questionnaire asked respondents to select the challenges to providing services in their communities. Respondents could select all that applied. See Figure 10. Respondents also provided a brief comment on the resources they identified.

Figure 11. Challenges Faced by HV Programs, Home Visiting Questionnaire, 2020



Client Recruitment/Retention and Lack of Local Knowledge

The two most frequently selected challenges were Client Recruitment/ Retention and Lack of Local Knowledge within the Community. These two were often interrelated with respondents suggesting that a lack of knowledge in the community about home visiting services impacted referrals, client recruitment, and retention. Two representative quotes are instructive:

Our "high risk" families often have previous or current involvement with Child and Family Services and had or have their children removed. This presents a challenge since families are very resistant to working with agencies who collaborate with CFSD. It's often a trust issue or they just don't want people in their homes after their case is closed. Many families seem very excited at first and even though we try our best to engage and adjust schedules and activities to meet their needs, they cancel appointments frequently which makes it hard to comply with the specific model requirements...Recruitment is also an issue. Even though we do continuous outreach with other agencies and are involved in multiple coalitions in our community, it seems like providers just don't understand what home visiting is all about, or, they even say they did not know that we do home visiting in [town].

I think [local knowledge] is always an issue, and as we get more restrictive about who we are able to serve (based on our funding / mostly more high-risk families), the services are not normalized within our community and the local knowledge decreases even more.

I never refer my [Spanish-speaking] clients if I know they don't have someone who speaks Spanish, you know. That's why I think about all the barriers to accessing resources, you know, all the resources in the community. If I don't know that there's an easy way and that they can accommodate clients like mine. To be able to access the services. I'm not going to refer them.

During focus groups, home visitors identified barriers to enrolling and retaining American Indian families in home visiting programs due, in part, to cultural barriers. One home visitor stated: "With the urban Indian population here, we are, maybe, I don't know, not available. Or, we have somewhere to go to be culturally relevant and we're learning. I believe we are learning, but there's, you know...We have some things to do there." Another said, "The biggest challenges and barriers that I've seen are primarily the Native American families because we just don't, it's such a different culture and we don't really understand or know all the family dynamics, so it can be intimidating because you don't want to be offensive." These statements suggest a gap in relevant cultural knowledge among home visitors who may be eager to engage with American Indian families but uncertain of how to do so.

Costs

Lack of funding was identified as a challenge to providing services by 10 programs (See Figure 10). Funding uncertainty was identified in focus group discussions. Below are comments from the focus group:

HMF has always supported our program. We have always had what we needed to grow and maintain a successful program. However, MIECHV is our only funding source for our home visiting program at this time and we would like more sustainability in the future outside of just one funding source.

While our MIECHV funds have been stable, and funding has increased for high risk families working with referred by CFSD, funding for universally available home visiting has decreased. One big loss was with the loss of our ability to bill for targeted case management. We would like to be able to more broadly serve our community, not just very high-risk families. For example, we would like to provide universal home visiting using an evidence-based model, for women who deliver at the two local hospitals but we have not found a funding source for that.

Home visitors suggested that increased flexibility to spend funds would benefit program services.

Key Findings

Home visiting models vary in terms of populations served, goals, outcomes, length or number of visits, and content. MIECHV data collection is reliable and provides a clear picture of the number and types of families served, their needs, and the impact that home visiting programs have. However, information from non-MIECHV programs was harder to obtain, and, when available, harder to compare or combine with MIECHV program data.

Montana's home visiting programs are staffed by a dedicated workforce serving high-priority populations. Though there are various home visiting services in Montana, there continue to be many at-risk children and families who do not have access to home visiting programs. Montana continues to be challenged to include poorer communities, tribal communities, rural/ frontier communities, and other subgroups with unique cultural or language needs.

Key findings about the quality and capacity of home visiting in Montana are:

- Seventy-two (72) organizations or agencies provide home visiting services in 36 counties across the state. This includes 23 MIECHV-funded organizations (LIAs) serving 19 counties. MIECHV-funded agencies served 32.9% of the population estimated to need home visiting services. In 2018-2019, MIECHV-funded agencies served 1,367 children in 1,444 households.
- Fourteen of the 38 counties identified as at-risk in this SNAU do not have an evidence-based home visiting program in their community. This represents 646 families who may benefit home visiting services.
- Montana families served by MIECHV programs tend to identify as low-income, having a history of child abuse or neglect, or a household where someone uses tobacco products.
- MIECHV-funded agencies support rural and tribal communities with home visiting services. Of the four smaller counties (populations of less than 10,000 residents) served by MIECHV-funded agencies, 61% of the estimated population in need received home visiting services. Additionally, 14% of MIECHV home visiting clients are American Indian (American Indians comprise 6.6% of the state's population). Sustained service to rural and tribal communities will provide needed support for these populations.
- Mirroring national trends in the characteristics of the home visiting workforce and state demographics, home visitors in Montana tend to be non-Hispanic white and female. Increasing the gender and racial diversity of home visiting staff may help to reach subgroups with unique cultural and language needs such as single fathers, American Indians, migrant workers, and Spanish-speakers.
- Home visitors reported feeling motivated by working with families and having supportive teams/colleagues. Some of barriers they face include client retention and lack of knowledge of home visiting services. Continuing or increasing outreach and other efforts to destigmatize home visiting may serve to reduce these barriers.



Capacity for Providing Substance Use Disorder Treatment and Counseling Services

There is a growing need in Montana for substance use disorder (SUD) treatment and counseling for pregnant women and families with young children. SUD is defined as a combination of cognitive, affective, and behavioral symptoms experienced as a result of using any of ten separate classes of drugs including: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, stimulants, and tobacco.^{xcvii}

Montanans have higher rates of substance use compared to national averages (see SUD section above). Additionally, the Title V MCH Block Grant Needs Assessment identified SUD as an emerging need for mothers and families in the state. This was echoed by home visitors from all six focus groups who identified a need for SUD treatment for clients. One home visitor stated, “all of my cases have a SUD component to them.” Another reported, “I’ve seen in our program a lot more referrals for moms with either current SUD or a history of SUDs.” One participant theorized that the rise in substance use may be due to an economic downturn:

We’re displaced—a displaced timber community. Twenty years ago, everybody worked in the woods or at the mill and now we still have two mills running, but one is tiny and the other one is a bigger mill, but it’s been bought by an out of state company and it’s been problematic so far. They’re bringing in people from out of state to work there. So that’s kind of created a problem. ... There are a number of people who make their living just running over to Washington and procuring substances and then bringing them back here to sell them.

Drug use during pregnancy is a serious public health concern in Montana. Despite the evidence that the problem is on the rise, Montana has a severe shortage of treatment for pregnant women or caregivers with substance use disorders. The number of Montana children in foster care has more than doubled since 2011 and increasingly those rates are related to parental SUD. As of 2016, only six percent of Montana’s state-approved SUD facilities reported programs for pregnant and post-partum women. Montana also has among the nation’s lowest rates of buprenorphine treatment capacity for people with opioid use disorders.^{xcviii}

Impact of Substance Use on Children and Families

Parental SUD can have significant short-term and long-term adverse health impacts on children.^{xcix} In utero drug exposure can lead to neonatal abstinence syndrome due to substance withdrawal.^c Parental substance use can cause long-term developmental problems with children; children whose parents struggle with alcohol and illicit drug disorders are more likely than other children to experience physical, mental, and behavioral problems and are more likely

to develop SUD themselves.^{ci} Children of parents who smoke cigarettes face an increased risk of smoking,^{cii} the leading preventable cause of death in the U.S.^{ciii} According to the 2018 Montana DPPHS strategic plan to prevent child abuse and neglect,^{civ} the rate of prenatal drug exposure in infants born to mothers receiving Medicaid has increased from 3.7% in 2010 to 12.3% in 2016 (Montana Department of Health and Human Services, 2018). The same plan revealed the number of Montana children in foster care due to parental substance use doubled between 2010 and 2017. Co-occurring mental health disorders can magnify the effects of SUD. In Montana, 7.7% of children ages zero to 17 live with a mother who reported a mental and emotional health status of “fair to poor” compared to 5% nationwide. Five percent of children ages zero to 17 live with a father who reported his mental and emotional health status to be “fair to poor” compared to the national average of 3.1%.

Native Montanans and Substance Use

Montana American Indians (approximately 78,000 people) have been disproportionately impacted by SUD. The most recent estimates found 26% of American Indians living on reservations in Montana reported having an alcohol use disorder and 9% reported having an illicit drug use disorder (Substance Abuse and Mental Health Services Administration, 2001).

Methods

The UM-RI Team drew from existing data, state reports, and data collected during focus groups. Interviews were conducted with six key informants from the Center on Children, Families, and Workforce Development (2 informants), Montana Obstetrics and Maternal Support (MOMS) TeleECHO Clinic (2), community-based maternal and child health programs (1), and the Addictive and Mental Health Disorders Division (1). The team also shadowed a training with Bureau of Indian Affairs child welfare staff (4).

Range of Substance Use Disorder Prevention and Treatment Services

The American Society of Addiction Medicine defines SUD treatment as a continuum of care,^{cv} consisting of early intervention and four levels of treatment—early intervention, outpatient services, intensive outpatient/partial hospitalization services, residential/inpatient services, and medically managed intensive inpatient services. The team organized the existing services in Montana using the ASAM Continuum. Appendix G includes a listing of Montana service providers highlighting some of the programs and initiatives relevant to prevention and intervention with parental substance use.

Early Intervention

All of Montana’s 56 counties are designated as mental health care professional shortage areas.^{cvi} This lack of mental health providers has led to challenges in identifying the need for SUD treatment and providing services. Substance use screening, brief intervention, and referral to treatment (SBIRT) is a public health model that involves universal screening, early identification of problematic substance use, early intervention, and referral and treatment of SUDs. Since 2016, the Montana DPHHS Chemical Dependency Bureau has dedicated federal block grant funds to reimbursement of SBIRT services. According to a survey conducted by the National Council for Behavioral Health and Montana Healthcare Foundation (2018), of 110 potential respondents, 60% of primary care providers were not using and did not plan to use SBIRT.^{cvi} A lack of training was reported as the most significant barrier to SBIRT use (10

respondents), followed by a lack of SUD treatment providers (8), low reimbursement (8), and a lack of care coordination (7). Initiatives like the Meadowlark Initiative and the Montana Obstetrics and Maternal Support (MOMS) TeleECHO Clinic (more below) are increasing universal screening and referral to treatment among those who provide prenatal healthcare.

Outpatient, Intensive Outpatient, and Residential Services

Medication-assisted treatment includes both the use of partial-agonist opioid medications (e.g., methadone and buprenorphine), as well as mental health counseling (e.g., cognitive-behavioral therapy). Community Medical Services provides medication-assisted treatment for individuals diagnosed with opioid use disorder in four communities in Montana including Bozeman, Kalispell, Missoula, and Belgrade. These clinics provide methadone, buprenorphine, and naltrexone in addition to counseling services. These clinics have an emphasis on SUD treatment during pregnancy and report to have integrated peer support into their treatment services through support groups, community outreach and education, and community partnerships with emergency medical services teams.

The Montana Healthcare Foundation started the Meadowlark Initiative (originally, the Perinatal Behavioral Health Initiative in 2015) to create multidisciplinary integrative health teams or clinics to meet the needs of pregnant women diagnosed with SUD. Funded primarily by Medicaid, these clinics are in 11 hospitals across the state of Montana.

Based in the Billings Clinic, the Montana Obstetrics and Maternal Support (MOMS) TeleECHO project is funded through a HRSA grant and administered by the Montana DPHHS. The program provides telehealth consultation, education, and training to primary care providers based in rural and frontier counties in Montana who are interested in further developing skills related to medical and behavioral health conditions among pregnant and postpartum women. MOMS is providing training and support to primary care providers in rural/frontier areas in Eastern Montana in the management of perinatal substance use disorder.

Healthy Mothers, Healthy Babies, a non-profit initiative in Montana is hoping to obtain funding to curate a list of perinatal mental health and SUD treatment providers. Currently, there is not a list of providers that specialize in perinatal mental health and substance use disorders. A search on the Bright App, a statewide web application compiling practice information for behavioral health providers in Montana produced 533 providers specializing in SUD treatment and parenting support and 435 providers specializing in SUD treatment in the perinatal period. A search for addiction medicine providers produced 67 results. The majority of these providers were located in urban areas.

Rimrock (located in Billings) is the largest SUD treatment provider in the state providing inpatient rehabilitation, day treatment, outpatient services, and long-term residential treatment for mothers with children (Willow Way and Michel's house). In addition to Rimrock's Willow Way and Michel's House, there are three residential facilities that serve women and their children—two in Missoula (Recovery Center's Aspen Way and Western Montana Addiction Service's Carole Graham Home) and Florence Crittenton located in Helena. Altogether, these facilities provide 29 placements.

Services in Tribal Areas

The Blackfeet Reservation is home to the Indian Health Services Blackfeet Health Center, Crystal Creek Lodge Treatment Center (an inpatient treatment facility for alcohol use disorder that specializes in culturally-responsive care),^{cviii} and the Northern Winds Recovery Center (outpatient mental health and substance use counseling). The Blackfeet Nation is addressing substance use through a community health improvement plan.^{cix} The tribes of the Fort Peck Reservation (Assiniboine and Sioux) identified several community assets and resources including a mental health center. The Northern Cheyenne needs assessment listed many community resources including the Dragonfly Project, which provides a culturally appropriate methamphetamine program. They also highlighted the Northern Cheyenne Recovery Center, which provides outpatient treatment classes and counseling to support people with SUDs, and the Northern Cheyenne Tribal Board of Health – Behavioral Health Services, which provides counseling services for tribal members. Specific to the needs of women, the Northern Cheyenne Reservation is home to the Wild Rose Center, a place for spiritual and cultural healing for women.^{cx} The Tribal Health Center of the Consolidated Salish and Kootenai Tribes (Flathead Reservation), offers substance abuse assessment and outpatient treatment for addiction and medication assisted therapy.^{cxii} The Fort Belknap Indian Reservation Chemical Dependency Program provides outpatient substance abuse treatment and counseling to adolescents and adults.^{cxiii} Big Horn Valley Health Center provides outpatient substance abuse treatment and medication assisted therapy to Big Horn county residents, including Crow reservation.^{cxiii}

Gaps in Current Substance Use Disorder Treatment Services

After conducting focus groups with home visitors and interviews with key informants, service gaps were identified. Focus group participants reported that “finding adequate treatment for the moms and families ... can be sometimes a challenge” and often parents have to “go out of state for [treatment for substance use problems].” In some communities, facilities have closed:

We had an inpatient SUD program, but it just closed for unknown reason. And that was a really good resource for families. The moms and kiddos could live there together while working on their substance abuse or other issues that they had. They took them to parenting classes and I came down and coaching resources. But now that it's closed, we don't have anything really – not like an inpatient.”

In communities with treatment options, participants described barriers to accessibility, stating “trying to find treatments that have openings or methods of payment for treatment can be a challenge.” Others believed the existing programs were insufficient:

Sadly, treatment [stays] ... are like 30 days max. ... They're getting weaned off these substances [they've used for a] lifetime. They have withdrawals after they're done ... even after that 30-day mark. And so that's where that relapses can come ... it's not good for these families.

These quotations identify a need for more residential services, especially for parents and their children. In particular, we identified a need for residential programs serving the needs of fathers and their children. In addition to residential treatment, we identified a need for recovery homes and other housing resources for parents and children as well as expectant couples. Given that SUD is often intergenerational, parents often must decide between relying on family members who also struggle with SUD or being homeless and disconnected from their support network. Recovery housing would help support these families and couples.

The Montana Healthcare Foundation completed a review of successful, evidence-based SUD interventions to identify strategies and programs that improve outcomes for both mothers and children.^{cxiv} They identified the following elements:

1. Team-based care that connects prenatal care and primary care with SUD treatment and care coordination
2. Collaboration among representatives of health care, child welfare, social services, and the judicial system
3. Addressing unmet social needs such as homelessness, domestic violence, and lack of transportation which complicate SUD treatment through care coordination services.

The team's findings identify a need for greater availability and access to SUD services as well as support for coordination and collaboration between early childhood programs across sectors.

Barriers to Receipt of Service

All key informants acknowledged the challenges of providing services in a rural/frontier state. The majority of existing services are in urban areas. Focus group participants also identified perceptions of stigma preventing individuals from seeking prenatal care. One participant stated, "I'm guessing [pregnant and parenting women with SUDs have] always been there and we haven't done a good job. Really, alienated those women from accessing services." Another home visitor reported concerns with how clients were treated in child protective services, "I've found that my clients are treated by child protective services very poorly for their addiction and it's not strengths-based and it's not 'let's help fix this problem.' It's more like a punishment." One home visitor described how this stigma is being addressed in her community:

And I've also seen a huge increase in awareness and services in our community... an awareness in terms of stigmatizing, getting services while pregnant, while also dealing with a substance use disorder. I feel like there's been a lot of progress. We've received a lot of extra training to support families, dealing with substance use disorders. I feel encouraged with that.

In addition to these barriers, a key informant identified barriers due to staffing. She identified the difficulty to recruit staff and high rates of turnover in Indian country as primary barriers to providing services to families in need. She also identified a lack of trained supervisors to support social service workers, especially during the current pandemic when workers experience isolation.

Opportunities for Collaboration

Home visiting are uniquely positioned to work collaboratively with other partners to provide support for mothers and parents in need of SUD treatment services.

The home visiting program in Montana has strong existing collaborations with Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Head Start programs, Best Beginnings collaboration, and the Meadowlark Initiative. Home visitors reported a range of cooperation with child welfare services (e.g., the First Years Initiative). Areas where the referral process between child services and home visiting is strong may serve as a model to strengthen the relationship in other communities. In addition to strengthening collaboration with child services, there is opportunity to grow collaborations with healthcare systems. See Appendix G for additional information.

The MOMS project is partnering with Rimrock Foundation to create demonstration sites to bring MAT—including both mediation for the treatment of SUD and behavioral health therapy in the form of individual and group therapy—to more rural parts of the state. Partnering with the MOMS project may help fill this gap of lack of training for home visitors who may feel overwhelmed by client challenges. MOMS TeleECHO project could provide training for home visitors on SBIRT and perinatal mental health disorders. Home visitors could provide a warm handoff to telehealth services provided by the MOMS project.

The nonprofit coalition, Healthy Mothers, Healthy Babies has a PURPLE crying prevention campaign to reduce shaken baby syndrome across the state. The first dose of the prevention program is provided by hospitals. There may be opportunity for home visiting to provide the second dose of the PURPLE prevention program. This is especially relevant to families whose newborns have been exposed to substances resulting in neonatal abstinence syndrome.

Impacts of Providing Home Visiting Services

There appears to be a lack of infrastructure to support new mothers, particularly new mothers with a history of SUD in Montana. Oftentimes, physicians are not trained or do not feel comfortable addressing perinatal SUD. As a result, home visitors report feeling that they have become front-line mental health and substance use disorder prevention and intervention providers. Given that home visitors enter the field from a myriad of backgrounds motivated by various concerns and experiences, they may not be fully prepared to address these issues. Further, the current home visiting models are not designed to provide services to the most at-risk clients and do not have specific curriculum related to the treatment of SUD, leaving home visitors vulnerable to secondary traumatic stress, burnout, and high rates of turnover.

Key Findings

Key findings regarding Montana's capacity to provide SUD treatment and counseling services to pregnant women, mothers, and families with young children include:

- SUD is a growing problem for Montana families evidenced by higher rates of SUD for alcohol use (57.3%), marijuana use (19.8%), methamphetamine use (0.97%), and opioid misuse (4.03%) compared to national rates (51.2% alcohol use, 15% marijuana use, 0.7% methamphetamine, and 3.6% opioid misuse) and the increasing number of children taken into foster care due in part to parent SUD. In 2018, 65% of cases where children were taken into care were SUD-related.
- SUD treatment capacity in the state is limited. There is a lack of mental health providers (55 out of 56 counties are designated mental health professional shortage areas) and limited outpatient and residential services. Additional barriers are faced by those in rural/frontier areas as most services are located in urban centers.
- There is a lack of infrastructure in Montana to support new mothers, particularly those with current or past substance use. Home visitors report not being fully prepared to recognize or address SUD issues. Home visitors may benefit from professional development around recognizing the sign of SUD and using trauma-informed, destigmatizing approaches to reduce chances of burnout and staff turnover.

The completion of this SUD treatment capacity assessment was limited by the available data. It was not possible to locate an estimate of the number of parents in need of SUD services. This

report is also missing key informant interviews with American Indian Tribes, which limits the HRSA's ability to report on barriers to services in tribal communities.



Coordinating with Title V MCHBG, Head Start, and CAPTA Needs Assessment

Title V Maternal and Child Health Block Grant

Findings from the Title V Maternal and Child Health Block Grant Needs Assessment conducted in 2020 were used to supplement this SNAU. Specifically, the Title V MCH Block Grant Needs Assessment identified the following as priority health needs: mental health services (depression and suicide), SUD treatment and prevention, infant mortality, and sleep-related infant deaths for mothers and infants. Other concerns include bullying and suicide among adolescents and oral health services for children. The Title V MCHBG findings also identified disparities in access to prenatal care across the state. Given these priority needs, we included data indicators for suicide, mental health provider rates, and access to prenatal care in the risk assessment component of this report.

We collaborated with the MCHBG program coordinator to collect information about home visiting services provided by county public health departments.

Head Start/Early Head Start

Consultations took place with the Head Start Collaboration Office to gather the 2019 Head Start Needs Assessment, the Montana Early Childhood Systems Report,^{cxv} and the Program Information Report (PIR) Statewide data findings. PIR data was used to identify the number of Early Head Start home-based programs, number of families enrolled, and models used.

The comprehensive statewide needs assessment of Montana's early childhood systems examined gaps related to access, quality, workforce, family engagement, and governance. Key findings include:

- Early childhood care and education (ECE) capacity varies widely across the state, with more access concerns for specific subpopulations and regions including infants and toddlers, rural communities, tribal communities, poorer communities, families with children with special needs, and families with irregular work hours.

- The quality of ECE programs has improved with Montana’s Quality Rating Improvement Systems. Lack of credentialing reciprocity between state, tribal, and Head Start programs results in a system where some ECE providers are not licensed.
- Professional development among the ECE workforce is generally siloed.
- Multiple developmental screening tools are used by different providers and screening is not universal.
- System navigation can be confusing for families and lack of current, connected, comprehensive information about services makes self-navigation challenging.
- In 2018, there was reported fragmentation between ECE programs located in different DPHHS divisions and bureaus. In 2020, the Montana Early Childhood and Family Support Division was created.
- Montana invests limited state dollars into early childhood programs. Disparate federal funding requirements, disaggregated information technology systems, a siloed and uncoordinated state early childhood system, and worries about perceived misuse of funds are barriers to funding coordination.

Child Abuse Prevention and Treatment

The 2018 Montana Child Abuse and Neglect Prevention Strategic Plan identified the increasing trend of children in foster care over the last 10 years as well as the impact of parental substance use on the number of child abuse and neglect cases. These data—the percent of children taken into care due in part to parent drug use—were added to the risk assessment for this reason.

In an ongoing partnership initiated in response to the growing concerns around child abuse in the state, the DPHHS launched the First Years Initiative (FYI). FYI provides targeted resources, education, and services during the early lives of children and their parents. The goal is to reduce child abuse, neglect, and child deaths by providing home visiting program services. Local partnerships between CPS and home visiting programs currently exist in 14 sites and 15 counties. The following counties are served by the FYI program: Silver Bow, Gallatin, Park, Flathead, Cascade, Custer, Yellowstone, Missoula, Lewis and Clark, Beaverhead, Madison, Mineral, Big Horn, Dawson, and Ravalli.

Data for the number of families per county with allegations of child maltreatment reported to CPS were used to create an alternative estimate of the number of families eligible for MIECHV services.

Stakeholder Involvement

Stakeholders from several programs were invited to review and contextualize preliminary SNAU results. These included: Title V MCH Block Grant, Tribal MIECHV, Early Childhood Comprehensive Systems, Child Welfare Services, Part C Early Intervention Program, Family Behavioral Health Program with the Addictive and Mental Disorders Division, Montana Coalition Against Domestic and Sexual Violence, Early Childhood Advisory Council, Head Start Collaboration Office, and WIC.

The first stakeholder meeting was held by video conference in June 2020. UM-RI presented the data, methods, and preliminary findings identifying counties with concentrations of risk in

Montana. Stakeholder feedback from the first meeting confirmed the importance of the data indicators used to assess risk. Stakeholders provided additional information for the SNAU.

A second stakeholder meeting was convened in August 2020. Stakeholders provided input on the home visiting inventory and capacity assessment information. They also provided feedback on the substance use disorder treatment capacity assessment information.

In 2025, data and information was collected from several stakeholders, including Title V MCH Block Grant, Child Welfare, Part C Early Intervention, Head Start Collaboration Office, and Public Health and Safety.

Summary

The SNAU was a collaborative effort between the UM-RI Team, HMF epidemiologist, HMF Program Director and other organizational stakeholders. Various dimensions of risk were included in the analyses: birth rates, single-parent households with children under the age of six, poverty, high school drop-out, unemployment, income inequality, premature birth, low birth weight, access to prenatal care, cocaine use, heroin use, marijuana use, alcohol use, number of arrests, juvenile arrests, child maltreatment, number of children in foster care due to parental substance use, domestic violence, suicide, and mental health provider rates. Additional risk factors were analyzed based on findings from other statewide needs assessments. Indicators were reviewed by a diverse stakeholder groups over several meetings. Appendix A summarizes the use of the HRSA Simplified Method and data tables.

Thirty-two at-risk counties were identified using HRSA's method. Four additional counties were designated as at-risk due to other considerations. The highest risk counties, except for one, share land with tribal reservations. Tribal reservations were not separately assessed for risk.

Additional SNAU information identified homelessness, food insecurity, and access to services as challenges for Montana's children and families. There is a potential for these risk factors to increase as responses to the COVID-19 pandemic continue to generate uncertainty, increased unemployment, and additional barriers to accessing services among other challenges.

There is a variety of home visiting services in Montana. There are 23 MIECHV-funded agencies (LIAs) serving 19 counties. These programs are generally well-established and effective with strengths in communication and teamwork. Service gaps remain in rural/ frontier areas, among American Indian populations, and other sub-groups.

Perinatal substance use is a known issue but there are limited resources to address it. Previous work has identified recommendations for improving substance use disorder treatment capacity including the need for more family-centered, trauma informed treatment options, more care coordination, and more case management services to meet basic needs.

Next Steps

Healthy Montana Families is committed to investing, supporting, and administering evidence-based home visiting programs across Montana. These findings inform statewide strategic planning and internal program assessments. They will be disseminated widely among stakeholders, local implementing agencies, and others interested in establishing evidence-based home visiting programs.

Home visiting workers are uniquely positioned to work collaboratively with other partners to provide support for mothers and parents in need of SUD treatment services.

The home visiting program in Montana has strong existing collaborations with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Head Start programs, Best Beginnings collaboration, and Meadowlark Initiative. During focus groups, Home visitors reported a range of cooperation with child welfare services (e.g., the First Years Initiative). Areas where the referral process between child protective services and home visiting is strong may serve as a model to strengthen the relationship in other communities. In addition to strengthening collaboration with child services, there is opportunity to grow collaborations with healthcare systems. See Appendix G for additional information.



Appendices

Appendices

Appendix A. Data Summary Tables for Identifying At-Risk Counties

Data Summary Table 1. Overview of Simplified Method

Simplified Method Overview

Indicators were selected to match as closely as possible the statutorily-defined¹ criteria for identifying target communities for home visiting programs. Issues were considered such as data availability and reliability of indicators at the county level when selecting the final indicator list. After selecting indicators, they were grouped according to eight domains (Population in Need, Socioeconomic Status, Adverse Perinatal Outcomes, Substance Use Disorder, Crime, Child Maltreatment, Domestic Violence, and Mental Health). The algorithm for identifying at-risk counties is as follows:

1. Obtain raw, county-level data for each indicator from the listed data source as defined in Tab 2. Description of Indicators.
2. Compute mean of counties and standard deviation (SD) for each indicator as well as other descriptive statistics (number of missing, range, etc.) (Tab 3. Descriptive Statistics).
3. Standardize indicator values (compute z-score) for each county so that all indicators have a mean of 0 and a SD of 1. $Z\text{-score} = (\text{county value} - \text{mean})/\text{SD}$. (Tab 5. Standardized Indicators).
4. Using the resulting z-scores for each county, calculate the proportion of indicators within each domain for which that county's z-score was greater than 1, that is, the proportion of indicators for which a given county is in the 'worst' 16% of all counties in the state (16% is the percentage of values greater than 1 SD above the mean in the standard normal distribution). If at least half of the indicators within a domain have z-scores greater or equal to 1 SD higher than the mean, then a county is considered at-risk on that domain. The total number of domains at-risk (out of 5) is summed to capture the counties at highest risk across domains. Counties with 2 or more at-risk domains is identified as at-risk. (Tab 6. At-Risk Domains).

¹ Infant mortality was excluded from the Adverse Perinatal Outcomes domain because the level of suppression at the county level for 5-year aggregate data was too high for meaningful inclusion (all but 13 states have >50% of counties with suppressed data). Preterm and low birth weight births together are the second largest cause of infant mortality. Given that the other two indicators in the domain are direct precursors of infant mortality, the team evaluated the extent to which similar counties were identified when infant mortality rate was

included or excluded (among counties with non-suppressed data). The level of suppression for preterm birth and low birthweight was also substantial for individual year data. Thus, 3-yr and 5-yr aggregated data was compiled to obtain reliable estimates for smaller counties.

Data Summary Table 2. Description of Indicators

Domain	Indicator	Indicator Definition	Alignment with statute definition of at-risk communities	Year	Source	Source Link	Source Notes
Population	Birth Rate	Number of births per 1000 residents	Population /Need Indicator	2014-2018	Office of Vital Statistics, Montana DPHHS	Retrieved Fri, 17 January 2020 12:20:47 from Office of Epidemiology and Scientific Support, Montana Department of Public Health and Human Services, Indicator-Based Public Health Information System for Public Health Web site: http://dphhs.mt.gov/	
	Single Parent Households	Number of households with children under 6 led by a single parent	Population /Need Indicator	2018	American Community Survey		

Socioeconomic Status (SES)	Poverty	% population living below %100 FPL	Poverty	2018	Census Small Area Income and Poverty Estimates	SAIPE State and County Estimates for 2018	
	Unemployment	Unemployed percent of the civilian labor force	Unemployment	2019	Bureau of Labor Statistics	Local Area Unemployment Statistics	
	HS Dropout	% of 16-19 year olds not enrolled in school with no high school diploma	High school dropouts	2017	American Community Survey	https://factfinder.census.gov	1 year estimates used for counties with populations >65,000; 5 year estimate used for counties with populations <65,000
		% of 16-19 year olds not enrolled in school with no high school diploma		2013-2017			
		% of 16-19 year olds not enrolled in school with no high school diploma		2013-2017 OR 2017			
	Income Inequality	Gini Coefficient - 1 Yr. Estimate	N/A	2017	American Community Survey	https://factfinder.census.gov	1 year estimates used for counties with populations >65,000; 5 year estimate used for counties with populations <65,000
Gini Coefficient - 5 Yr. Estimate		2014-2018					

Adverse Perinatal Outcomes	Preterm Birth	% live births <37 weeks	Premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect or other indicators of at-risk prenatal, maternal, newborn, or child health	2014-2018	NVSS - Raw Natality File	File received by HRSA	Births <10 were suppressed ; the mean of counties was inputted for counties with missing data
	Low Birth Weight	% live births <2500 g		2014-2018	NVSS - Raw Natality File	File received by HRSA	Births <10 were suppressed ; the mean of counties was inputted for counties with missing data

	Access to Prenatal Care	% of Women Receiving Prenatal Care in the First Trimester	Access to prenatal improves birthweight and decreases premature birth and infant mortality, especially for socio-economically disadvantaged groups.	2014-2018	Montana Office of Vital Statistics	Retrieved Thu, 13 February 2020 10:27:35 from Office of Epidemiology and Scientific Support, Montana Department of Public Health and Human Services, Indicator-Based Public Health Information System for Public Health Web site: http://dphhs.mt.gov/ "	Births <10 were suppressed ; the mean of counties was inputted for counties with missing data; negative z-scores were used to identify counties with a lack of prenatal care access.
Substance Use Disorder	Marijuana 2016	Prevalence rate: Marijuana use in past month	Substance abuse	2016-2018	SAMHSA - National Survey of Drug Use and Health	2016-2018 NSDUH Substate Region Estimates - Tables	County estimates are inputted using the estimate for the Substance Abuse Treatment Planning Region in which they belong.
	Alcohol 2016	Prevalence rate: Alcohol Use Disorder in past year among 12					
	Cocaine 2016	Prevalence rate: Cocaine use in past year among 12 and older					
	Heroin 2016	Prevalence rate: Heroin use in past year among 12 and older					

Crime	Crime Reports	# reported crimes/1000 residents	Crime	2016	Institute for Social Research - National Archive of Criminal Justice Data	Uniform Crime Reporting Program Data: County-Level Detailed Arrest and Offense Data, United States, 2016	Used county population count from ICPSR - NACJD, not PEP
	Juvenile Arrests	# crime arrests ages 0-17/100,000 juveniles aged 0-17		2016	Institute for Social Research - National Archive of Criminal Justice Data	Uniform Crime Reporting Program Data: Arrests by Age, Sex, and Race, United States, 2016	Used county population of 0-17 year olds from PEP
Child Maltreatment	Child Maltreatment	Rate of maltreatment victims aged <1-17 per 1,000 child (aged <1-17) residents	Child maltreatment	2016	ACF	File received by HRSA	
		Percent of children taken into care due in part to parental drug use	Child maltreatment	2010-2019	Montana Board of Crime Control		
Domestic Violence	Violence against spouses	Rate of violence against intimate partners per 1000 residents	Domestic Violence	2014-2018	Montana Board of Crime Control	-	Used 2015-2018 aggregate data and 2017 population data, Data is reporting on violations of the Partner or Family

							Member Assault (PFMA) statute (MCA 45-5-206 and 45-5-215).
Mental Health	Suicide	Rate of Death by Suicide, per 100000 residents	Other Indicators of At-Risk Maternal Health	2009-2018	Office of Vital Statistics, Montana DPHHS	Retrieved Mon, 30 March 2020 17:27:49 from Office of Epidemiology and Scientific Support, Montana Department of Public Health and Human Services, Indicator-Based Public Health Information System for Public Health Web site: http://dphhs.mt.gov/	10 year data aggregate was used due to the high amount of suppressed data. For counties where data was still suppressed due to low number of events, the state average was used.

	Access to mental health providers	Mental Health Providers per 100000 residents		2019	Robert Wood Johnson Foundation and University of Wisconsin population health Institute; National Provider Identification Registry	<u>County Health Rankings Model</u>	Mental health provider rates are calculated from Mental Health provider ratios. Mean of counties was inputted for counties with missing/suppressed data.
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Data Summary Table 3. Descriptive Statistics

Domain	Indicator	Indicator Definition	Year	Missing (n)	Missing %	Mean of Counties	SD	Median	Interquartile Range	Min	Max	State Estimate	
Population	Birth Rates	Birth Rate per 1000 People based on Mother's County of Residence	2014-2018	1.0	1.79	11.6	3.1	11.4	6.0	6.0	20.7	11.6	
	Single Parent Households	% of households with children under 6 led by a single parent, 5 yr. estimate	2018	0.0	0.00	22.0	13.2	21.0	11.1	0.0	56.6		
Socioeconomic Status	Poverty	% population living below %100 FPL	2018	0.0	0.0	14.4	4.3	13.7	7.7	7.7	27.0	14.4	
	Unemployment	Unemployed percent of the civilian labor force	2019	0.0	0.0	3.6	1.3	3.3	1.8	1.8	7.5	3.6	
	HS dropout	% of 16-19 year olds not enrolled in school with no high school diploma - 1 Yr. Estimate	2017	56.0	100.0								5.4
			2013-2017	0.0	0.0	6.6	5.9	5.3	9.3	0.0	19.5	5.0	
			2013-2017 OR 2017	0.0	0.0	6.6	5.9	5.3	9.3	0.0	19.5		
	Income Inequality	Gini Coefficient - 1 Yr. Estimate	2017	50.0	89.3	0.5	0.0	0.5	0.0	0.4	0.5	0.5	
			2014-2018	0.0	0.0	0.4	0.0	0.4	0.4	0.36	0.57	0.5	

Adverse Perinatal Outcomes	Preterm Birth	% live births <37 weeks	2014-2018	21.0	37.5	9.4	1.4	9.4	8.7	6.0	13.4	9.0
	Low Birth Rate	% live births <2500 g	2014-2018	24.0	42.9	7.9	0.8	7.9	5.4	5.4	10.3	7.5
	Prenatal Care Access	% of Women Receiving Prenatal Care in the First Trimester	2014-2018	1	1.8	68.5	11.1	71.6	35.7	35.7	80.7	71.7
Substance Use Disorder	Marijuana	Prevalence rate: Marijuana use in past month	2016-2018	0.0	0.0	13.0	2.1	11.8	11.1	11.1	16.5	14.0
	Alcohol	Prevalence rate: Alcohol Use Disorder in past year among 12	2016-2018	0	0.0	7.5	0.8	7.6	6.6	6.6	8.8	7.8
	Cocaine	Prevalence rate: Cocaine use in past year among 12 and older	2016-2018	0	0.0	1.8	0.3	1.7	1.5	1.5	2.3	2.0
	Heroin	Prevalence rate: Heroin use in past year among 12 and older	2016-2018	0	0.0	0.4	0.1	0.4	0.3	0.3	0.5	0.4
Crime	Crime Reports	# reported crimes/1000 residents	2016	1.0	1.8	16.5	12.6	13.4	16.6	0.0	53.5	30.9
	Juvenile Arrests	# crime arrests ages 0-17/100,000 juveniles aged 0-17	2016	0.0	0.0	1390.5	1529.5	922.9	2337.3	0.0	6046.3	2198.5
Child Maltreatment	Child Maltreatment	Rate of maltreatment victims aged <1-17 per 1,000 child (aged <1-17) residents	2016	0.0	0.0	10.8	8.3	10.3	10.9	0.0	39.4	13.7
	Child Maltreatment related to Substance Use Disorder	Percent of children taken into care due in part to parental drug use	2010-2019	5.0	8.9	24.5	13.0	23.0	13.3	4.7	57.0	25.7

Domestic Violence	Violence against spouses	Rate of violence against intimate partners per 1000 residents	2014-2018	3	5.4	2.4	1.6	2.3	1.3	0.0	6.7	3.2
Mental Health	Suicide	Rate of Death by Suicide, per 100000 residents	2009-2018	26	46.4	26.2	6.3	24.4	13.1	13.1	42.5	24.40
	Access to mental health providers	Mental Health Providers per 100000 residents	2019	8	14.3	171.10	119.49	172.0	75.4	0.0	534.7	281

Data Summary Table 4. Raw Indicators

County	Birth Rate	Single Parent	Poverty	Unemployment	HS dropout	HS dropout 5 Yr.	Income Inequality 5yr	Preterm Birth	Low Birth Weight	Prenatal Care	Marijuana	Alcohol	Cocaine	Heroin	Crime Reports	Juvenile Arrests	Child Maltreatment	% of Children Removed SUD	Domestic Violence	Suicide	MHP Rate
Beaverhead	9.1	17.9	13.8	2.9	2.5	2.5	0.5	9.1	7.5	66.4	15.3	8.8	2.3	0.3	6.0	4575.6	11.5	48.9	2.2	28.9	191
Big Horn	19.3	37.9	25.6	7.4	7.4	7.4	0.4	11.8	8.4	35.7	11.1	7.6	1.7	0.3	36.3	5381.8	15.1	22.0	2.2	21.3	52
Blaine	16	24.5	20.8	3.5	13.6	13.6	0.4	8.7	7.6	37.7	11.4	7.4	1.6	0.5	3.2	502.0	6.0	30.8	1.0	19.6	104
Broadwater	8.9	3.6	10.3	4	17.4	17.4	0.4	9.4	7.9	72.6	15.3	8.8	2.3	0.3	11.4	864.3	11.2	17.5	2.9	26.1	101
Carbon	7	7.0	11.7	3.4	5.7	5.7	0.4	7.8	6.4	76.9	11.1	7.6	1.7	0.3	14.3	374.7	10.9	13.9	2.1	22.2	65
Carter	14.7	10.6	13.7	2.8	1.4	1.4	0.5	9.4	7.9	71.3	11.8	6.6	1.5	0.4	0.0	0.0	0.0	10.0	0.0	24.4	174
Cascade	13.5	20.9	13.4	3.4	6.2	6.2	0.5	9.6	8.0	74.3	11.4	7.4	1.6	0.5	40.7	3552.7	24.6	50.8	3.2	23.8	295
Chouteau	9.6	16.5	18.7	2.7	8.2	8.2	0.4	11.1	9.0	71	11.4	7.4	1.6	0.5	16.8	149.0	1.4	15.0	0.7	27.5	69
Custer	12.2	18.1	12.5	2.9	5.3	5.3	0.4	10.3	7.5	79.1	11.8	6.6	1.5	0.4	19.5	1714.1	16.1	23.0	2.6	29.7	350
Daniels	10.3	27.7	10.1	2	0.0	0.0	0.4	9.4	7.9	72.2	11.8	6.6	1.5	0.4	1.1	779.2	0.0	15.0	0.4	24.4	174
Dawson	11.9	21.2	11.4	2.4	4.1	4.1	0.4	8.4	7.0	70.2	11.8	6.6	1.5	0.4	20.9	6046.3	13.5	33.0	3.7	13.1	168
Deer Lodge	8.2	30.0	15.9	3.2	19.3	19.3	0.5	11.2	9.6	77.3	15.3	8.8	2.3	0.3	41.0	3602.9	23.7	22.9	5.1	42.5	461
Fallon	14.6	13.0	9.2	1.8	0.9	0.9	0.4	8.9	7.9	77.7	11.8	6.6	1.5	0.4	6.1	0.0	6.8	13.0	1.8	24.4	174
Fergus	10.7	39.0	12.2	3.1	0.5	0.5	0.4	8.5	7.3	78.6	11.1	7.6	1.7	0.3	18.2	1214.9	27.9	34.4	2.8	18.4	239
Flathead	11.5	18.3	11.2	4.7	3.1	3.1	0.5	6.9	6.1	76.3	16.5	7.6	2.2	0.4	33.9	1574.0	11.0	12.3	3.6	22.5	263
Gallatin	11.4	15.4	9	2.3	1.3	1.3	0.5	8.6	7.6	76.7	15.3	8.8	2.3	0.3	23.4	1723.0	8.8	4.7	1.9	19.1	290
Garfield	12.9	13.5	16.3	2.4	5.2	5.2	0.5	9.4	7.9	80.7	11.8	6.6	1.5	0.4	6.7	1034.5	0.0		0.4	24.4	77
Glacier	17.4	40.9	27	7.5	10.4	10.4	0.5	12.7	9.0	52	11.4	7.4	1.6	0.5	12.0	491.5	10.6	55.6	4.0	20.6	139
Golden Valley	10	30.8	18.9	4.1	0.0	0.0	0.4	9.4	7.9	58.5	11.1	7.6	1.7	0.3	9.8	0.0	22.2	20.0	2.8	24.4	0
Granite	6	21.1	13.4	5.7	0.9	0.9	0.5	9.4	7.9	73.5	15.3	8.8	2.3	0.3	19.5	0.0	1.7	10.0	1.6	37.9	30
Hill	18.4	38.7	13.5	3.7	5.4	5.4	0.4	10.3	7.6	43.2	11.4	7.4	1.6	0.5	37.4	4855.0	11.4	35.2	6.6	17.1	304
Jefferson	7.6	36.6	7.7	3.3	2.8	2.8	0.4	7.2	6.5	77.1	15.3	8.8	2.3	0.3	15.4	2763.8	9.8	11.3	2.7	27.6	67
Judith Basin	8.2	33.6	13.3	3.1	0.0	0.0	0.5	9.4	7.9	80	11.1	7.6	1.7	0.3	7.4	0.0	3.1	25.0	0.5	24.4	51
Lake	11.5	37.9	18.2	4.2	10.0	10.0	0.5	11.7	8.2	67.7	16.5	7.6	2.2	0.4	30.5	552.4	7.9	20.9	4.5	32.0	228
Lewis and Clark	11.4	31.0	10.5	3	3.8	3.8	0.4	8.2	7.3	79.8	15.3	8.8	2.3	0.3	29.9	2558.8	12.6	25.2	3.9	22.3	444

Liberty	10.3	3.2	19	2.5	6.0	6.0	0.6	9.4	7.9	66.1	11.4	7.4	1.6	0.5	3.3	0.0	4.6	10.0	0.2	24.4	170
Lincoln	8.7	21.8	20.3	7.2	10.0	10.0	0.5	6.0	6.4	71.3	16.5	7.6	2.2	0.4	17.4	2489.4	18.2	6.6	2.7	33.4	195
Madison	11.3	14.6	9.2	3.2	0.0	0.0	0.4	9.4	7.9	74	15.3	8.8	2.3	0.3	6.5	321.5	0.0	18.2	0.1	23.9	174
McCone	7.7	0.0	14.2	2	0.0	0.0	0.4	9.4	7.9	73.6	11.8	6.6	1.5	0.4	7.8	0.0	11.6		6.7	24.4	49
Meagher	9.7	3.7	15.9	3.5	12.4	12.4	0.4	9.4	7.9	72.2	15.3	8.8	2.3	0.3	8.2	0.0	4.7	10.0	1.2	37.5	54
Mineral	9.8	39.3	14	5.7	2.2	2.2	0.5	9.7	7.9	60.2	16.5	7.6	2.2	0.4	0.9	0.0	39.4	28.7	0.8	38.1	212
Missoula	10.1	24.7	12.7	3.2	2.8	2.8	0.5	8.1	7.2	75.6	16.5	7.6	2.2	0.4	39.9	2489.1	14.9	10.5	3.4	23.8	433
Musselshell	9.3	31.0	15	3.9	0.0	0.0	0.4	9.4	7.9	74.2	11.1	7.6	1.7	0.3	26.8	981.5	24.6	47.5	2.7	32.3	43
Park	9.3	31.4	10.5	3.4	2.5	2.5	0.4	8.7	8.2	79.6	15.3	8.8	2.3	0.3	23.3	563.3	5.6	35.2	3.6	34.5	238
Petroleum		16.1	16.2	3.6	0.0	0.0	0.4	9.4	7.9		11.1	7.6	1.7	0.3		0.0	0.0		0.0	24.4	0
Phillips	13.4	8.6	15.2	3.7	19.5	19.5	0.4	7.6	7.9	59.4	11.8	6.6	1.5	0.4	12.0	3148.0	14.1	27.0	3.3	28.9	97
Pondera	12.4	30.2	17.8	3.8	9.5	9.5	0.5	9.6	8.5	61.4	11.4	7.4	1.6	0.5	7.9	486.8	13.8	36.2	1.8	13.1	117
Powder River	10.3	28.0	12.2	2.4	0.0	0.0	0.4	9.4	7.9	73.3	11.8	6.6	1.5	0.4	5.0	0.0	0.0	25.0	1.6	24.4	174
Powell	8.2	21.5	18.1	3.6	15.6	15.6	0.4	8.9	8.2	70.4	15.3	8.8	2.3	0.3	24.2	1785.7	22.5	12.2	2.5	28.8	118
Prairie	12.6	6.8	13.5	3.8	18.4	18.4	0.4	9.4	7.9	78.9	11.8	6.6	1.5	0.4	13.0	0.0	2.9		2.3	24.4	174
Ravalli	9.2	17.8	15.5	4	7.5	7.5	0.5	9.8	7.3	71.2	16.5	7.6	2.2	0.4	13.4	2902.6	9.9	24.7	2.2	31.1	186
Richland	14.2	32.9	8.7	2.7	3.2	3.2	0.4	7.7	5.4	70.9	11.8	6.6	1.5	0.4	22.3	1078.5	3.9	35.0	4.5	28.6	118
Roosevelt	20.7	56.6	25.4	4.3	14.5	14.5	0.5	13.4	8.4	45	11.8	6.6	1.5	0.4	16.2	1703.5	4.7	57.0	1.0	40.2	198
Rosebud	16.2	8.0	17	5	14.3	14.3	0.4	13.1	8.3	49.7	11.8	6.6	1.5	0.4	5.3	73.0	3.6	31.0	1.7	33.5	238
Sanders	9.8	12.6	16	5.9	13.0	13.0	0.5	8.0	9.4	56.2	16.5	7.6	2.2	0.4	13.6	192.8	10.0	12.9	3.0	20.1	299
Sheridan	12.2	10.4	10.9	2.2	5.7	5.7	0.5	9.4	7.9	70.2	11.8	6.6	1.5	0.4	17.6	1948.1	8.8	28.0	3.9	31.2	86
Silver Bow	11.2	24.3	16.7	3.8	5.8	5.8	0.5	9.0	8.9	74	15.3	8.8	2.3	0.3	53.5	3752.3	21.4	40.0	4.3	34.1	535
Stillwater	8.7	9.0	8.1	3.1	4.3	4.3	0.4	10.0	10.3	77.8	11.1	7.6	1.7	0.3	9.6	1287.1	7.0	13.5	1.7	29.1	42
Sweet Grass	8.6	43.0	10	2.8	14.0	14.0	0.4	9.4	7.9	77.1	11.1	7.6	1.7	0.3	4.7	800.0	0.0	16.0	1.4	27.4	54
Teton	13.3	3.7	15.8	3.3	4.0	4.0	0.4	9.6	8.4	67.3	11.4	7.4	1.6	0.5	11.3	1118.9	15.3	33.5	2.0	19.8	115
Toole	11.5	16.5	15.1	2.4	11.5	11.5	0.5	8.7	9.8	64.3	11.4	7.4	1.6	0.5	18.8	1068.4	17.3	36.3	3.9	21.6	143
Treasure	16.7	7.9	11.4	2.7	15.6	15.6	0.4	9.4	7.9	68.4	11.8	6.6	1.5	0.4	1.4	0.0	6.1		0.0	24.4	174
Valley	11.7	11.3	13.7	3.2	2.0	2.0	0.4	9.6	6.8	71.6	11.8	6.6	1.5	0.4	8.3	2421.7	14.0	16.0	2.9	20.0	94
Wheatland	12.2	9.3	19	3.8	13.7	13.7	0.4	9.4	7.9	49.6	11.1	7.6	1.7	0.3	7.6	617.3	16.3	31.2	1.6	24.4	47
Wibaux	11.6	55.4	12	3	0.0	0.0	0.4	9.4	7.9	60.7	11.8	6.6	1.5	0.4	1.7	0.0	4.0	10.0	0.7	24.4	174
Yellowstone	12.3	25.9	10.9	3.2	4.0	4.0	0.5	9.2	7.9	77.6	11.1	7.6	1.7	0.3	42.1	2325.8	17.6	25.3	4.0	22.5	318

Data Summary Table 5. Standardized Indicators

	Birth Rate	Single Parent	Poverty	Unemployment	HS dropout	Income Inequality	Preterm Birth	Low Birth Weight	Prenatal Care	Marijuana	Alcohol	Cocaine	Heroin	Crime Reports	Juvenile Arrests	Child Maltreatment	% Children Removed	Domestic Violence	Suicide	MHP Ratio
Beaverhead	-0.8	-0.3	-0.1	-0.5	-0.7	1.5	-0.2	-0.4	-0.2	1.2	1.6	1.5	-0.9	-0.8	2.1	0.1	1.9	-0.1	0.4	0.2
Big Horn	2.5	1.2	2.6	3.0	0.1	-0.5	1.8	0.6	-3.0	-0.9	0.2	-0.4	-1.1	1.6	2.6	0.5	-0.2	-0.1	-0.8	-1.0
Blaine	1.4	0.2	1.5	-0.1	1.2	-0.4	-0.5	-0.3	-2.8	-0.7	-0.2	-0.7	1.8	-1.0	-0.6	-0.6	0.5	-0.9	-1.1	-0.6
Broadwater	-0.8	-1.4	-1.0	0.3	1.9	-0.3	0.0	0.0	0.4	1.2	1.6	1.5	-0.9	-0.4	-0.3	0.0	-0.5	0.3	0.0	-0.6
Carbon	-1.5	-1.1	-0.6	-0.1	-0.1	-0.8	-1.2	-1.7	0.8	-0.9	0.2	-0.4	-1.1	-0.2	-0.7	0.0	-0.8	-0.2	-0.6	-0.9
Carter	1.0	-0.9	-0.2	-0.6	-0.9	1.9	0.0	0.0	0.3	-0.5	-1.2	-0.9	0.4	-1.3	-0.9	-1.3	-1.1	-1.5	-0.3	0.0
Cascade	0.6	-0.1	-0.2	-0.1	-0.1	0.7	0.2	0.1	0.5	-0.7	-0.2	-0.7	1.8	1.9	1.4	1.7	2.0	0.5	-0.4	1.0
Chouteau	-0.6	-0.4	1.0	-0.7	0.3	-0.2	1.3	1.3	0.2	-0.7	-0.2	-0.7	1.8	0.0	-0.8	-1.1	-0.7	-1.1	0.2	-0.9
Custer	0.2	-0.3	-0.5	-0.5	-0.2	-0.4	0.7	-0.4	1.0	-0.5	-1.2	-0.9	0.4	0.2	0.2	0.6	-0.1	0.1	0.6	1.5
Daniels	-0.4	0.4	-1.0	-1.2	-1.1	-0.3	0.0	0.0	0.3	-0.5	-1.2	-0.9	0.4	-1.2	-0.4	-1.3	-0.7	-1.3	-0.3	0.0
Dawson	0.1	-0.1	-0.7	-0.9	-0.4	-0.6	-0.7	-1.0	0.2	-0.5	-1.2	-0.9	0.4	0.3	3.0	0.3	0.7	0.8	-2.1	0.0
Deer Lodge	-1.1	0.6	0.3	-0.3	2.2	0.4	1.3	2.0	0.8	1.2	1.6	1.5	-0.9	1.9	1.4	1.5	-0.1	1.7	2.6	2.4
Fallon	0.97	-0.7	-1.2	-1.4	-1.0	-0.5	-0.4	0.0	0.8	-0.5	-1.2	-0.9	0.4	-0.8	-0.9	-0.5	-0.9	-0.4	-0.3	0.0
Fergus	-0.3	1.3	-0.5	-0.4	-1.0	-0.3	-0.6	-0.7	0.9	-0.9	0.2	-0.4	-1.1	0.1	-0.1	2.0	0.8	0.2	-1.2	0.6
Flathead	0.0	-0.3	-0.8	0.9	-0.6	0.3	-1.8	-2.1	0.7	1.7	0.2	1.1	-0.1	1.4	0.1	0.0	-0.9	0.7	-0.6	0.8
Gallatin	0.0	-0.5	-1.3	-1.0	-0.9	0.6	-0.6	-0.3	0.7	1.2	1.6	1.5	-0.9	0.5	0.2	-0.2	-1.5	-0.3	-1.1	1.0
Garfield	0.4	-0.6	0.4	-0.9	-0.2	0.6	0.0	0.0	1.1	-0.5	-1.2	-0.9	0.4	-0.8	-0.2	-1.3	-1.9	-1.3	-0.3	-0.8
Glacier	1.9	1.4	2.9	3.1	0.7	2.2	2.4	1.3	-1.5	-0.7	-0.2	-0.7	1.8	-0.4	-0.6	0.0	2.4	1.0	-0.9	-0.3
Golden Valley	-0.5	0.7	1.0	0.4	-1.1	0.2	0.0	0.0	-0.9	-0.9	0.2	-0.4	-1.1	-0.5	-0.9	1.4	-0.3	0.3	-0.3	-1.4
Granite	-1.8	-0.1	-0.2	1.7	-1.0	1.0	0.0	0.0	0.5	1.2	1.6	1.5	-0.9	0.2	-0.9	-1.1	-1.1	-0.5	1.9	-1.2
Hill	2.2	1.3	-0.2	0.1	-0.2	-0.3	0.7	-0.3	-2.3	-0.7	-0.2	-0.7	1.8	1.7	2.3	0.1	0.8	2.7	-1.4	1.1
Jefferson	-1.3	1.1	-1.6	-0.2	-0.6	-1.0	-1.6	-1.6	0.8	1.2	1.6	1.5	-0.9	-0.1	0.9	-0.1	-1.0	0.2	0.2	-0.9
Judith Basin	-1.1	0.9	-0.3	-0.4	-1.1	0.4	0.0	0.0	1.0	-0.9	0.2	-0.4	-1.1	-0.7	-0.9	-0.9	0.0	-1.2	-0.3	-1.0
Lake	0.0	1.2	0.9	0.5	0.6	0.7	1.7	0.4	-0.1	1.7	0.2	1.1	-0.1	1.1	-0.5	-0.3	-0.3	1.3	0.9	0.5

Lewis and Clark	0.0	0.7	-0.9	-0.5	-0.5	-0.9	-0.9	-0.7	1.0	1.2	1.6	1.5	-0.9	1.1	0.8	0.2	0.1	0.9	-0.6	2.3
Liberty	-0.4	-1.4	1.1	-0.9	-0.1	3.5	0.0	0.0	-0.2	-0.7	-0.2	-0.7	1.8	-1.0	-0.9	-0.7	-1.1	-1.4	-0.3	0.0
Lincoln	-0.9	0.0	1.4	2.9	0.6	1.0	-2.5	-1.7	0.3	1.7	0.2	1.1	-0.1	0.1	0.7	0.9	-1.4	0.2	1.1	0.2
Madison	-1.2	-1.7	-0.1	-1.2	-1.1	-1.2	0.0	0.0	0.5	1.2	1.6	1.5	-0.9	-0.8	-0.7	-1.3	-1.9	2.8	-0.4	-1.0
McCone	-0.1	-0.6	-1.2	-0.3	-1.1	0.0	0.0	0.0	0.5	-0.5	-1.2	-0.9	0.4	-0.7	-0.9	0.1	-0.5	-1.5	-0.3	-1.0
Meagher	-0.6	-1.4	0.3	-0.1	1.0	-1.1	0.0	0.0	0.3	1.2	1.6	1.5	-0.9	-0.6	-0.9	-0.7	-1.1	-0.8	1.8	-1.0
Mineral	-0.6	1.3	-0.1	1.7	-0.7	0.4	0.2	0.0	-0.8	1.7	0.2	1.1	-0.1	-1.2	-0.9	3.4	0.3	-1.0	1.9	0.3
Missoula	-0.5	0.2	-0.4	-0.3	-0.6	0.9	-0.9	-0.8	0.6	1.7	0.2	1.1	-0.1	1.9	0.7	0.5	-1.1	0.6	-0.4	2.2
Musselshell	-0.7	0.7	0.1	0.3	-1.1	-0.6	0.0	0.0	0.5	-0.9	0.2	-0.4	-1.1	0.8	-0.3	1.7	1.8	0.2	1.0	-1.1
Park	-0.7	0.7	-0.9	-0.1	-0.7	0.1	-0.5	0.4	1.0	1.2	1.6	1.5	-0.9	0.5	-0.5	-0.6	0.8	0.8	1.3	0.6
Petroleum	-3.7	-0.4	0.4	0.0	-1.1	-0.6	0.0	0.0	-6.2	-0.9	0.2	-0.4	-1.1		-0.9	-1.3	-1.9	-1.5	-0.3	-1.4
Phillips	0.6	-1.0	0.2	0.1	2.2	-0.7	-1.3	0.0	-0.8	-0.5	-1.2	-0.9	0.4	-0.4	1.1	0.4	0.2	0.6	0.4	-0.6
Pondera	0.3	0.6	0.8	0.2	0.5	0.3	0.2	0.7	-0.6	-0.7	-0.2	-0.7	1.8	-0.7	-0.6	0.4	0.9	-0.4	-2.1	-0.4
Powder River	-0.4	0.5	-0.5	-0.9	-1.1	-1.3	0.0	0.0	0.4	-0.5	-1.2	-0.9	0.4	-0.9	-0.9	-1.3	0.0	-0.5	-0.3	0.0
Powell	-1.1	0.0	0.9	0.0	1.5	-0.8	-0.4	0.4	0.2	1.2	1.6	1.5	-0.9	0.6	0.3	1.4	-0.9	0.0	0.4	-0.4
Prairie	0.3	-1.1	-0.2	0.2	2.0	0.2	0.0	0.0	0.9	-0.5	-1.2	-0.9	0.4	-0.3	-0.9	-0.9	-1.9	-0.1	-0.3	0.0
Ravalli	-0.8	-0.3	0.2	0.3	0.2	0.5	0.3	-0.7	0.2	1.7	0.2	1.1	-0.1	-0.2	1.0	-0.1	0.0	-0.2	0.8	0.1
Richland	0.8	0.8	-1.3	-0.7	-0.6	-1.4	-1.2	-2.9	0.2	-0.5	-1.2	-0.9	0.4	0.5	-0.2	-0.8	0.8	1.4	0.4	-0.4
Roosevelt	2.9	2.6	2.6	0.6	1.4	1.0	3.0	0.6	-2.1	-0.5	-1.2	-0.9	0.4	0.0	0.2	-0.7	2.5	-0.9	2.2	0.2
Rosebud	1.5	-1.1	0.6	1.1	1.3	-0.4	2.7	0.5	-1.7	-0.5	-1.2	-0.9	0.4	-0.9	-0.9	-0.9	0.5	-0.5	1.2	0.6
Sanders	-0.6	-0.7	0.4	1.8	1.1	0.7	-1.0	1.8	-1.1	1.7	0.2	1.1	-0.1	-0.2	-0.8	-0.1	-0.9	0.4	-1.0	1.1
Sheridan	0.2	-0.9	-0.8	-1.1	-0.1	0.2	0.0	0.0	0.2	-0.5	-1.2	-0.9	0.4	0.1	0.4	-0.2	0.3	0.9	0.8	-0.7
Silver Bow	-0.1	0.2	0.5	0.2	-0.1	1.0	-0.3	1.2	0.5	1.2	1.6	1.5	-0.9	2.9	1.5	1.3	1.2	1.2	1.3	3.0
Stillwater	-0.9	-1.0	-1.5	-0.4	-0.4	-1.3	0.5	2.9	0.8	-0.9	0.2	-0.4	-1.1	-0.5	-0.1	-0.5	-0.8	-0.5	0.5	-1.1
Sweet Grass	-0.9	1.6	-1.0	-0.6	1.3	-0.5	0.0	0.0	0.8	-0.9	0.2	-0.4	-1.1	-0.9	-0.4	-1.3	-0.6	-0.7	0.2	-1.0
Teton	0.6	-1.4	0.3	-0.2	-0.4	-0.4	0.2	0.6	-0.1	-0.7	-0.2	-0.7	1.8	-0.4	-0.2	0.5	0.7	-0.3	-1.0	-0.5
Toole	0.0	-0.4	0.2	-0.9	0.8	1.2	-0.5	2.3	-0.4	-0.7	-0.2	-0.7	1.8	0.2	-0.2	0.8	0.9	1.0	-0.7	-0.2
Treasure	1.6	-1.1	-0.7	-0.7	1.5	-1.1	0.0	0.0	0.0	-0.5	-1.2	-0.9	0.4	-1.2	-0.9	-0.6	-1.9	-1.5	-0.3	0.0
Valley	0.0	-0.8	-0.2	-0.3	-0.8	-0.9	0.2	-1.3	0.3	-0.5	-1.2	-0.9	0.4	-0.6	0.7	0.4	-0.6	0.3	-1.0	-0.6
Wheatland	0.2	-1.0	1.1	0.2	1.2	-0.8	0.0	0.0	-1.7	-0.9	0.2	-0.4	-1.1	-0.7	-0.5	0.7	0.5	-0.5	-0.3	-1.0
Wibaux	0.0	2.5	-0.6	-0.5	-1.1	-2.3	0.0	0.0	-0.7	-0.5	-1.2	-0.9	0.4	-1.2	-0.9	-0.8	-1.1	-1.1	-0.3	0.0
Yellowstone	0.2	0.3	-0.8	-0.3	-0.4	0.4	-0.1	0.0	0.8	-0.9	0.2	-0.4	-1.1	2.0	0.6	0.8	0.1	1.0	-0.6	1.2

Data Summary Table 6. At-Risk Domains

County	Population	SES	Adverse Perinatal Outcomes	Substance Use Disorder	Crime	Child Maltreatment	Domestic Violence	Mental Health	Number of At-Risk Domains
Beaverhead	0.00	0.25	0.00	0.75	0.50	0.50	0.00	0.0	3
Big Horn	1.00	0.50	0.67	0.00	1.00	0.00	0.00	0.0	4
Blaine	0.50	0.50	0.33	0.25	0.00	0.00	0.00	0.0	2
Broadwater	0.00	0.25	0.00	0.75	0.00	0.00	0.00	0.0	1
Carbon	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0
Carter	0.50	0.25	0.00	0.00	0.00	0.00	0.00	0.0	1
Cascade	0.00	0.00	0.00	0.25	1.00	1.00	0.00	0.0	2
Chouteau	0.00	0.00	0.67	0.25	0.00	0.00	0.00	0.0	1
Custer	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0
Daniels	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0
Dawson	0.00	0.00	0.00	0.00	0.50	0.00	0.00	0.0	1
Deer Lodge	0.00	0.25	0.67	0.75	1.00	0.50	1.00	0.5	6
Fallon	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0
Fergus	0.50	0.00	0.00	0.00	0.00	0.50	0.00	0.0	2
Flathead	0.00	0.00	0.00	0.50	0.50	0.00	0.00	0.0	2
Gallatin	0.00	0.00	0.00	0.75	0.00	0.00	0.00	0.0	1
Garfield	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0
Glacier	1.00	0.75	1.00	0.25	0.00	0.50	0.00	0.0	4
Golden Valley	0.00	0.25	0.00	0.00	0.00	0.50	0.00	0.5	2
Granite	0.00	0.25	0.00	0.75	0.00	0.00	0.00	1.0	2
Hill	1.00	0.00	0.33	0.25	1.00	0.00	1.00	0.0	3
Jefferson	0.50	0.00	0.00	0.75	0.00	0.00	0.00	0.0	2
Judith Basin	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.5	1
Lake	0.50	0.00	0.33	0.50	0.50	0.00	1.00	0.0	4
Lewis and Clark	0.00	0.00	0.00	0.75	0.50	0.00	0.00	0.0	2
Liberty	0.00	0.50	0.00	0.25	0.00	0.00	0.00	0.0	1
Lincoln	0.00	0.50	0.00	0.50	0.00	0.00	0.00	0.5	3

Madison	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.5	1
McCone	0.00	0.00	0.00	0.75	0.00	0.00	1.00	0.0	2
Meagher	0.00	0.00	0.00	0.75	0.00	0.00	0.00	0.5	2
Mineral	0.50	0.25	0.00	0.50	0.00	0.50	0.00	0.5	4
Missoula	0.00	0.00	0.00	0.50	0.50	0.00	0.00	0.0	2
Musselshell	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.5	2
Park	0.00	0.00	0.00	0.75	0.00	0.00	0.00	0.5	2
Petroleum	0.00	0.00	0.33	0.00	0.00	0.00	0.00	0.5	1
Phillips	0.00	0.25	0.00	0.00	0.50	0.00	0.00	0.0	1
Pondera	0.00	0.00	0.00	0.25	0.00	0.00	0.00	0.0	0
Powder River	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0
Powell	0.00	0.25	0.00	0.75	0.00	0.50	0.00	0.0	2
Prairie	0.00	0.25	0.00	0.00	0.00	0.00	0.00	0.0	0
Ravalli	0.00	0.00	0.00	0.50	0.00	0.00	0.00	0.0	1
Richland	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.0	1
Roosevelt	1.00	0.75	0.67	0.00	0.00	0.50	0.00	0.5	5
Rosebud	0.50	0.50	0.67	0.00	0.00	0.00	0.00	0.5	4
Sanders	0.00	0.50	0.67	0.50	0.00	0.00	0.00	0.0	3
Sheridan	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0
Silver Bow	0.00	0.25	0.33	0.75	1.00	1.00	1.00	0.5	5
Stillwater	0.00	0.00	0.33	0.00	0.00	0.00	0.00	0.5	1
Sweet Grass	0.50	0.25	0.00	0.00	0.00	0.00	0.00	0.0	1
Teton	0.00	0.00	0.00	0.25	0.00	0.00	0.00	0.0	0
Toole	0.00	0.25	0.33	0.25	0.00	0.00	0.00	0.0	0
Treasure	0.50	0.25	0.00	0.00	0.00	0.00	0.00	0.0	1
Valley	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0
Wheatland	0.00	0.50	0.33	0.00	0.00	0.00	0.00	0.5	2
Wibaux	0.50	0.00	0.00	0.00	0.00	0.00	0.00	0.0	1
Yellowstone	0.00	0.00	0.00	0.00	0.50	0.00	1.00	0.0	2

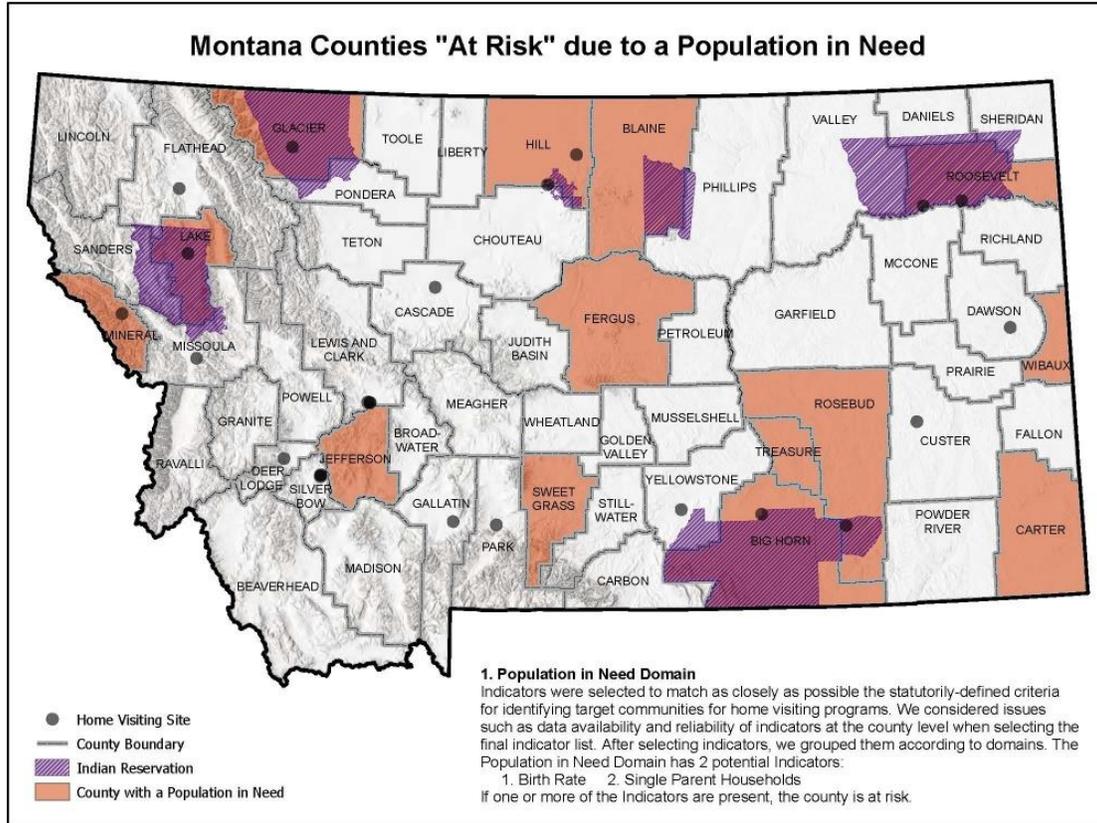
Data Summary Table 7. At-Risk Counties

At-Risk Counties	The county is served, in whole or in part, by at least one home visiting program (Yes or No or Not Sure)	The county is served, in whole or in part, by at least one home visiting program that implements evidence-based home visiting service delivery models eligible for implementation by MIECHV (Yes or No or Not Sure)	The county is served, in whole or in part, by home visiting programs which are funded by MIECHV (Yes or No or Not Sure)	Estimated number of families served by a home visiting program located in the county in the most recently completed program fiscal year	Estimate of need in the county (data provided by HRSA)	Optional: Alternate estimated need of eligible families in the county as defined by the awardee
Deer Lodge County	Yes	Yes	Yes	27	28	42
Roosevelt County	Yes	Yes	Yes	54	66	213
Silver Bow County	Yes	Yes	Yes	140	108	192
Big Horn County	Yes	Yes	Yes	35	49	247
Glacier County	Yes	Yes	Yes	18	33	116
Lake County	Yes	Yes	Yes	35	42	256
Mineral County	Yes	Yes	Yes	53	26	24
Rosebud County	Yes	Yes	Yes	26	33	104
Beaverhead County	No	No	No	0	29	35
Hill County	Yes	Yes	Yes	20	105	207
Lincoln County	No	No	No	0	47	104
Sanders County	No	No	No	0	71	63
Blaine County	No	No	No	0	42	79
Cascade County	Yes	Yes	Yes	127	517	457
Flathead County	Yes	Yes	Yes	147	239	512
Fergus County	No	No	No	0	72	41
Golden Valley County	No	No	No	0	3	4
Granite County	No	No	No	0	11	8

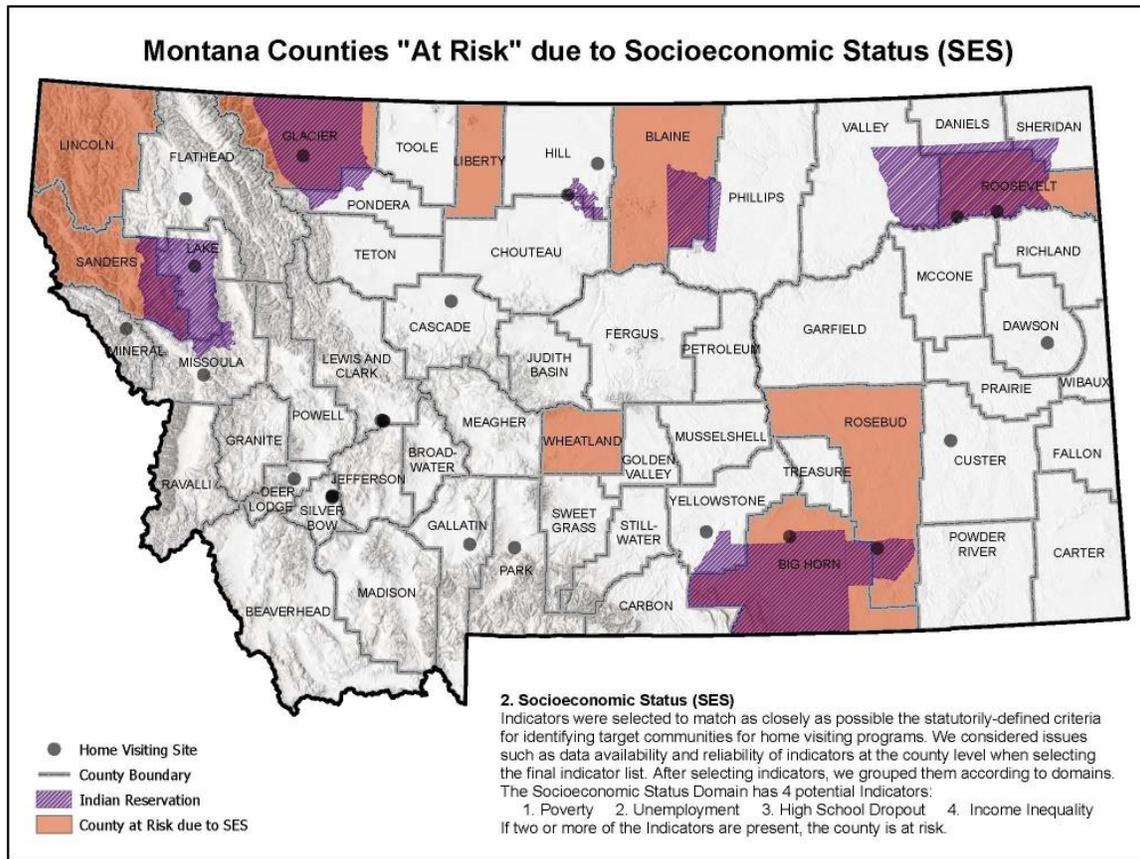
Lewis and Clark County	Yes	Yes	Yes	110	210	297
Jefferson County	No	No	No	0	37	42
Missoula County	Yes	Yes	Yes	103	713	432
McCone County	No	No	No	0	6	7
Meagher County	No	No	No	0	11	14
Park County	Yes	Yes	Yes	93	66	48
Musselshell County	No	No	No	0	17	22
Powell County	No	No	No	0	21	30
Yellowstone County	Yes	Yes	Yes	170	173	868
Wheatland County	No	No	No	0	13	22
Dawson county	Yes	Yes	Yes	22	34	39
Gallatin County	Yes	Yes	Yes	219	426	262
Ravalli County	Yes	Yes	No	0	259	175
Richland County	Yes	Yes	Yes	8	42	45
Custer County	Yes	Yes	Yes	55	43	76
Valley County	No	No	No	0	28	50
Sanders County	No	No	No	0	71	63
Daniels County	No	No	No	0	6	4
Pondera County	No	No	No	0	38	37
Phillips County	No	No	No	0	15	27
Chouteau County	No	No	No	0	36	13

Appendix B. Maps of At-Risk Counties by Domain

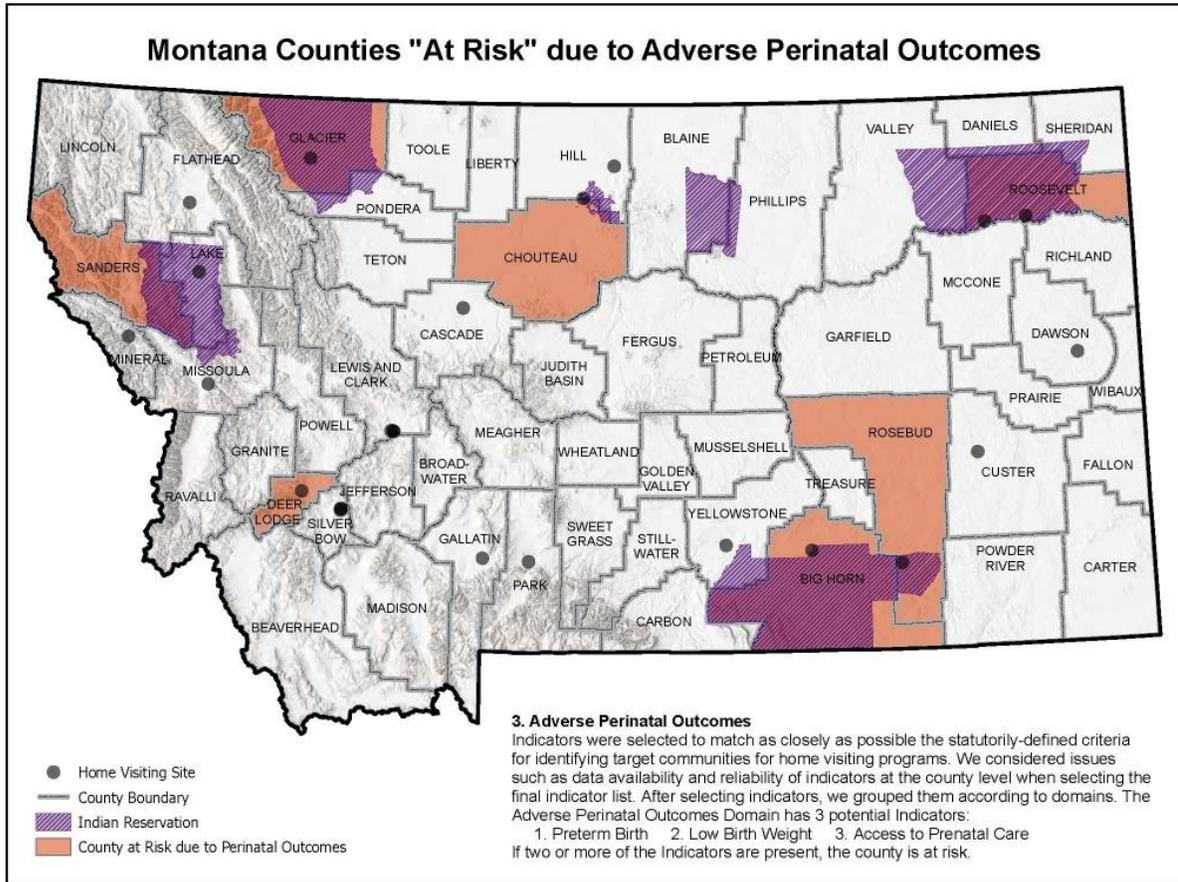
At-Risk Counties by Population in Need



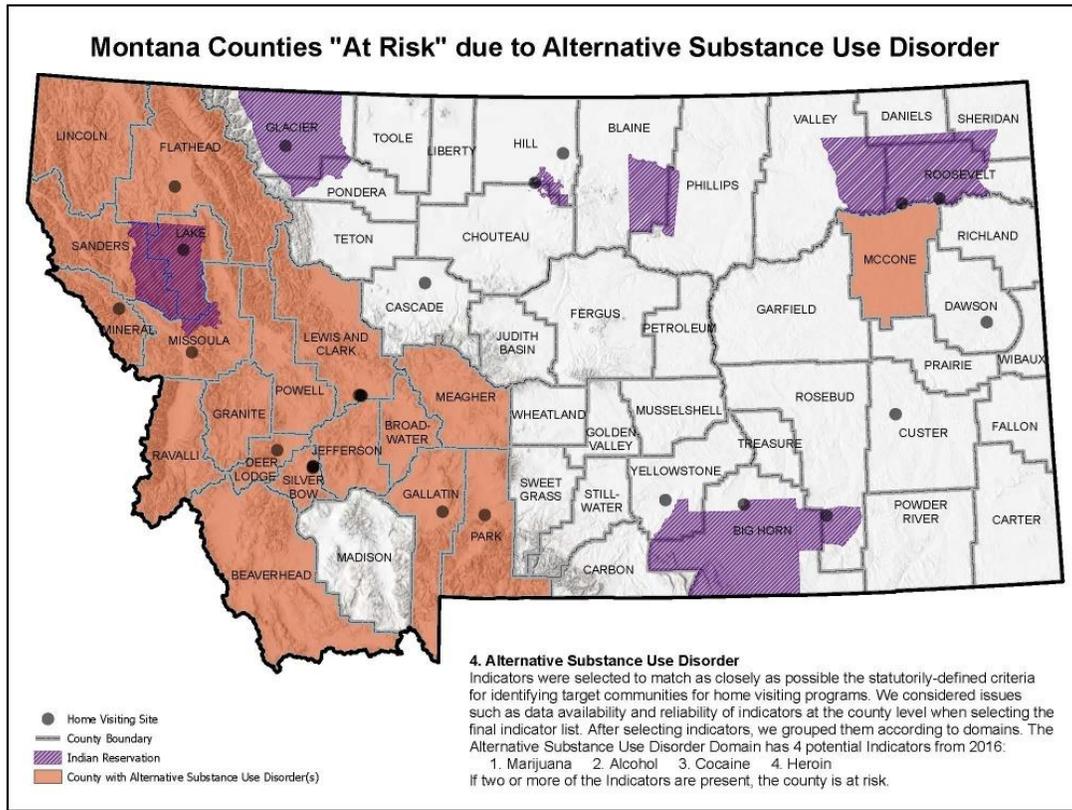
At-Risk Counties by Socioeconomic Status



At-Risk Counties by Adverse Perinatal Outcomes

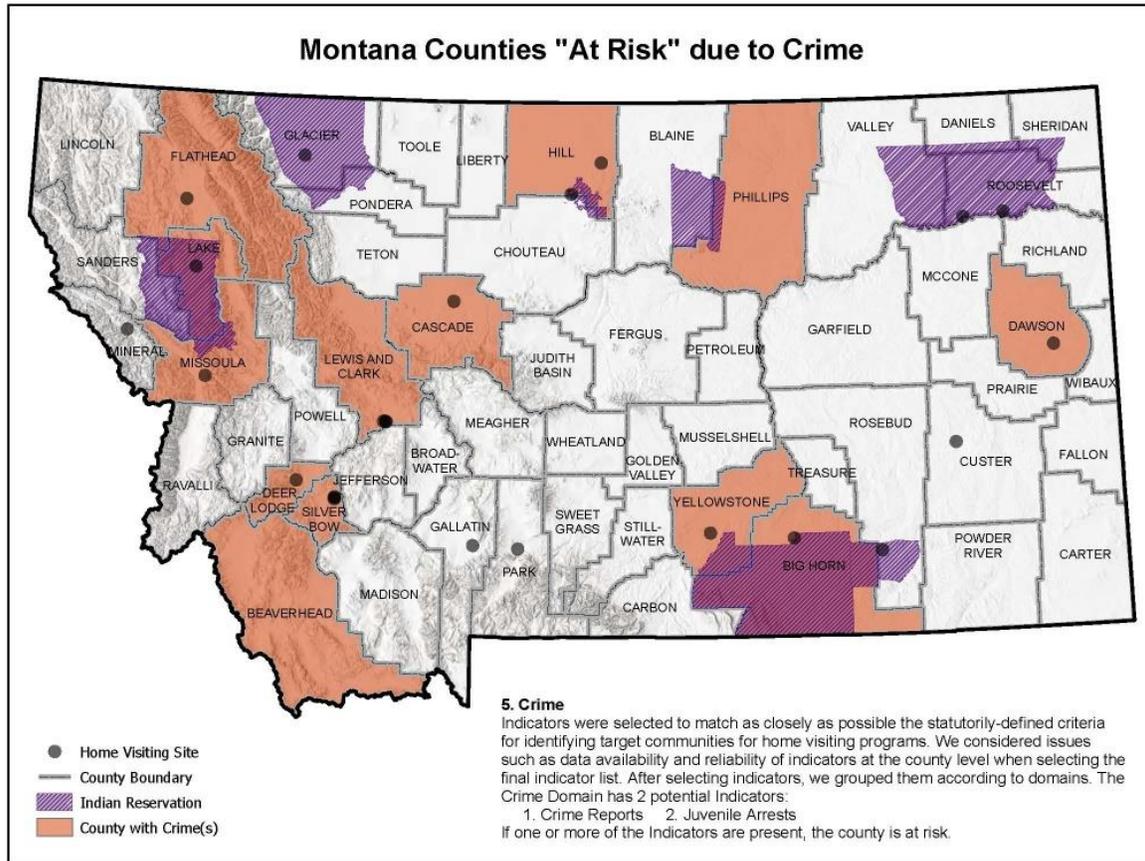


At-Risk Counties by Substance Use Disorder Rates

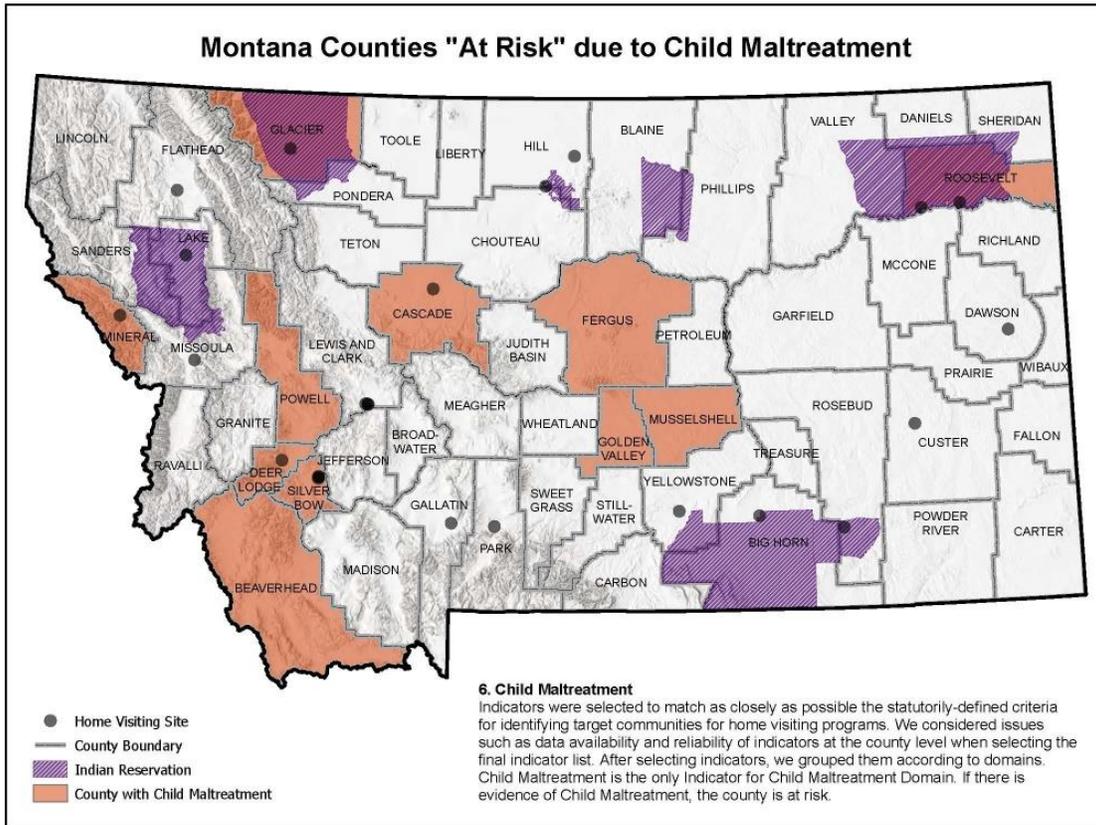


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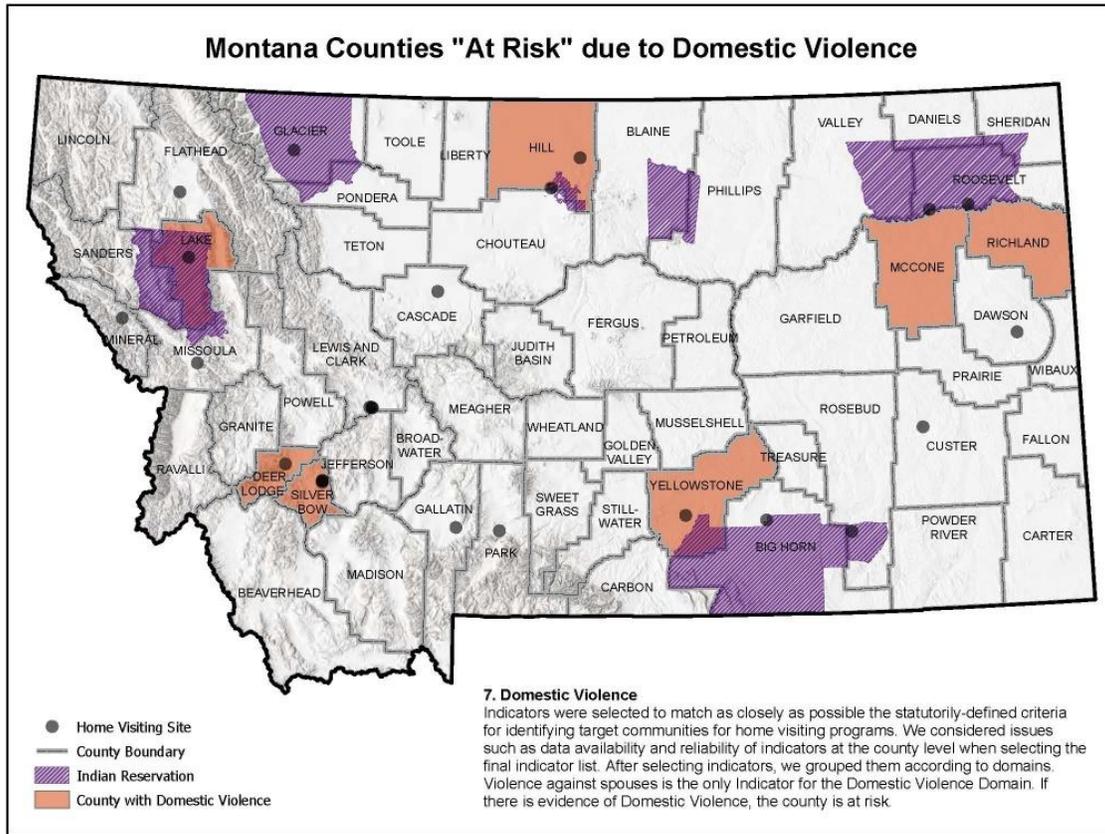
At-Risk Counties by Crime Rates



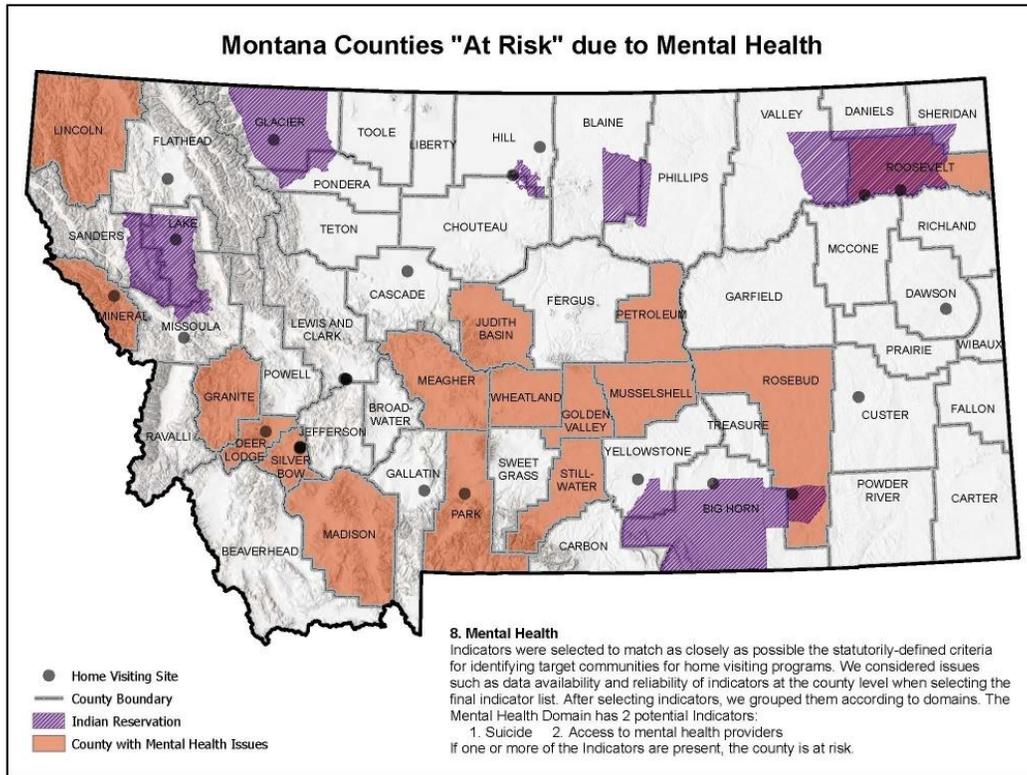
At-Risk Counties by Child Maltreatment Rates



At-Risk Counties by Domestic Violence Rates



At-Risk Counties by Mental Health



Additional Counties Designated At-Risk

Additional Counties Designated as At-Risk	Rationale for At-Risk Designation (Note all numbers in this column are z-scores, unless otherwise explained).
Custer County	Existing MIECHV program served 55 families in last program year.
Dawson County	Existing MIECHV program served 22 families in last program year.
Gallatin County	Existing MIECHV program served 219 families in last program year.
Ravalli County	High number of families eligible for MIECHV services; Adjacent to Missoula County
Daniels County	Within boundaries of Fort Peck Indian Reservation
Valley County	Within boundaries of Fort Peck Indian Reservation
Sheridan County	Within boundaries of Fort Peck Indian Reservation
Phillips County	Within boundaries of Fort Belknap Indian Reservation
Chouteau County	Within boundaries of Rocky Boy Indian Reservation
Pondera County	Within boundaries of Blackfeet Indian Reservation

Appendix C. Data Sources for Capacity and Quality Measures

Measures	Home Visiting Questionnaires	Home Visitor Focus Group	Administrative Data
List of Local Implementing Agencies (LIA)			Provided by HMF
Other providers of home visiting services	X		FCHB Pre-Contract Survey/ Head Start
Retention rates among families served by HV programs		X	Provided by HMF
HV program waiting lists	X		
Rate of enrollment in alternative early childhood programs			Provided by Head Start
HV staff attrition rate	X		
Funding for HV services	X		
Demographics and characteristics of families served by HV programs	X		Provided by HMF
HV staff qualifications, professional development opportunities, and relevant labor statistics	X		
Cultural and language needs of eligible families	X	X	
Strengths and weaknesses in service utilization and outcome data		X	Performance Measures and Outcomes (HMF)
Barriers faced by Home Visiting programs	X	X	
Buy-in and/or public support for evidence-based Home Visiting	X	X	
Policies and protocols for community referrals	X	X	
Technological resources for information management and useful data analysis	X		
Partnerships, communication channels, and collaborations with public and private entities	X	X	

Appendix D. Home Visiting Models Used by MIECHV-Funded Sites in Montana

Local Implementing Agency	County/Counties	Model
Anaconda-Deer Lodge Health Department	Anaconda-Deer Lodge County	PAT
Bighorn Valley Health Center	Big Horn County	PAT
OneHealth	Custer County	PAT
Blackfeet Indian Health Services	Glacier and Pondera Counties	Family Spirit
Boys and Girls Club of Northern Cheyenne Nation	Rosebud County	Family Spirit
Butte 4-C's	Butte-Silver Bow County	SafeCare Aug.
Butte-Silver Bow Health Department	Butte-Silver Bow County	NFP PAT
Cascade City-County Health Department	Cascade County	PAT
Cascade City-County Health Department	Cascade County	SafeCare Aug.
Community Health Partners	Park County	PAT
Dawson County Health Department	Dawson County	PAT
Flathead City-County Health Department	Flathead County	PAT
Flathead City-County Health Department	Flathead County	SafeCare Aug.
Fort Peck Health Promotion and Disease Prevention Wellness Program	Roosevelt, Valley, Daniel and Sheridan Counties	PAT
Gallatin City-County Health Department	Gallatin County	PAT
Hill County Health Department	Hill County	PAT
Lake County Health Department	Lake County	PAT
Lewis and Clark City-County Health Department	Lewis and Clark County	NFP SafeCare Aug. PAT
Mineral County Health Department	Mineral County	PAT
Missoula City-County Health Department	Missoula County	NFP
Riverstone Health	Yellowstone County	NFP PAT
Rocky Boy Health Center	Hill and Chouteau Counties	Family Spirit
Roosevelt County Health Department	Roosevelt County	PAT

Appendix E. Home Visiting Models Used in Montana

Parents as Teachers (PAT)

Intended Recipients: Universal—All pregnant women and children birth through 5 (families may enter at any time before age 5).

Goals for Home Visiting:

- Increase parent knowledge of early childhood development and improve parenting skills
- Provide early detection of developmental delays and health issues
- Prevent child abuse and neglect
- Increase children's school readiness and school success

Specific Services Provided: Parent-child activity and book sharing, child observation and discussion, problem-solving and goal setting, parenting information sharing and handouts, resource referral and follow-up, developmental screening using a standardized tool, informal health information, hearing and vision screening

Recommended Age of Enrollment and Length of Service: A child client can be enrolled any time from prenatal to start of kindergarten. To receive full dosage of the intervention, it is recommended they are enrolled for at least two consecutive years.

Average Cost: \$75.75 per Montana family

Home Visiting as Part of the Model: Home visits are the primary method of service delivery. The model also includes parent group meetings, at least monthly.

SafeCare Augmented

Intended Recipients: Any family with a child between ages of birth and 5 years old, with no other inclusion or exclusion family characteristics necessary for enrollment.

Goals for Home Visiting:

- Prevent child neglect and physical abuse of children
- Improve positive parenting skills so that all parents can provide a nurturing, safe, and healthy home environment for children

Specific Services Provided: SafeCare is delivered across 18 weekly home visits, which typically last 60 minutes each. Each family receives three out of four modules of the SafeCare Program: Parent Child or Infant Interaction, Safety, and Health. Training sessions use principles from well-established social learning theory and research. Parenting skills are taught by: Explaining the skills and why they are important, demonstrating each skill, having parents practice the skills, and providing positive and corrective feedback to parents on their use of skills.

Length of Service: 18 sessions lasting approximately 6 months

Average Cost: \$126.14 per Montana family

Home Visiting as Part of the Model: Home visits are the primary method of service delivery

Nurse-Family Partnership

Intended recipients: Young women pregnant with their first child

Goals for Home Visiting:

- Improve pregnancy outcomes by helping women engage in good preventive health practices, including thorough prenatal care from their healthcare providers, improving their diets and reducing their use of cigarettes, alcohol and illegal substances;
- Improve child health and development by helping parents provide responsible and competent care; and
- Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

Specific Services Provided: Each Nurse-Family Partnership nurse, specially trained to deliver our unique program: the original model, regularly visit young, first-time moms-to-be, starting early in the pregnancy, and continuing through the child's second birthday.

Age of Enrollment and Length of Service: Recommended for enrollment to begin in prenatal period through 24 months of age

Average Cost: \$106 per Montana family

Home Visiting as Part of the Model: Home visits are the primary method of service delivery.

Family Spirit

Intended recipients: Young parents from pregnancy to 3 years post-partum.

Goals for Home Visiting: To break intergenerational cycles of despair in historically-disenfranchised communities by empowering a local work force as change agents for promoting the best start for young families.

Specific Services Provided: Family Spirit addresses intergenerational behavioral health problems, applies local cultural assets, and overcomes deficits in the professional healthcare workforce in low-resource communities. It is the only evidence-based home-visiting program ever designed for, by, and with American Indian families. Family Spirit's culturally-tailored intervention is delivered by community-based paraprofessionals as the core strategy to support young parents from pregnancy to 3 years post-partum. It is a behaviorally-focused intervention, responsive to parents' and children's needs.

Age of Enrollment and Length of Service: Recommended enrollment to begin in prenatal period; intervention includes 52 sessions.

Average Cost: \$92.68

Home Visiting as Part of the Model: Home visits are the primary method of service delivery.

Parent Aide Program

Intended recipients: At risk families

Goals for Home Visiting: Improve parenting skills, Increase their understanding of child development, Have children with better behavior, Enhance family communication, Learn to solve problems, Develop a sense of self-sufficiency, Are better at dealing with and reducing stress, Develop support systems, Gain confidence and pride in being a healthy family unit

Specific Services Provided: Family Support Specialists (FSS) visit families in their homes each week for as long as one year. During the weekly visits, an FSS discusses different topics with

families such as discipline, setting routines, and creating a safe home environment. Family Support Specialists use an evidence-based home visiting program called SafeCare to make sure that each family receives the same quality of service.

Home Visiting as Part of the Model: Parent Partners™ Program, Parenting Classes, and Family Enrichment Workshops.

Part C Early Intervention

Intended recipients: infants and toddlers with disabilities, ages birth through age 2 years, and their families.

Goals for Home Visiting: enhance the development of infants and toddlers with disabilities, reduce educational costs by minimizing the need for special education through early intervention, minimize the likelihood of institutionalization, and maximize independent living and enhance the capacity of families to meet their child's needs.

Specific Services Provided: Outreach and referral, assessment, planned services, case management, transition planning.

Home Visiting as Part of the Model:

Contact: Wendy Studt, Part C Coordinator, Developmental Disabilities Program, Community Services Bureau, Department of Public Health and Human Services

Creative Curriculum (Infant, Toddlers and Twos)

Intended recipients: Teachers and caregivers

Goals for Home Visiting: Create responsive daily routines and meaningful learning experiences for young learners.

Specific Services Provided: three comprehensive volumes that provide 'Early Childhood 101' and an overview of everything teachers and caregivers need to know to build a high-quality program—with a rich collection of resources, the *Daily Resources*, that help teachers put knowledge into practice and help them foster children's learning and growth.

Home Visiting as Part of the Model: Home visits are the primary method of service delivery.

HELP Me Grow Home Visiting

Intended recipients: Pregnant women and new parents

Goals for Home Visiting: Improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, promote child development and school readiness.

Specific Services Provided: Address parent concerns, answer questions, provide education related to health pregnancy, baby and child health, breastfeeding, nutrition, immunizations, growth and development, discipline, toilet training, child safety, household safety, and local resources.

Home Visiting as Part of the Model: Home visits are the primary method of service delivery.

Early Head Start/Early Head Start Home based Option

Intended recipients: low-income pregnant women and families with children from birth to age 3 years.

Goals for Home Visiting: The Early Head Start-Home-Based Option aims to (1) promote healthy prenatal outcomes for pregnant women, (2) enhance the development of very young children, and (3) promote healthy family functioning.

Specific Services Provided: Provide one home visit per week per family that lasts at least an hour and a half and provide a minimum of 46 visits per year. Provide, at a minimum, 22 group socialization activities distributed over the course of the program year.

Home Visiting as Part of the Model: Home visits are the primary method of service delivery. The model also includes group socialization activities.

Appendix F. Alternative Estimate of Families in Need of Home Visiting Services by County

County Name	HRSA Estimated Number of Families in Need	Alternative Estimate of Families in Need
Beaverhead County	29	35
Big Horn County	49	247
Blaine County	42	79
Broadwater County	18	24
Carbon County	43	25
Carter County	4	3
Cascade County	517	457
Chouteau County	36	13
Custer County	43	76
Daniels County	6	4
Dawson County	34	39
Deer Lodge County	28	42
Fallon County	11	10
Fergus County	72	41
Flathead County	239	512
Gallatin County	426	262
Garfield County	5	8
Glacier County	33	116
Golden Valley County	3	4
Granite County	11	8
Hill County	105	207
Jefferson County	37	42
Judith Basin County	12	6
Lake County	183	256
Lewis and Clark County	210	297
Liberty County	15	11
Lincoln County	47	104
Madison County	25	20
McCone County	6	7
Meagher County	11	14
Mineral County	26	24
Missoula County	713	432
Musselshell County	17	22
Park County	66	48
Petroleum County	3	1
Phillips County	15	27
Pondera County	38	37

Powder River County	6	7
Powell County	21	30
Prairie County	4	6
Ravalli County	259	175
Richland County	42	45
Roosevelt County	41	213
Rosebud County	33	104
Sanders County	71	63
Sheridan County	14	14
Silver Bow County	108	192
Stillwater County	38	32
Sweet Grass County	15	9
Teton County	38	28
Toole County	32	26
Treasure County	3	6
Valley County	28	50
Wheatland County	13	22
Wibaux County	4	0
Yellowstone County	173	868
TOTAL	4121	5450

Appendix G. Programs and Initiatives for SUD Treatment in Montana, 2020

ASAM Level	Program/Initiative
0.5 – Early Intervention	<ul style="list-style-type: none"> • Substance use screening, brief intervention, and referral to treatment (SBIRT) • Meadowlark Initiative – Montana Healthcare Foundation • Montana Obstetrics and the Montana Support (MOMS) TeleECHO clinic
1.0 – Outpatient Services	<p>Medication-Assisted Treatment</p> <ul style="list-style-type: none"> • Community Medical Services • Meadowlark Initiative – Montana Healthcare Foundation • MOMS TeleECHO clinic
2.1 – Intensive Outpatient	<ul style="list-style-type: none"> • Rimrock Foundation • Western Montana Mental Health
2.5 – Partial Hospitalization Services	<ul style="list-style-type: none"> • Rimrock Foundation • Western Montana Mental Health
3.1 – Clinically Managed Low Intensity Residential (e.g. Recovery Homes)	<p>Women Only</p> <ul style="list-style-type: none"> • Selene House in Kalispell (8 beds) (Gateway Recovery) • New Day in Billings (8 beds) (New Day, Inc.) • White Sky Hope Lodge in Box Elder (8 beds) (White Sky Hope Center) <p>Women and children</p> <ul style="list-style-type: none"> • Willow Way & Michel’s House in Billings (6 beds & 7 beds) (Rimrock) • Aspen Way in Missoula (6 beds) (Recovery Center Missoula) • Carole Graham Home in Missoula (6 beds) (Western MT Addiction Services – Turning Point) • Florence Crittenton in Helena (4 beds) (Florence Crittenton)
3.5 - Clinically Managed High Intensity Residential (e.g. Community based homes)	<ul style="list-style-type: none"> • Rimrock in Billings • Ada’s House – 8 beds (female only) • Cedar Way 1 – 6 beds • Cedar Way 2 – 6 beds • Cottonwood – 8 beds • Elm House – 8 beds • Green Leaf – 6 beds • White Birch Center – 8 beds • White Birch 2 – 6 beds • White Birch 3 – 3 beds • White Birch 4 - 3 beds

<p>ASAM 3.5 – Clinically Managed High Intensity Residential (e.g. freestanding facility)</p>	<ul style="list-style-type: none"> • Crystal Creek in Browning (16 beds) – Blackfeet reservation • Elkhorn in Boulder (8 beds – not Medicaid billable) (female only) • Montana Chemical Dependency Center in Butte (40 beds total) • Recovery Center Missoula (12 beds) • Rimrock – Main building (40 beds - not Medicaid billable) • Rocky Mountain Treatment Center in Great Falls (20 beds – not Medicaid billable) • Wilderness Treatment Center in Marion (adolescent male) (35 beds – private pay)
<p>ASAM 3.7 – Medically Monitored Intensive Inpatient (e.g. freestanding facility)</p>	<ul style="list-style-type: none"> • Montana Chemical Dependency Center in Butte (8 beds) • Recovery Center Missoula (2 beds) • Rimrock in Billings (10 beds) • Rocky Mountain Treatment Center in Great Falls (6 beds – not Medicaid billable)

Appendix H. References

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Appendix I. FY25 Data Summary Tables for Identifying Additional At-Risk Counties

Data Summary Table 1. Overview of Method

Indicators were selected to match as closely as possible the statutorily-defined criteria for identifying target communities for home visiting programs. Issues were considered such as data availability and reliability of indicators at the county level when selecting the final indicator list. After selecting indicators, they were grouped according to nine domains (Population in Need, Socioeconomic Status, Cost of Living, Adverse Perinatal Outcomes, Substance Use Disorder, Crime, Child Maltreatment, Domestic Violence, and Mental Health). The process for identifying at-risk counties is as follows:

1. Obtain raw, county-level data for each indicator from the listed data source.
2. Compute mean of counties and standard deviation (SD) for each indicator as well as other descriptive statistics (number of missing, range, etc.).
3. Calculate the proportion of indicators within each domain for which that county's data was more at risk than the state estimate. If at least half of the indicators within a domain were more at risk than the state estimate, then a county is considered at-risk for that domain. The total number of domains at-risk (out of 9) is summed to capture the counties at highest risk across domains. Counties with 2 or more at-risk domains are identified as at-risk.

Data Summary Table 2. Descriptive Statistics

Domain	Indicator	Indicator Definition	Year	Source	Missing (n)	Missing %	Mean of Counties	SD	Median	Min	Max	State Estimate
Population	Single Parent Households	% of households with children under 6 led by a single parent, 5-yr est	2023	American Community Survey S1101	0.0	0.00	25.3%	22.2%	19.7%	0.0%	99.7%	25.0%
	Population Change	% change in population of children under 6, 2020-2023, 5-yr est	2020-2023	American Community Survey B23008	0.0	0.00	-1.7%	21.4%	-1.1%	-67.7%	52.2%	-1.8%
Socioeconomic Status	Poverty	% population living below %100 FPL, all ages	2023	Census Small Area Income and Poverty Estimates	0.0	0.0	14%	4%	13%	8%	28%	11.8%
	Unemployment	Unemployed percent of the civilian labor force	2023	Bureau of Labor Statistics, Labor force data by county, 2023 annual averages	0.0	0.0	3.0%	0.8%	2.9%	1.7%	5.4%	2.9%
Cost of Living	Crowded Housing	Percentage of occupied housing units with more people than rooms, 5-yr est	2019-2023	American Community Survey DP04	0.0	0.0	2.0%	1.8%	1.7%	0.0%	11.9%	1.9%
	Transportation	Percentage of households with no vehicle, 5-yr est	2019-2023	American Community Survey DP04	0.0	0.0	4.6%	2.5%	4.6%	0.0%	13.3%	4.6%
	Child Food Insecurity	Percentage of children experiencing food insecurity	2022	Feeding America's Map the Meal Gap	0.0	0.0	19.0%	4.2%	18.5%	10.3%	28.1%	16.9%
	Childcare Capacity	Childcare Capacity as a Percent of Demand from Children Under 6	2023	Montana Department of Labor & Industry - Child Care Deserts: An Analysis of Child Care Supply and Demand Gaps in Montana	0.0	0.0	34%	22%	30%	0%	88%	44%
Adverse Perinatal Outcomes	Preterm Birth	% live births <37 weeks	2019-2023	Montana Office of Vital Statistics	9.0	16.1	10.6%	3.3%	10.1%	4.7%	26.5%	9.9%
	Low Birth Weight Rate	% live births <2500 g	2019-2023	Montana Office of Vital Statistics	13.0	23.2	8.4%	2.6%	8.4%	4.7%	21.4%	7.8%
	Prenatal Care Access	% of Women Receiving Prenatal Care in the First Trimester	2019-2023	Montana Office of Vital Statistics	0	0.0	71.7%	11.8%	75.3%	41.6%	84.5%	75.5%
Substance Use Disorder	Marijuana	Percent of adults who report using marijuana in past month	2023	Montana Behavioral Risk Factor Surveillance System	0.0	0.0	18.2%	3.5%	18.3%	14.3%	23.4%	20.3%
	Alcohol	Percent of adults who report binge drinking	2023	Montana Behavioral Risk Factor Surveillance System	0	0.0	19.8%	1.4%	19.5%	17.8%	21.9%	19.5%
	Tobacco	Percent of adults who report being current smokers	2023	Montana Behavioral Risk Factor Surveillance System	0	0.0	12.9%	2.3%	12.9%	9.3%	16.1%	12.4%
Crime	Juvenile Arrests	# crime arrests ages 0-19 per 100,000 juveniles aged 0-19	2022	Institute for Social Research - National Archive of Criminal Justice Data	1.0	1.8	1020.1	1311.8	508.0	0.0	5671.2	1916.8
Child Maltreatment	Child Maltreatment	Rate of maltreatment victims aged <1-17 per 1,000 child residents aged <1-17	2019-2023	Montana DPHHS Child & Family Services Division	8.0	14.3	52.4	22.0	47.8	16.8	110.7	54.8
		Rate of removal of children aged <1-17 per 1,000 child residents aged <1-17	2019-2023	Montana DPHHS Child & Family Services Division	12.0	21.4	30.7	19.6	29.6	0.0	78.9	36.7
Domestic Violence	Violence against spouses	Rate of violence against intimate partners per 1000 residents	2019-2023	Montana Board of Crime Control	1	1.8	1.6	1.0	1.6	0.0	4.1	2.3
Mental Health	Suicide	Rate of Death by Suicide, per 100,000 residents	2014-2023	Montana Office of Vital Statistics	16	28.6	30.5	7.1	30.5	15.6	50.1	27.00
	Access to mental healthcare	Mental Health Providers per 100,000 residents	2023	Robert Wood Johnson Foundation and University of Wisconsin population health Institute; National Provider Identification	8	14.3	209.75	143.04	210.3	0.0	588.2	357.1

Data Summary Table 3. Raw Indicators for Additional At-Risk Counties

County	Single Parent Households	Population Change	Poverty	Unemployment	Crowded Housing	Transportation	Food Insecurity	Childcare Capacity	Preterm Birth	Low Birth Weight	Prenatal Care	Marijuana	Alcohol	Smoking	Juvenile Arrests	Child Maltreatment Victims	Child Removals	Domestic Violence	Suicide	MHP Rate
Broadwater	27.4%	21.9%	8.7%	3.5%	2.5%	2.0%	16.8%	18%	13.1%	9.5%	75.1%	20.9%	19.5%	9.3%	295.5	28.7	29.6	1.9	19.9	83
Carbon	21.5%	-14.9%	10.6%	2.8%	0.6%	3.6%	17.8%	30%	7.8%	6.8%	74.8%	15.7%	19.0%	14.5%	92.6	42.8	21.1	1.2	29.8	111
Carter	2.0%	0.0%	13.7%	2.0%	1.0%	6.7%	22.5%	26%	10.7%	8.4%	82.7%	14.3%	21.9%	12.9%	0.0	47.2	0.0	0.0	30.5	212
Fallon	40.1%	-18.4%	9.1%	1.7%	1.7%	6.5%	12.7%	15%	9.2%	8.4%	83.0%	14.3%	21.9%	12.9%	1822.3	35.0	37.1	1.4	30.5	212
Garfield	0.0%	38.6%	16.9%	3.4%	3.1%	2.0%	16.3%	57%	26.5%	21.4%	84.0%	14.3%	21.9%	12.9%	0.0	47.2	37.1	0.4	30.5	83
Judith Basin	3.8%	-18.7%	13.7%	2.8%	0.0%	2.1%	19.7%	56%	8.9%	8.4%	82.6%	15.7%	19.0%	14.5%	0.0	32.9	0.0	0.4	30.5	212
Liberty	0.0%	36.2%	16.5%	2.5%	2.8%	13.3%	25.2%	82%	9.9%	8.4%	66.7%	21.0%	17.8%	16.1%	0.0	24.1	57.8	0.4	30.5	212
Madison	4.5%	-0.7%	9.1%	3.0%	1.7%	1.8%	14.9%	24%	4.7%	4.7%	72.8%	20.9%	19.5%	9.3%	250.8	42.6	9.2	1.1	25.7	79
Petroleum	0.0%	-43.8%	13.0%	3.3%	0.0%	0.0%	17.7%	40%	10.7%	8.4%	80.0%	15.7%	19.0%	14.5%	0.0	58.0	0.0	0.6	30.5	0
Powder River	51.1%	19.8%	11.7%	2.5%	1.8%	4.6%	15.8%	29%	10.7%	8.4%	68.2%	14.3%	21.9%	12.9%	0.0	43.1	37.1	0.2	30.5	212
Prairie	99.7%	22.4%	13.4%	2.5%	1.5%	6.5%	20.3%	88%	10.7%	8.4%	79.6%	14.3%	21.9%	12.9%	0.0	47.2	0.0	0.9	30.5	212
Richland	3.1%	-3.6%	9.5%	2.6%	1.2%	5.4%	12.8%	22%	8.7%	6.0%	79.2%	14.3%	21.9%	12.9%	556.3	33.5	24.8	3.3	27.5	133
Stillwater	7.2%	13.4%	8.3%	2.4%	1.4%	2.9%	13.9%	21%	8.3%	6.0%	81.5%	15.7%	19.0%	14.5%	1804.4	40.4	20.4	1.2	25.8	55
Sweet Grass	0.0%	17.9%	10.0%	2.3%	1.9%	3.7%	14.8%	32%	9.2%	8.5%	75.5%	15.7%	19.0%	14.5%	3201.0	64.7	14.5	1.5	29.8	161
Teton	8.1%	-4.3%	13.3%	2.9%	2.2%	5.8%	18.9%	19%	13.4%	8.8%	71.2%	21.0%	17.8%	16.1%	767.0	58.4	15.9	1.4	24.3	128
Toole	0.0%	21.2%	17.0%	2.2%	2.0%	7.4%	19.6%	19%	10.5%	12.0%	60.8%	21.0%	17.8%	16.1%	427.0	61.1	46.3	1.9	20.1	139
Treasure	22.5%	52.2%	12.6%	2.7%	2.6%	5.2%	21.6%	0%	10.7%	8.4%	70.8%	14.3%	21.9%	12.9%	0.0	83.3	37.1	0.3	30.5	0
Wibaux	49.9%	-14.9%	12.7%	2.7%	4.1%	1.9%	25.2%	0%	10.7%	8.4%	78.3%	14.3%	21.9%	12.9%	0.0	47.2	37.1	0.2	30.5	0

More at-risk than state estimate

Data Summary Table 4. Standardized Indicators for Additional At-Risk Counties

County	Single Parent	Population Change	Poverty	Unemployment	Housing	Transportation	Food	Childcare	Preterm Birth	Low Birth Weight	Prenatal Care	Marijuana	Alcohol	Smoking	Juvenile Arrests	Child Maltreatment	Child Removals	Domestic Violence	Suicide	MHP Rate
Broadwater	1	1	0	1	1	0	0	1	1	1	1	1	0	0	0	0	0	0	0	1
Carbon	0	0	0	0	0	0	1	1	0	0	1	0	0	1	0	0	0	0	1	1
Carter	0	1	1	0	0	1	1	1	1	1	0	0	1	1	0	0	0	0	1	1
Fallon	1	0	0	0	0	1	0	1	0	1	0	0	1	1	0	0	1	0	1	1
Garfield	0	1	1	1	1	0	0	0	1	1	0	0	1	1	0	0	1	0	1	1
Judith Basin	0	0	1	0	0	0	1	0	0	1	0	0	0	1	0	0	0	0	1	1
Liberty	0	1	1	0	1	1	1	0	1	1	1	1	0	1	0	0	1	0	1	1
Madison	0	0	0	1	0	0	0	1	0	0	1	1	0	0	0	0	0	0	0	1
Petroleum	0	0	1	1	0	0	1	1	1	1	0	0	0	1	0	1	0	0	1	1
Powder River	1	1	0	0	0	0	0	1	1	1	1	0	1	1	0	0	1	0	1	1
Prairie	1	1	1	0	0	1	1	0	1	1	0	0	1	1	0	0	0	0	1	1
Richland	0	0	0	0	0	1	0	1	0	0	0	0	1	1	0	0	0	1	1	1
Stillwater	0	1	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	1
Sweet Grass	0	1	0	0	0	0	0	1	0	1	0	0	0	1	1	1	0	0	1	1
Teton	0	0	1	1	1	1	1	1	1	1	1	1	0	1	0	1	0	0	0	1
Toole	0	1	1	0	1	1	1	1	1	1	1	1	0	1	0	1	1	0	0	1
Treasure	0	1	1	0	1	1	1	1	1	1	1	0	1	1	0	1	1	0	1	1
Wibaux	1	0	1	0	1	0	1	1	1	1	0	0	1	1	0	0	1	0	1	1

Key:
 Additional at-risk counties
 1= More at risk than the state estimate

Data Summary Table 5. At-Risk Domains for Additional At-Risk Counties

County	Population	SES	Cost of Living	Adverse Perinatal Outcomes	Substance Use	Crime	Child Maltreatment	Domestic Violence	Mental Health	Number of At-Risk Domains
Broadwater	1.00	0.5	0.5	1	0.33	0	0	0	0.5	5
Carbon	0.00	0	0.5	0.33	0.33	0	0	0	1	2
Carter	0.50	0.5	0.75	0.67	0.67	0	0	0	1	6
Fallon	0.50	0	0.5	0.33	0.67	0	0.5	0	1	5
Garfield	0.50	1	0.25	0.67	0.67	0	0.5	0	1	6
Judith Basin	0.00	0.5	0.25	0.33	0.33	0	0	0	1	2
Liberty	0.50	0.5	0.75	1	0.67	0	0.5	0	1	7
Madison	0.00	0.5	0.25	0.33	0.33	0	0	0	0.5	2
Petroleum	0.00	1	0.5	0.67	0.33	0	0.5	0	1	5
Powder River	1.00	0	0.25	1	0.67	0	0.5	0	1	5
Prairie	1.00	0.5	0.5	0.67	0.67	0	0	0	1	6
Richland	0.00	0	0.5	0	0.67	0	0	1	1	4
Stillwater	0.50	0	0.25	0	0.33	0	0	0	0.5	2
Sweet Grass	0.50	0	0.25	0.33	0.33	1	0.5	0	1	4
Teton	0.00	1	1	1	0.67	0	0.5	0	0.5	6
Toole	0.50	0.5	1	1	0.67	0	1	0	0.5	7
Treasure	0.50	0.5	1	1	0.67	0	1	0	1	7
Wibaux	0.50	0.5	0.75	0.67	0.67	0	0.5	0	1	7

Data Summary Table 6. At-Risk Counties (Table 7)

At-Risk Counties	The county is served, in whole or in part, by at least one home visiting program (Yes or No or Not Sure)	The county is served, in whole or in part, by at least one home visiting program that implements evidence-based home visiting service delivery models eligible for implementation by MIECHV (Yes or No or Not Sure)	The county is served, in whole or in part, by home visiting programs which are funded by MIECHV (Yes or No or Not Sure)	Estimated number of families served by a home visiting program located in the county in the most recently completed program fiscal year
Beaverhead	No	N/A	N/A	N/A
Big Horn	Yes	Yes	No	Information Unavailable
Blaine	No	N/A	N/A	N/A
Broadwater	Yes	Yes	No	Information Unavailable
Carbon	No	N/A	No	N/A
Carter	No	N/A	No	N/A
Cascade	Yes	Yes	Yes	92
Chouteau	No	N/A	N/A	N/A
Custer	Yes	Yes	Yes	39
Daniels	No	N/A	N/A	N/A
Dawson	Yes	Yes	Yes	26
Deer Lodge	Yes	Yes	Yes	22
Fallon	No	N/A	No	N/A
Fergus	Yes	No	No	Information Unavailable
Flathead	Yes	Yes	Yes	109
Gallatin	Yes	Yes	Yes	173
Garfield	No	N/A	N/A	N/A
Glacier	Yes	Yes	Yes	19
Golden Valley	Yes	No	No	Information Unavailable
Granite	No	N/A	N/A	N/A
Hill	Yes	Yes	No	13
Jefferson	Yes	No	No	Information Unavailable
Judith Basin	Yes	No	No	Information Unavailable
Lake	Yes	Yes	Yes	24
Lewis and Clark	Yes	Yes	Yes	99
Liberty	No	N/A	N/A	N/A
Lincoln	Yes	Yes	No	38
Madison	No	N/A	N/A	N/A
McCone	No	N/A	N/A	N/A
Meagher	No	N/A	N/A	N/A
Mineral	Yes	Yes	Yes	43
Missoula	Yes	Yes	Yes	62
Musselshell	Yes	No	No	Information Unavailable
Park County	Yes	Yes	Yes	55
Petroleum	Yes	No	No	Information Unavailable
Phillips	No	N/A	N/A	N/A
Pondera	No	N/A	N/A	N/A
Powder River	No	N/A	N/A	N/A

At-Risk Counties	The county is served, in whole or in part, by at least one home visiting program (Yes or No or Not Sure)	The county is served, in whole or in part, by at least one home visiting program that implements evidence-based home visiting service delivery models eligible for implementation by MIECHV (Yes or No or Not Sure)	The county is served, in whole or in part, by home visiting programs which are funded by MIECHV (Yes or No or Not Sure)	Estimated number of families served by a home visiting program located in the county in the most recently completed program fiscal year
Powell	No	N/A	N/A	N/A
Prairie	Yes	No	No	Information Unavailable
Ravalli	Yes	Yes	No	42
Richland	No	N/A	N/A	N/A
Roosevelt	Yes	Yes	Yes	18
Rosebud	Yes	Yes	Yes	16
Sanders	No	N/A	N/A	N/A
Sheridan	No	N/A	N/A	N/A
Silver Bow	Yes	Yes	Yes	43
Stillwater	Yes	No	No	Information Unavailable
Sweet Grass	No	N/A	N/A	N/A
Teton	Yes	No	No	Information Unavailable
Toole	No	N/A	N/A	N/A
Treasure	Yes	No	No	Information Unavailable
Valley	No	N/A	N/A	N/A
Wheatland	Yes	No	No	Information Unavailable
Wibaux	Yes	No	No	Information Unavailable
Yellowstone	Yes	Yes	Yes	117

Appendix J: Endnotes

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