Montana Maternal & Child Health Block Grant

III.C. Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

The Family & Community Health Bureau (FCHB) administers the Title V Maternal & Child Health Block Grant (MCHBG). In October 2018, the FCHB created a team to begin work on the 2020 Statewide 5-Year Title V MCHBG Needs Assessment (hereafter referred to as NA).

Goals

The FCHB NA team identified the following goals:

- Incorporate findings from the 2015 NA to assess changes and trends;
- Develop realistic and relevant program priorities;
- Identify unmet needs and major health issues of the maternal and child population, and who is currently working to address them;
- Understand where local public health support services could have the greatest impact;
- Provide an opportunity for program partners and families to provide input on priorities; and,
- Augment with information gathered by other recent DPHHS program needs assessments.

Framework and Methods

The NA Team identified three phases outlined in Table 1.

Table 1. Overview of NA Process

Phase 1: Preliminary Assessment Steps	Phase 2: Data Review and Broader Stakeholder Engagement	Phase 3: Final Assessment
1. Key Informant Interviews	1. Administrative/Secondary Data (ASD) Review	1. Review of recommendations and data summaries
2. Collection and Analysis of Existing Data	2. Stakeholder Survey	2. Internal discussion to identify final priorities
3. Domain Meetings with Key Stakeholders	3. Additional Stakeholder Interviews	
4. Leadership Advisory Board Meetings	4. Data Analysis - Triangulation of Needs and Community Capacity	

Phase 1

Preliminary Assessment Steps – Initial Key Informant Interviews:
The process began with internal team meetings and DPHHS staff interviews in October 2018. The SSDI Epidemiologist completed 13 one-on-one interviews with key informants to learn about their MCH programs, populations, data, and program specific NAs. The interviews were beneficial for: the selection of subject matter experts to present at subsequent population domain meetings; gaining information on DPHHS programs in other divisions which serve the maternal and child population; and, potential NA partnerships with those programs.

Interviews were conducted with these DPHHS staff: American Indian Health Director; Tribal Relations Manager; WIC Director; Head Start Collaboration Director; FICMMR Coordinator; PCO Program Specialist Children & Youth with Special Health Care Needs (CYSHCN).
Director; Home Visiting and Adolescent Epidemiologists; Immunization Program Manager; and Children and Family Services Administrator. Also interviewed were the MT *Healthy Mothers Healthy Babies* (HMHB) Executive Director and a Montana State University Early Childhood Education professor.

Preliminary Assessment Steps – Domain Advisory Group Meetings:
In December 2018 an advisory group of 73 members, including MCH epidemiologists and program and population experts, was recruited and invited to separate domain meetings: Women & Maternal; Perinatal & Infant; Children; and, Adolescent. The group was split between the domains, with some overlap. Integrated into each domain meeting was data and discussion pertaining to health disparities, and CYSHCN.
The meetings included domain specific information and data. Attendees participated in small group discussions to select the top areas needing attention. These meetings developed the foundation for subsequent questions and surveys and gathering additional qualitative and quantitative information on the root causes of these issues. Root causes were then analyzed to identify systems and cross-cutting issues.

The advisory group also identified six goals for guiding the NA process:

- Gather meaningful feedback from as many possible disciplines and demographics;
- Identify and address avoidable health disparities;
- Collaborate to maximize resources and efficacy;
- Apply a life course perspective to identify and analyze data;
- Identify and build on strengths; and,
- Make data-driven decisions.

These goals also informed the collection and analysis of additional quantitative and qualitative data; and provided guidance to a Leadership Advisory Board (LAB) in the selection of final priorities.

Preliminary Assessment Steps – Leadership Advisory Board:
The LAB, comprised of the Title V, CYSHCN, and WIC Directors; State Medical Officer; American Indian Health Director; MCHBG Program Specialist; FCHB Bureau Chief and Section Supervisors; SSDI and Senior FCHB Epidemiologists; and, the HMHB Executive Director met in May and June 2019. LAB members were charged with applying criteria for selecting key MCH priorities.

As of July 2019, the domain NA information included: the SSDI Epidemiologist's data analysis; other DPHHS programs' formal and informal data collection and analysis efforts and reports; the top areas identified as needing more attention; and, the two highest scoring issues per domain identified by the LAB members. See Table 2.

Table 2. LAB Scoring Results

Leadership Advisory Board Scoring Results: Top Areas Needing More Attention & Two Highest Issues Per Population Domain

Domain	Areas Needing More Attention	Two Highest Scoring Issues
Women & Maternal	1. Access to Physical Healthcare 2. Access to Mental Health Care	1. Well-Woman Visit; 2. Postpartum Depression
Perinatal & Infant	1. Parental Mental Health 2. Home Visiting	1. Infant Mortality; 2. Safe Sleep
Children	1. Comprehensive Care Coordination 2. Trauma	1. Developmental Screening 2. Preventive Dental Visit
Adolescent	1. Relationship with Trusted Adult 2. Life-Skills	1. Vaping 2. Suicide
CYSHCN	1. See Domain Listings for Perinatal & Infant, Children, and Adolescent	1. Medical Home 2. Foster Youth

Preliminary Assessment Steps – State Health Improvement Plan:
Another key contributor to the NA work was the *2019 – 2023 Montana State Health Improvement Plan (SHIP)* and four workgroups assigned to address its five health priority areas. The 2019 SHIP, published in February 2019, was derived from the 2017 State Health Assessment (SHA). In 2017, a 24-member steering committee determined top State health priorities, using: SHA data; input from stakeholders; and a prioritization matrix. DPHHS held 12 meetings across the state and gathered input from 300+ stakeholders to identify existing and emerging health topics, including issues that disproportionately impact American Indians, the elderly, and individuals living in rural areas.

In the implementation phase, workgroups determined by the Public Health System Improvement Task Force (PHSITF) identified evidence-based or informed, or best/emerging practices activities and strategies, to address outcome measures the five health priority areas:

- Behavioral health, including substance use disorders, mental health, suicide prevention, and opioid misuse;
- Chronic disease prevention and self-management;
- Healthy mothers, babies, and youth;
- Motor vehicle crashes; and,
- Adverse childhood experiences.

The 2017 SHA is at: https://dphhs.mt.gov/assets/ahealthiermontana/2017SHAFinal.pdf
The 2019-2023 SHIP is at: https://dphhs.mt.gov/assets/ahealthiermontana/2019SHIPfinal.pdf

Phase 2

Administrative Data Review:
In January 2020, the FCHB contracted with the University of Montana Rural Institute for Inclusive Communities (UM-RI) to assist with Phases Two and Three: Data Review & Broader Stakeholder Engagement and Final Assessment. The UM-RI team worked with FCHB epidemiologists to identify and review additional data regarding changes and trends in the needs of MT's maternal and child health population.

From each of the Administrative/Secondary Data (ASD) sources, potential MCH needs were identified based on statistically significant differences from national averages and positive or negative trends over time. Race and rurality were also considered as key factors in assessing data, as American Indian and rural populations generally show evidence of health disparities. Finally, effectiveness of, and capacity to implement potential strategies was considered.

Stakeholder Survey and Interviews:
The UM-RI Evaluation Team, in conjunction with the FCHB epidemiologist and the MCHBG Program Specialist, created an online survey using the 2015 NA survey as a starting point so as to allow for comparison. It was distributed to key stakeholders across the state including: the 56 County Public Health Departments (CPHD); Federally Qualified Health Centers (FQHC); non-profit organizations; existing family groups and organizations; and stakeholders from several other programs. The survey asked participants to provide:

- Input on unmet health needs of the maternal and child population in their county;
- Feedback on how their current activities relate to, and are successful in addressing the priority needs identified in the 2015 NA;
- Challenges and strengths of their activities and initiatives in addressing those priority needs;
- Identification of groups or organizations in their counties working to address maternal and child health needs; and,
- Input regarding maternal and child health priorities, and which NPM/SPMs choices they believe would be best – especially given local capacity.

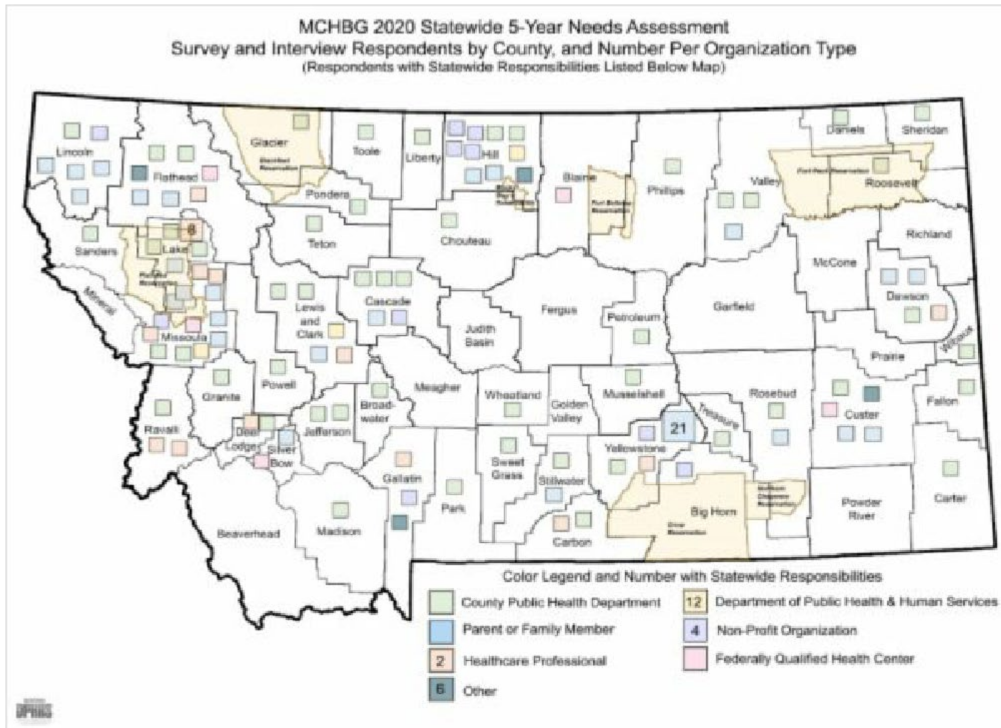
165 survey responses were received. Table 3 illustrates the responders' self-identified affiliation:

Table 3. Needs Assessment Stakeholder Survey Groups

Group	Number of Responses
County Public Health Department Staff	52
Parent or Family Member	45
Healthcare Professional	23
DPHHS Staff	15
Non-Profit Organization Staff	14
Other	11
Federally Qualified Health Center Staff	5

Forty-eight of MT's 56 counties responded and of these 24 respondents represented all counties in the state. Parent or family members from 14 counties across the state were also represented. Despite the American Indian Health Director and FCHB BC's efforts, there were no American Indian specific responses to help inform the NA. Strategies are being discussed to increase AI input in the next five years.

Geographic representation by stakeholders from across the state is significant because of its vast size and small population, which create significant disparities in the delivery of health care services. More than half the population of the state lives in rural or frontier areas, characterized by limited access to health care and barriers such as transportation and healthcare professional shortages. The following map illustrates the location of responses by category.

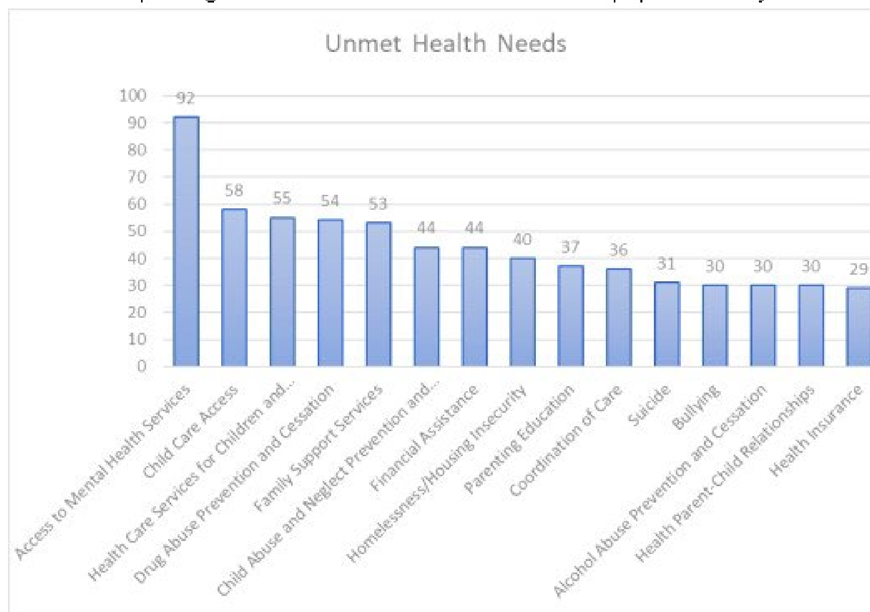


Data Analysis - Qualitative and Quantitative:

The surveys used both closed and open-ended questions to assess needs, capacity, and priorities within stakeholder communities. Survey respondents were asked to identify the most important unmet health needs in their communities. Each respondent could choose up to 7 needs from a list of 37 items. Responses were used to indicate priority needs and assess changes from the 2015 NA.

Participants provided brief explanations for their selections, which were analyzed for relevant themes. Preliminary coding focused on health needs. Secondary coding assessed capacity, barriers, and resources. A third coding round was used to assess statements as positive or negative, when applicable. Figure 1 indicates the top 15 selections for unmet health needs.

Figure 1. Survey Responses "Considering the past 12 months, please identify the top 7 unmet needs impacting the health of the maternal and child population in your county."



In March 2020, 14 stakeholder interviews were conducted from the same population as those who completed the survey. The sampling goal was to reach 15-20% of the survey respondents for follow-up interviews. However, COVID-19 activities disrupted several scheduled interviews, limiting the number. Stakeholders interviewed represented these roles: CPHD staff; health care professionals; academics; non-profit organization staff; and one FQHC.

Interviews were designed to elicit further explanation and elaboration of the following:

- Unmet needs and emerging issues for maternal and child populations;
- Existing programs or organizations working to address those needs;
- Capacity of and collaboration between existing public health activities and initiatives;
- Barriers and challenges associated with the issues in their counties; and,
- Selected priority SPMs for the next 5-year plan.

Phase 2 - Summary

The UM-RI Evaluation Team made preliminary recommendations for performance measure selections by triangulating ASD and quantitative and qualitative data from the stakeholder survey and interviews. Those preliminary recommendations were shared with the DPHHS team and evaluated considering CPHD capacity and the ability to address identified need. A summary of the survey and key stakeholder interviews is included with the supporting documents (see MCHBG Needs Assessment Data Report 2020).

Phase 3 – Final Assessment

Phase 3 involved a meeting between the NA team and FHCB leadership to make a final decision regarding state priority needs. Results from Phase 1 and Phase 2 were reviewed, and potential priorities were evaluated against the following criteria:

- Ability to make a measurable impact in the short- and long-term;
- Feasibility of population-based approaches;
- State and local capacity to address;
- Incidence/prevalence;
- Severity;
- Cost of potential strategies;
- Alignment with existing programs and initiatives; and,
- Alignment with National Performance Measures.

Leadership selected seven state priority needs covering the five required MCH population domains, and the optional sixth Cross-Cutting & Systems Building domain. These priorities are covered in detail in the “MCH Population Health Status” and “Identifying Priority Needs and Linking to Performance Measures” narratives and are:

- Comprehensive preventive healthcare for women;
- Infant mortality;
- Preventive dental care for children;
- Risk factors around adolescent mental health;
- Care coordination for CYSHCN;
- Access to public health services and geographic disparities; and,
- Social Determinants of Health and family health education.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

In this section, key findings are reported and organized by public health domain (PHD). The data presented are derived from Administrative/Secondary Data (ASD) and the 2020 Key Stakeholders Survey and Interviews (KSSI). The following sections outline an overview of health status as well as successes, gaps, and challenges for each population domain.

Maternal Health

ADS Overview

- In 2017, 73.2% of women received early prenatal care in Montana, which falls below the national average (for 2014) of 77.1%, and below the HP2020 Goal of 77.9%. Also, rural populations and American Indian women receive early prenatal care at lower rates. In 2018 the percentage of American Indian women was 45.3%. In 2017, the percentage for women living in counties with population less than 60,000 was 66.2%, in contrast to 77.9% for those in counties

with higher populations.
- In 2017 23.8% of women had caesarean deliveries with low risk pregnancies, which meets the HP2020 goal of 23.9%.
- In 2017, 14.9% of women reported smoking while pregnant; 0.9% of women reported drinking alcohol while pregnant.
- 2017-2018 PRAMS data show 16.9% of women self-reported post-partum depressive symptoms, higher than the national average of 12.5%.
- PRAMS data also show 93.8% of mothers in MT report ever breastfeeding, and 80.3% report breastfeeding at 8 weeks.
- The CDC Breastfeeding Report Card shows that in 2018 27.9% of MT babies were born in baby-friendly facilities, one of the highest rates inthe US.

KSSI Results

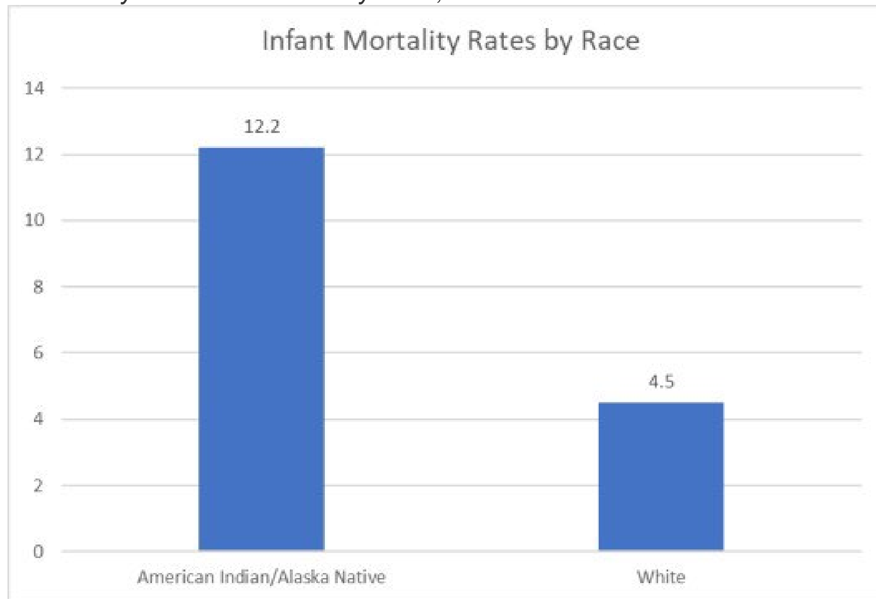
Primary challenges for the maternal domain include access to mental health services, substance use prevention and treatment, and coordination of care. There is need for more frequent screening and non-stigmatized services to address post-partum depression. Forgone health care due to distance to services or cost was also a concern.

Perinatal/Infant Health

ASD Overview

- In 2017, 9.7% of Montana births were preterm; 7.8% of infants were low-weight.
- The rate of infants born with neonatal abstinence syndrome per 1000 hospital births has increased from 4.5% in 2009 to 8.3% in 2015.
- Infant mortality rates were 5.8 in 1000 live births, with significant disparities between white (4.5 in 1000) and American Indian (12.2 in 1000) populations (see Figure 2).
- SUID rate per 100,000 live births is 138.4, an increase from 129.3 in 2013. The *2015 Health Survey of Montana's Mothers and Babies* showed that 80.6% of mothers put their infants to sleep on their back, though only 28.6% of moms reported practicing all safe sleep techniques. The survey also showed that American Indian mothers were more likely to practice co-sleeping (53.6%) than white mothers(33.1%).

Figure 2. Infant Mortality Rates in Montana by Race, 2016-2018



KSSI Results

Results confirmed the need to address infant mortality and support safe sleep programs. These are viewed by respondents as a key resource, but one where there is ongoing need. Safe sleep programs should be delivered in a culturally appropriate, non-stigmatizing manner to help ensuresuccess.

Child Health

ASD Overview

- Montana has reduced the rate of non-fatal childhood injuries and child mortality, though they remain higher than the national average. Nonfatal injury hospitalization rates (per 100,000) for children (ages 0-9) have decreased from 127.6 in 2013 to 112.7 in 2017. The child mortality rate (ages 1-9) in 2017 was 10.5 in 100,000.
- The National Immunization Survey indicate MT remains behind the national average (63.6% compared to US covered by 70.7%). However, there has been a 27.2% increase in immunizations between 2010 and 2016. MT reached the HP2020 goal for Polio, MMR, HepB, PCV, and Rotavirus in 2017. It is important to note that religious exemptions to vaccinations are also on the rise.
- MT has seen an increased rate of children (ages 0-17) in Foster Care from 10 (per 1,000) in 2014 to 17 (per 1,000) in 2018, one of the highest rates in the US according to data from KIDSCOUNT.
- Disparities in access to oral health services persist in MT. The percent of children (ages 1-17) with tooth decay was 9.7%; 81.9% of children (ages 1-17) received a dental visit in the last 12 months. Geographic disparity around access to oral health services remains an issue. American Indian children also experience disparities with higher rates of untreated decay (see Figures 3 And 4).

Figure 3. Prevalence of decay experience and untreated tooth decay among Montana's kindergarten children by geographic location, 2015-2016

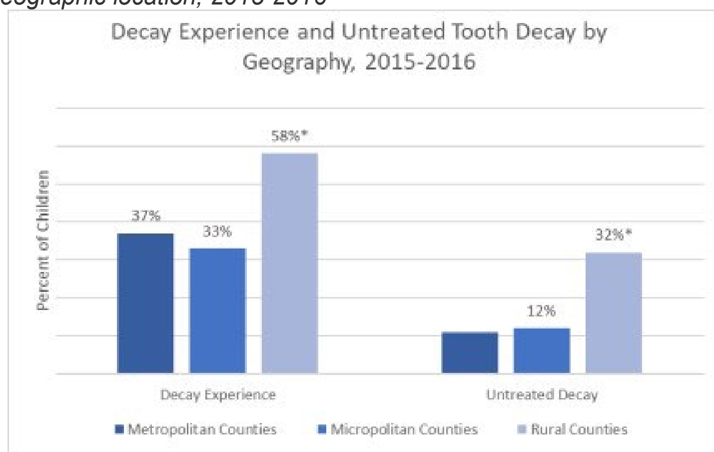
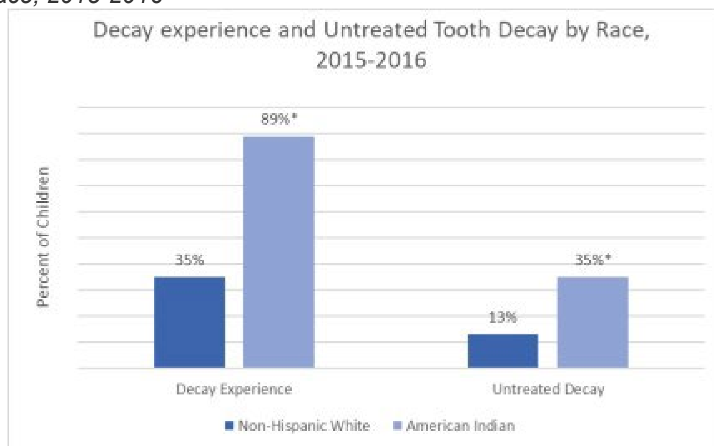


Figure 4. Prevalence of decay experience and untreated tooth decay among Montana's kindergarten children by race, 2015-2016



KSSI Results

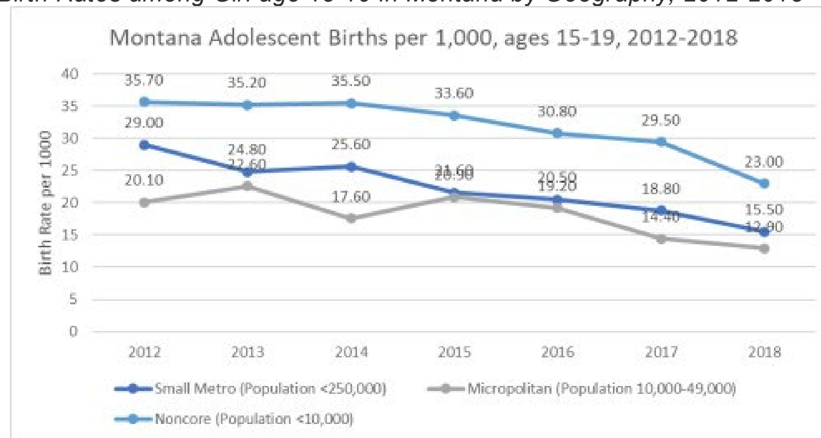
Stakeholder input supports evidence that the increasing number of children in foster care is of significant concern, connected to lack of prevention programs and limited substance use disorder treatment services. Stakeholders from rural counties also reported limited capacity to address oral health concerns; as well as significant need in areas where access to services is limited by distance, awareness, and/or affordability.

Adolescent Health

ASD Overview

- Adolescents have relatively low rates of obesity; National Survey of Children's Health, combined 2016-2017 show that 12.3% of adolescents (age 10-17) are obese, below the HP2020 goal of 14.5%.
- Teen birth rates are trending down, though they are still higher than the 2017 national average of 18.8 in 1000. In MT, 21.3 per 1000 births were among adolescents (age 15-19) in 2017, down from 27.8 in 2013. Teen birth rates continue to be higher among rural populations and with American Indian adolescents.

Figure 5. Adolescent Birth Rates among Girl age 15-19 in Montana by Geography, 2012-2018



- The 2019 Youth Risk Behavioral Survey shows 33% of high school students currently use a tobacco product (including cigarettes and e-cigarettes). While smoking tobacco is on the decline from 2011-2019 (from 44% to 32%); Vaping use is significantly higher (51% in 2015 to 58% in 2019).
- Adolescent suicide rates have increased. Using a 3-year estimate, 2015-2017 aggregate suicide rate for teens per 100,000 was 24.1, up from 21.3 in 2013-2015 (CDC data).
- According to the Youth Risk Behavior Survey (YRBS), in 2017, 21.6% of Montana adolescents in grades 9-12 reported being bullied on school property in the last 12 months, higher than the national average of 19%.
- In 2013-2016 aggregate data, 79.2% of adolescents (12-17 years old) had an adult with whom they could talk with about serious problems.
- The National Survey of Children's Health shows 85.3% of adolescents had a preventative medical visit in 2016/2017.

Key Stakeholder Survey and Interview Results

Stakeholders identified significant needs for access to mental health services for adolescents in Montana. Suicide and bullying emerged as areas where MCHBG programs could use strong existing partnerships with local schools to address these needs. Challenges that emerged from the KSSI include access to services due to cost and distance.

Children and Youth with Special Health Care Needs

ASD Overview

- According to the NSCH, the percent of children in Montana with special health care needs (ages 0-17) in 2016/2017 was 19.3%, up from 18.6% in 2016. While over the same time period, the percent of CSHCN (ages 0-1) who receive care in a well-functioning system declined from 17.1% to 14.9%.
- Between 2016-2017, MT saw an increase in the percent of children diagnosed with an autism spectrum disorder or ADD/ADHD (2.8% to 3.1%).
- 52.7% of Montana's CYSHCN have a condition that requires emotional, developmental, or behavioral treatment or counseling, and 62.7% of those children (ages 3-17) received treatment or counseling.
- 50.5% of children in Montana had a medical home in 2016-2017, while CYSHCN were less likely to have to a medical home at 39.9%.

Key Stakeholder Survey and Interview Results

Parents and family members of CYSHCN identified as areas of concern: access to mental health services; health care

services for CYSHCN; coordination of care; health insurance; and, developmental screenings. Care coordination emerged as a theme among respondents that intersected with other needs. Major challenges identified by this group of stakeholders included lack of services and distance toservices.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

Montana's Title V Program is one of 150 programs in the Department of Public Health and Human Service (DPHHS), which is organized into three branches, Operations Services; Medicaid & Health Services; and, Economic Security Services, whose managers oversee 12 divisions. Appointed by the governor, the Director oversees the largest agency with approximately 3,000 employees, 2,500 contracts, and a biennial budget of about $4.2 billion. Public health services are delivered primarily through contracts with local and tribal public health agencies in each MT county and reservation and with outpatient clinics, community health centers, hospitals and other community-based organizations.

The Early Childhood & Family Support Division (ECFSD) houses the Title V Program. Established in January 2020 it consolidated several DPHHS programs to improve collaboration; align funding, priorities, and practices; create operational efficiencies; and support the DPHHS strategic plan. The ECFSD includes: health programs for infants, children with and without special healthcare needs, adolescents, women of child bearing age, and their families; child care licensing; early childhood services, including financial assistance and quality improvement; early intervention services for young children with developmental delays; child nutrition programs; and home visiting. See the Organizational attachment.

The ECFSD, within the Economic Security Services Branch, is structured as follows:

- Division Administrator
- Bureaus: Family & Community Health (FCHB); Financial & Operations; Early Childhood Services
- Programs: No Kid Hungry and Children's Trust Fund

Title V is in the FCHB and administered by the Title V and CSHS Directors who are also the Maternal & Child Health Coordination Section (MCHC) and Children's Special Health Services (CSHS) Section Supervisors. They are responsible for their respective sections' programs addressing maternal and child health services as described in Title V of the Social Security Act.

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

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

Form 2 indicates the Title V share was $2,300,122, and expenditures meeting the Title V legislation are:

- Preventive & Primary Care for Children expenditures: 39.45%
- Children with Special Health Services: 30.09%
- Administrative costs: 5.39%.

The Title V funds were supported with:

- State funds: $3,058,820
- Federal funds: $25,270,885
- Local support: $11,381,026
- Program income: $7,085,446

These FCHB sections Adolescent Health; Family Planning; Healthy Montana Families Home Visiting; and Women, Infant and Child Nutrition work with other DPHHS programs; state agencies; professional organizations; profit and non-profit agencies; CPHDs; university systems; and healthcare providers to support the Title V efforts addressing these state priorities:

- Comprehensive preventive healthcare for women
- Infant mortality
- Preventive dental care for children
- Risk factors around adolescent mental health
- Care coordination for CYSHCN

- Access to public health services and geographic disparities
- Social Determinants of Health and family health education

These CSHS programs and services, which focus on promoting a medical home (NPM 11), also support these priorities:

- Assisting parents with navigating the system of care in efforts to easily access needed services
- Supporting the non-medical social emotional needs of CYSHCN and caregivers through peer mentorship programs and support.
- Screening and follow-up for newborn metabolic and hearing, and critical congenital heart disease screening;
- Coordinating cleft and craniofacial services;
- Supporting comprehensive genetic screening;
- Promoting pediatric mental health telehealth access;
- Providing financial assistance to eligible families for services not covered by insurance;
- Participating in evidence-based and informed telehealth initiatives that aim to improve care coordination in and outside of emergency care settings and after-hours care.
- Implementing a quality improvement project to improve the transition to adult health care.

III.C.2.b.ii.b. Agency Capacity

The Maternal and Child Health Coordination (MCHC) and Children Special Health Services (CSHS) and FCHB sections' partnerships are key to ensuring Montana's Title V statewide programs and services are comprehensive, community-based, culturally appropriate, coordinated and family-centered. These partnerships allow the state to leverage its Title V funding and to expand its capacity to effectively support statewide collaboration and coordination of numerous maternal and child health services and programs to the population domains.

CSHS is focused to provide health services that address the National Consensus Standards for Systems of Care for CYSHCN. Key to meeting these standards is the input and insight from the 40+ member CSHS Stakeholders Group, comprised of: clinicians, multidisciplinary health care providers, Medicaid, Part C Early Intervention, WIC, Home Visiting, Family-to-Family coordinators, home healthcare nurses, regional parent and self-advocate representatives, and the CSHS and Title V Directors. At their quarterly meetings, they discuss local and statewide concerns, evidence-based and informed initiatives, and NPM 11 progress.

CSHS offers a General Financial Assistance Program which provides direct financial assistance for CYSHCN and foster care families for medications, testing, medical services, and access to therapies and activities not covered by Medicaid or private insurance. Staff also work with Medicaid to ensure that Early and Periodic Screening, Diagnosis and Treatment program services are covered. CSHS staff also engage with:

Council/Committee
Part-C Early Intervention Family Support Services Advisory Council
Disability Rights Montana
Mountain State Regional Genetics Advisory Council
Emergency Medical Services for Children Advisory Council
Lifespan Respite Coalition
Partner Contracts
The HALI Project: Montana Parent Partner Program
Butte 4-C's Circle of Parents Program
Shodair Children's Hospital: State Genetics Program
University of Montana Rural Institute
Medical Home Portal
Montana Pediatric Medical Passport

The MCHBG Program Specialist and FICMMR Coordinator are instrumental in providing technical assistance and guidance to the CPHDs, who are key players connecting with and supporting community-level systems and services for the maternal and child population. The CPHDs are adept at blending their Title V MCHBG funds with their local or other MCH program funds. Their contract includes 15 MCHBG/FICMMR deliverables, i.e. N/SPM activities; evaluation; data collection; FFY expenditures; CPHD needs assessment results; and, an infant, child, or maternal injury-prevention activity.

A key goal of the 2020 Needs Assessment was to understand where local public health support services could have the greatest impact. To achieve this goal, the capacity of local organizations for addressing the unmet health needs that they identified as priorities was accessed. The results informed the N/SPMs that the CPHDs could select beginning in FFY 2021. MCHC staff, with assistance from other FCHB programs, will oversee the CPHDs' N/SPMs programmatic efforts and activities, goals, and evaluation framework plans, as reported on their FFY Pre-Contract Survey (see following table). CSHS will oversee the NPM 11: Medical Home State Action Plan.

FFY 2021 N/SPM Selection	#CPHDS includes 2 CPHDs selecting 2 N/SPM	Total Title V Funding
NPM 1	3	$51,521
NPM 5	6	$423,427
NPM 9	2	$7985
NPM 13.2	4	$103,250
SPM 1	27	$151,300
SPM 2:	9	$327,479

The MCHC section includes the FICMMR, Oral Health (OH), Primary Care Office (PCO), State Loan Repayment (SLRP), and Montana Obstetric and Maternal Support Program (MOMS) Programs. Each program has established collaborations and partnerships and contracts, all of which contribute to and support the FCHB's Title V efforts for addressing the N/SPMs. The OH Coordinator oversees the HRSA *Grants to States to Support Oral Health Workforce Activities,* which funds numerous partners' activities that support NPM 13. These include:

- From September 2018 to February 2020, University of Washington School of Dentistry students completed 1714 procedures and had 1047 patient encounters while on rotations.
- Since 2018, MT State University School of Nursing students have completed 239 screenings, 311 fluoride varnish applications, and 803 sealant applications to the eight Northern Cheyenne Nation Head Start sites located in Big Horn County;
- Providing technical assistance to the five CPHDs that selected NPM 13, which includes Big Horn County;
- Contracting with the Caring Foundation of MT (CFMT) to provide preventive dental health services using a mobile clinic. CFMT has partnerships in 42 counties, four reservations and 12 Hutterite colonies.
- Contracting with the FQHC Alluvion Health to utilize their mobile dental unit, funded by the 2019 HRSA Oral Health Infrastructure grant, to serve rural communities with nodental provider.

The PCO's mission: *to increase access to comprehensive primary and preventive health care to improve the health status of underserved and vulnerable populations in Montana,* benefits ALL the N/SPMS and ECFSD programs. In FFY 2019, the PCO:

- Approved J-1 Visa Waivers for 8 specialists and 2 primary care doctors practicing in healthcare shortage areas;
- Awarded SLRP grants to six healthcare providers, bringing the contracted total to 28;
- Provided over 14,000 hours of technical assistance to address questions about the National Health Service Corps and SLRP loan repayment programs; HPSA designations; and J-1 Visa Waiver; to partners such as the MT Primary Care Association, MT Hospital Association, Indian Health Services, Critical Access Hospitals, Rural Health Clinics and Mental Health Centers, and community stakeholders seeking a designation or working to recruit healthcare providers.

As illustrated in the NPM 5 and 7 narratives, the FICMMR Coordinator continues to enlist partners and involvement on committees to increase the county FICMMR teams' capacity to implement and evaluate evidence-based prevention activities. The Coordinator's reach includes:

- Participating on the Department of Transportation's Child Passenger Safety Committee, the State Trauma Care Committee; and Western States Child Death Review
- Facilitating annual trainings by the MT Chief Medical Examiner and the President of the Montana Coroners Association
- Supporting the Healthy Mothers Healthy Babies' Safe Sleep Initiative
- Connecting teams with the state suicide prevention resources
- Promoting the Cribs for Kids Safe Sleep Ambassador Program

Addressing NPM 1 will be enhanced with the activities funded by the MOMS program, which offers expert consultation, training, resources and support to help providers deliver effective prenatal, delivery and postpartum care. MOMS has contracted with the Billings Clinic to coordinate the delivery of a package of virtual/remote provider services from specialists to isolated providers. Billings Clinic will coordinate the delivery of these services to rural hospitals in Eastern Montana to start.

The other FCHB sections, Adolescent Health (AH), Family Planning (FP); Healthy Montana Families Home Visiting (HMF); and Women, Infant and Children's Nutrition Program (WIC) are subject matter experts on their specific programs that aide the CPHDs Title V efforts. Their impact is especially seen with CPHDs that serve as a one-stop shop for services. The 2020-2025 Needs Assessment indicated the need for SPMs 1 and 2 to remain, which supports health services such as: immunizations or hearing screening; referrals to resources such as WIC, prenatal care, or family planning; and, health education on topics which include suicide prevention or communicating with sexually active teens. Women and families served by FP reaches 14,100 clients; WIC reaches an average of 16,468 per month; and HMF's reach is felt in the 14 CPHDs, 5 non-profit agencies, and 3 tribal health agencies. Funding from the 2021 Application will support a current AH Section Program Specialist being co-located with the MCHC section, to work with two CPHDs that selected NPM 9.

III.C.2.b.ii.c. MCH Workforce Capacity

The Family and Community Health Bureau (FCHB) is one of three bureaus in the newly formed Early Childhood & Family Support Division (ECFSD). The ECFSD includes a new Fiscal & Operations Bureau (FOB) with three sections: Epidemiology; Fiscal/Budget Services; and Systems/Operations. The FOB Bureau Chief (BC) is onboarding Section Supervisors and support staff.

The Title V and CSHS Directors also serve as the Maternal and Child Health Coordination (MCHC) and CSHS Section Supervisors, and report to the FCHB Bureau Chief who has 25+ years working in the field of maternal and child health. The Title V Director/MCHC Supervisor has 14 years in this position supervising 5.5 FTE and managing a section budget of $4,986,503. The Title V Director has a Master of Public Administration degree. The MCHBG Program Specialist has been in this position for seven years, and is working on a Master of Public Health degree from the University of MT.

The FICMMR Coordinator, with a Master of Communication degree, has been in the position for five years - guiding the CPHD FICMMR Teams to implement and evaluate evidence-based and informed prevention activities. Title V funding fully supports these three individuals and for FFY 2021, a .5 FTE Adolescent Health Section Program Specialist will oversee NPM 9.

The MCHC Section also includes staff contributing as follows to the National and State Performance Measures (NPM/SPM):

- Oral Health Program Specialist: NPM 13
- Montana Obstetric and Maternal Health Program: NPM 1
- Primary Care Office Program Specialist: all N/SPMs

The Title V funding directly supports the CSHS Director/Supervisor (1 FTE). The FCHB BC and ECFSD Administrator are working with DPHHS Human Resources (HR) staff to fill the position, which became vacant in July 2020. The Title V Director will aid in the onboarding of the selected individual and will aid in referring to HRSA/ Maternal and Child Health Bureau, AMCHP, and other mentoring resources. Title V also supports these CSHS Staff:

- Health Education Specialist .75 FTE: One year on the job, with a BA in Business
- Nurse Consultant .5 FTE: Interviews are occurring to fill the position vacated on August 31, 2020
- Data Manager .25 FTE; Three years in CSHS and 21 years of data-analysis experience. Master's degree in Mathematics.

The CSHS Director/Supervisor also oversees the Program Specialists responsible for Newborn Screening and Montana Access to Pediatric Psychiatry Network grant programs.

Montana's AMCHP Family Delegate, Tarra Thomas, is completing the 5th year in this position. Ms. Thomas is the parent of a child with special healthcare needs, has a Business degree and a Master of Social Work. She is a Social Work Licensure Candidate presently practicing as a Child and Family Outpatient Therapist, working with the child protective services' population. In addition to assisting with the Title V/MCHBG throughout the years, she is: a principle member of Montana's MCH Workforce Development Center (WDC) Cohort; was a recipient of the MCH WDC's Leadership Coaching opportunity; and, was invited by Montana's Governor to participate in a conversation regarding issues affecting the CYSHCN population, to assist in informing a critical policy decision regarding program funding.

Prior to the formation of the ECFSD, the FCHB included an Epidemiology Section. This is now in the ECFSD's Fiscal and Operations Bureau. The assigned MCH/CSHS Epidemiologist is 100% Title V funded and has 10+ years in this field having earned her Master of Public Health, with epidemiology as her major field of study in 2011. She recently completed the 2017 AMCHP Leadership Lab Peer to Peer Epidemiologist Cohort and will be mentoring two staff in the 2020 AMCHP Leadership Lab Peer to Peer Epidemiologist Cohort.

At the time of this submission, individuals are being interviewed for the CSHCN Director & CSHS Supervisor, and Nurse Consultant positions. There are no foreseeable staff changes in the MCHC section.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

The FCHB houses these grant funded programs, which support, enhance, and expand the state's Title V efforts for addressing the National and State Performance Measures (NPM/SPM):

Title X	WIC
Maternal, Infant, and Early Childhood Home Visiting	Grants to States to Support the Oral Health Workforce
State Systems Development Initiative Grant	Maternal Health Innovation Program
Newborn Hearing Screening	Rape Prevention and Education
Teen Pregnancy Prevention	Pediatric Mental Health
Pregnancy Risk Assessment Monitoring System	Primary Care
State Loan Repayment Program	WIC Farmers Market
WIC Peer Counseling	Sexual Risk Avoidance

These grant opportunities allow for formal and informal partnerships with private and public entities to improve the health of all mothers and children living in one of Montana's 56 counties. These partnerships, ranging from contractual to participating on workgroups or advisory councils, are rooted in the relationships FCHB staff have created and maintained. Many of Title V's partnerships and collaborative efforts are explained throughout Montana's FFY 2021 Application & FFY 2019 Annual Report: in the NPM/SPM narratives; and, illustrated on the 2019 MCH Services map attachment.

The creation of the ECFSD has generated these potential new partnerships to support the FCHB's Title V work.

Tribal and non-Tribal Head Start and Early Head Start Programs	Childcare centers and home day care providers participating in the Child and Adult Care Food Program
The 21 statewide Best Beginnings Community Coalitions	The 60-member Best Beginnings State Council
Part C Service providers	900+ licensed childcare providers
Child Care Resource and Referral Agencies	Montana State University Early Childhood Project
University of Montana-Western School of Outreach and Early Childhood Program	Children's Trust Fund Board
Montana No Kid Hungry Project with schools, community sites, and childcare programs	

Tables which list current and future programs, and agencies and organizations in the Title V MCHBG collaborative network, have been added to the supporting document of Montana's *MCHBG 2021 Application & 2019 Report*.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Drawing from the data presented in the MCH Population Health Status section, DPHHS identified priority needs for each population health domain (PHD). Data for National Outcome and Performance Measure trends were evaluated on whether there was improvement, met or unmet goals, the severity of the issues (life-threatening or disabling), and the role as a protective influence (contribution to well-being).

Significant health disparities in the population based on race and geography were also considered. In some cases the statewide data do not provide a complete description of need for this population; as seen with oral health, prenatal care, and infant mortality due to disparities.

Capacity and feasibility were accounted for by considering the impact of other agencies addressing similar issues, public support and political will, local leadership buy-in, and known evidence-based strategies for addressing needs.

The identification of priority health needs drove Montana's National and State Performance Measure (NPM/SPM) selections, as seen in the following table.

Domain	2020 Priority Health Needs	2018 Performance Measure Selection	2020 Performance Measure Selection
Perinatal & Infant	SUID and Infant Mortality	Infant Safe Sleep (NPM 5)	Infant Safe Sleep (NPM 5)
Children	Oral Health Services	Child Injury (NPM 7.1)	Preventative Dental Visit (NPM 13.2)
Adolescent	Bullying, Suicide	Adolescent Preventive Care Visit (NPM 10)	Bullying (NPM 9)
Women & Maternal	Mental health services, SUD treatment and prevention, post-partum depression, care coordination	Oral Health (NPM 13.1)	Well-Woman Visit (NPM 1)
CYSHCN	Care coordination, meeting developmental milestones, foster youth	Medical Home (NPM 11)	Medical Home (NPM 11)
Cross-Cutting & Systems Building	Limited or lack of available public health services; geographic health disparities; health equity	Access to Public Health Services (SPM 1)	Access to Public Health Services (SPM 1)
Cross-Cutting & Systems Building	Poverty, financial assistance, adequate health insurance, healthy parent-child relationships, parenting education, safe home environment, child abuse and neglect.	Family Support & Health Education (SPM 2)	Family Support & Health Education (SPM 2)

For each PHD, these areas were addressed:

- Factors that contributed to changes in the state's priority needs;
- Rationale for priority needs selections;
- Relationship between priority needs and the selected NPM/SPM; and,
- Other frequently cited needs that were NOT included and an explanation for why not.

Infant Domain—NPM 5 Safe Sleep

Changing Priority Needs**:** Infant mortality in Montana continues to be a priority need in the state.

Rationale: Montana's SUID rate is much higher than the national rate. These data show socio-economic and racial disparities as SUID rates are higher among American Indian women who also report higher rates of co-sleeping. This is also supported by a *2015 Health Survey of Montana Mothers and Babies* which found that unsafe sleep environments correlated with lower education, age, and income. KSSI data identified infant safe sleep programs as both a significant resource for supporting mothers and infants and an unmet need in the state. Given the continued need to address infant mortality, the severity of the issue, and the current strength and capacity of existing safe sleep programs in the state, NPM 5 was selected.

Other Needs: The KSSI identified breastfeeding as an infant domain need. Continued support for Montana's breastfeeding initiatives is crucial for their continued success, ASD did not provide strong support for breastfeeding as a priority *unmet* need at this time

Child Domain—NPM 13.2 Preventative Dental Visits

Changing Priority Needs: In 2018, Montana selected Child Injury Reduction NPM 7.1 and 7.2 to help reduce child hospitalization rates. While child injury rates remain higher than the national average, Montana has transitioned away from NPM 7 because efforts across several other programs and organizations are showing a positive impact on this health indicator.

Rationale: As previously noted, Montana children have high rates of tooth decay compared to children in the US population. Access to oral health services correlates with lower socio-economic status, geographic disparities, and race in Montana. American Indian children are more likely to have dental decay than white children; children in rural counties have more decay experience than those in metropolitan counties; poverty is also a stronger indicator as many periodontists do not accept Medicaid insurance. Stakeholders broadly agreed that addressing oral health needs in rural counties is an area where significant impacts can be made because of strong partnerships between CPHDs and local schools for preventative

oral health education programs, transportation programs to reach dentists, and other collaborative partnerships to address barriers.

Other Needs: Other frequently cited needs by stakeholders were family support services, healthy parent-child relationships, and child abuse and neglect prevention and response. Family support and healthy parent-child relationships can be addressed by SPM 2 (see below). Child abuse and neglect prevention and response is an increasingly significant need in Montana with rising rates of children in foster care and increased caseloads. This need may also be addressed by SPM 2. Additionally, access to quality childcare was the second more frequently selected unmet need among all stakeholders who noted lack of facilities and lack of adequately trained staff.

Adolescent Domain—NPM 9 Bullying

Changing Priority Needs: Montana previously identified teen pregnancy prevention due to the relatively high teen birth rates, particularly in rural areas and among American Indian adolescents. Teen birth rates remain high but have declined significantly since 2013. In the 2020 NA other needs including adolescent bullying and suicide emerged as interrelated issues with greater severity. Capacity to address these issues is currently limited but could be increased given existing supportive partnerships between CPHDs and local schools.

Rationale**:** Adolescent suicide and bullying emerged as priority needs because of Montana's high rates of teen suicide, which have increased in recent years, and high incidence of bullying. 2017 YRBS data show that high school students who attempted suicide were more likely to have been electronically bullied (46%) during the past 12 months than students who had not attempted suicide (14%). Additionally, stakeholders identified local schools as key partners where program to address bullying could be implemented.

Other Needs: Access to mental health services, homelessness/housing insecurity, and care coordination were other significant unmet needs for adolescent populations highlighted by the KSSI. Challenges to addressing these needs include shortages of mental health care professionals in large regions of the state.

Maternal Domain—NPM 1 Well-Woman Visit

Changing Priority Needs: In 2018, Montana selected NPM 13.1, preventative oral health visit, for the maternal domain. PRAMS 2017 data show 47% of women had their teeth cleaned during pregnancy. While still low, this rate is just above PRAMS sites overall rate for participating states. Other needs were more frequently cited in the 2020 NA as significant, unmet needs; therefore, NPM 1 was selected for the maternal domain.

Rationale: The priority needs identified for the maternal PHD include mental health services, post-partum depression, coordination of care (particularly for mental health services), and substance use disorder treatment and prevention. Montana has high rates of post-partum depression and qualitative data from KSSI suggest that stigma around mental health issues is a barrier to receiving care. Additionally, getting referrals for mental health care services in a navigable and timely manner is a challenge. Well-woman visits (NPM 1) is the most appropriate means to address these priority health needs. Mothers can be screened for mental health concerns and referred to other services as deemed appropriate.

Other Needs**:** Other needs for women in Montana include homelessness and housing insecurity, food insecurity and nutrition, and prenatal care access and utilization.

CYSCHN Domain—NPM 11 Medical Home

Changing Priority Needs: Montana will continue to support efforts for NPM 11 Medical Home for CYSHCN.

Rationale: Priority needs for CYSHCN identified in the 2020 NA include Health Care Services for CYSHCN, particularly Access to Mental Health Services. Children with a special health care need were less likely to have a medical home than children without a special health care need. Montana will continue to support Medical Home initiatives given the significant need among CYSHCN for health care services and care coordination.

Other Needs: Data support findings that there has been a significant increase in the number of children in foster care and developmental screenings. Stakeholders reported increase of children in foster care as a significant area of concern.

State Performance Measures

SPMS were developed to address priorities not covered by NPMs. SPM 1 and SPM 2 will continue.

SPM 1 - Access to Public Health Services

Rationale: Access to Care was consistently identified as a continuing health care need on the NA Surveys and KSSI. Montana faces a large geographic health disparity evidenced by HPSA scores showing much of the state is a shortage area for primary care, mental health care, and dental care. Access to Care is a fundamental action area.

SPM 2 – Family Support and Health Education

Rationale**:** Family support and parental education emerged as essentials which are increasingly being unmet. Care coordination and referral follow-up were also frequently cited as unmet needs with major effects on the health of the whole MCH population, especially ages 0 to 19 years.