Maternal and Child Health Services Title V Block Grant

Montana

FY 2025 Application/ FY 2023 Annual Report

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Table of Contents

I. General Requirements

I.A. Letter of Transmittal

GREG GIANFORTE
GOVERNOR

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

CHARLIE BRERETON
DIRECTOR

July 10, 2024

Shirley Payne, PhD, MPH
Director, Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Division
Rockville, Maryland 220857

Dear Ms. Payne:

Enclosed is Montana's application for the 2025 Title V Maternal and Child Health Block Grant (MCHBG) and 2023 Annual Report. MCHBG funding supports Montana's state and community-based work in improving the health of the maternal and child population.

The State of Montana maintains on file all assurance and certifications required by this application. The agency also assures that MCHBG funds will be used for non-construction programs and that the agency is a drug-free and tobacco-free work place.

We look forward continuing in partnership with the Maternal and Child Health Bureau.

Sincerely,

Tracy Moseman, Division Administrator
Early Childhood & Family Support Division

EARLY CHILDHOOD AND FAMILY SUPPORT DIVISION
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I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 2 of the 2026 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the 2021 Title V application/Annual Report guidance.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Introduction

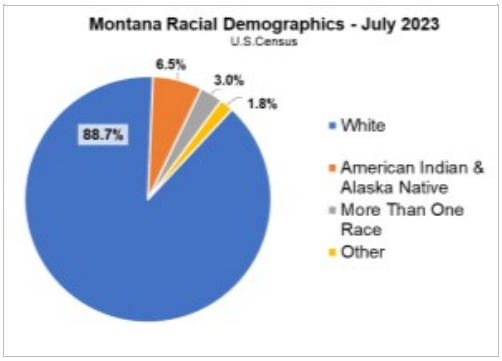
Montana's Title V Maternal & Child Health Block Grant (MCHBG) is administered by the Family & Community Health Bureau (FCHB), in the Early Childhood and Family Support Division (ECFSD) at the Department of Public Health & Human Services (DPHHS). Collaboration among ECFSD programs extend their impact. These partners and contractual relationships are key to overall MCHBG success.

The *2025 Application & 2023 Annual Report (A&R)* highlights the work to improve the health of Montana's (MT's) women, infants, and children; and covers the fourth year of a 5-year cycle. Priorities for Federal Fiscal Years (FFYs) 2021-2025 were selected as the result of the *2020 Statewide 5-Year Needs Assessment (NA)*. Key information on performance measures is presented under the following domain categories: Women & Maternal; Perinatal & Infant; Children; Adolescent; Children & Youth with Special Health Care Needs (CYSHCN); and, Cross-Cutting/Systems-Building.

Evaluation of NA data, paired with State Health Improvement Plan (SHIP) goals, helped to create the FFYs 2021-2025 priorities:

- Access to Public Health Services
- Bullying Prevention
- Family Support & Health Education
- Infant Safe Sleep
- Medical Home
- Children's Oral Health
- Women's Preventive Healthcare

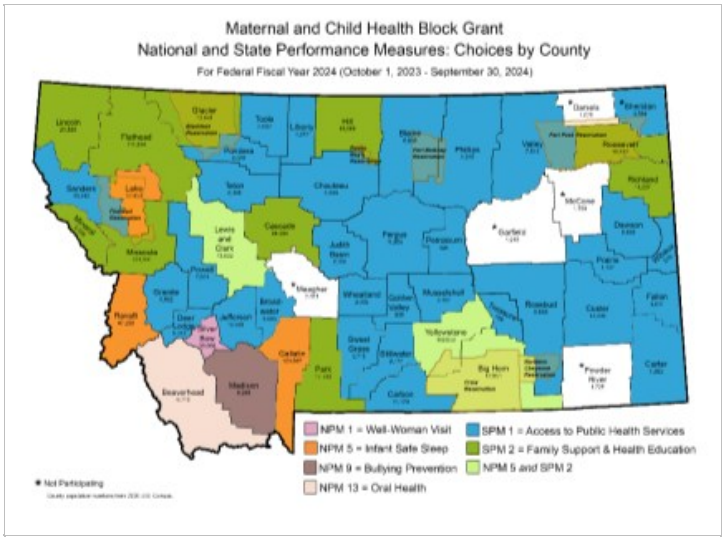
Background information on MT is in the *Overview of the State* narrative of the *A&R*. It covers geography; demographics; economy; income and poverty; education; health insurance; and, access to health care. The following graph illustrates racial demographics:



The *Overview of the State* also examines geographic rurality, and race, particularly American Indian, as key factors in health disparities. Additionally, access to health services may be impacted by: travel distances; seasonal challenges, i.e., winter weather and wildfires; the maldistribution of providers; and barriers to broadband internet connection.

At the state level, a focus on maternal and child health is present in many programs and services, not just those supported through MCHBG-funded strategies. For example, the Behavioral Health & Developmental Disabilities Division is addressing adult substance use in parents and also targets efforts to address youth suicide prevention through programs administered in local schools.

In addition, local public health is decentralized, resulting in County Public Health Departments (CPHDs) as the primary source of public health service access throughout MT. About 42% of MCHBG funding is allocated to CPHDs. The contracted CPHDs submit semi-annual and annual reports on their identified National or State Performance Measure (N/SPM) activity and evaluation plans. The following map shows FFY 2024 N/SPMs:



MCHBG funds also support Children & Youth Special Health Care Needs (CYSHCN), and the Fetal, Infant, Child, & Maternal Mortality Review (FICMMR) Programs. CPHDs are also required to implement and report on a FICMMR injury-prevention activity.

Population Domains - Activities Report

The following section provides a synopsis report of MCHBG activities for FFY 2023, and a brief description of current activities in FFY 2024. These are grouped by the standard MCHBG population categories. The FCHB is currently finalizing FFY25 plans for these domains.

Women & Maternal Health: Well-Woman Visit *(WWV, previously NPM 1)*:

Three CPHDs chose the Well-Woman Visit performance measure for FFY 2023. The overarching theme for their activities was partnerships and collaboration. Since a well-woman visit is clinical in nature, the three CPHDs working on WWV met and consulted with many types of organizations and providers, i.e.: Title X Family Planning; Supplemental Nutrition for Women, Infants, and Children (WIC); hospitals; family-practice clinics; and colleges.

Additionally, the state-level MCHBG Program added a question regarding barriers to receiving prenatal care to the Pregnancy Risk Assessment Monitoring Survey (PRAMS), which closed in June 2023. The MT Obstetrics and Maternal Support (MOMS) Program is also a state-level partner, and has its own metric regarding annual well-woman visits. In FFY23, MOMS researched information on maternal health, focusing on the experiences of pregnant people and providers within the health system. Analysis and reporting on these studies is underway.

For FFY24, the CPHDs with specific well-woman visit activities are Silver Bow and Deer Lodge. Silver Bow has made working on WWV activities a priority since FFY21, due to the results of their Community Health Needs Assessments. This year they are implementing staff training and a local digital marketing campaign. Deer Lodge is implementing mobile services at underserved locations, i.e. jails, congregate work/living facilities, rural areas.

Perinatal & Infant Health: Infant Safe Sleep *(SS, previously NPM 5)*:

During FFY23, the nine CPHDs focused on SS, implementing nineteen activities. Fifteen were education-related, with most aimed at caregivers and parents. All of these education activities used evidence-based/informed materials, the majority from the American Academy of Pediatrics, but also included: Cribs for Kids Safe Sleep Ambassadors; Safe to Sleep; and Charlie's Kids. Three CPHDs worked on infant safe sleep for their FICMMR injury prevention activity in FFY 2023. Their activities were also directed to education of participants and staff at partner organizations: WIC; childcare facilities; pediatric physicians; and hospitals.

For FFY24, the FCHB is contracting with six CPHDs who have chosen to focus on SS. They are implementing and evaluating a total of eleven community-level activities during the fiscal year. Overall, parent/caregiver education continues to be the leading activity, using a variety of methods and agency partners. Utilizing cross-department partnerships with other programs is the most common method, including: Home Visiting, WIC, and Family Services. Additionally, training staff in other organizations is a widespread activity. It helps to broaden the scope of families reached with infant safe sleep messaging. This includes reaching Obsteptrics providers, Child Protective Services, and daycares.

Child Health: Children's Annual Preventive Dental Visit *(PDV-Child, previously NPM 13b)*:

Two County Public Health Departments implemented activities for PDV-Child in FFY 2023. Activities included: a Dentist and Registered Nurse providing screenings, applying fluoride, and presenting education at Head Starts; distribution of oral health education to families at WIC, home visiting, and daycares; the CPHD Oral Health Educator providing oral health education in all the schools in the county, and coordinating with local dentists to provide oral health screenings to 25 schools in the county.

For FFY24, One CPHD is implementing activities specific to PDV-Child, and six CPHDs who chose SPM 1 also have activities related to oral health. Here is a quote is representative of the oral health needs all counties face: "These are needs that are in our county due to a lack of other options locally, and the frontier-level population size of the county. In addition, the rise of living costs, and burden of time required to reach options outside the county, contribute to the continued need."

At the state-level, the Oral Health Program is surveying a sampling of the third grade population to update surveillance data. The data is stratified by geographic location and income variables. Upon completion, data will be submitted to the National Oral Health Surveillance System. Survey data will also be shared with: participant sites; and a broad group of oral health stakeholders to support oral health literacy, access to dental care in Montana communities, and inform future programming.

Adolescent Health: Adolescent Bullying Prevention *(BLY, previously NPM 9):*

MT's annual average suicide rate for people ages 15-19 is 35.98 per 100,000 (source: CDC, 2020-2022), which is *more than double* the U.S. rate of 17.4. MT also experiences significant incidences of physical- and cyber-bullying. Research has shown that youth who report being bullied, and/or bullying, are at increased and long-term risk of suicide-related behaviors; depression; anxiety; and, negative physical and mental health.

The four CPHDs working on BLY activities for FFY 2023 are all in smaller population-size counties, with good relationships in local schools. Examples of activities include supporting bullying prevention education of teachers using online curriculums provided through the MT Office of Public Instruction's Teacher Learning Hub; student assemblies with national speakers; and afterschool supports for at-risk youth. Twelve CPHDs are addressed suicide prevention for their FICMMR injury-

prevention activities.

One CPHD is implementing activities specific to BLY during FFY 2024, and two CPHDs who chose SPM 1 also have activities related to bullying prevention. In addition, nine CPHDs are addressing suicide prevention for their FICMMR injury-prevention activity. At the state-level, MCHBG staff are implementing a bullying prevention social media campaign, using resources from StopBullying.Gov.

Children & Youth with Special Health Care Needs: CYSHCN Medical Home *(MH, previously NPM 11):*

Children's Special Health Services (CSHS) addresses MH by offering gap-filling programs, such as peer support services and resource coordination programs, to all children and their families in MT. For FFYs 23 and 24, CSHS continues to offer a variety of population health and direct service programs while collaborating with CYSHCN programs across DPHHS:

- *Family Peer Support Program:* Strives to offer every parent and caregiver of a CYSHCN access to a Parent Partner.
- *Circle of Parents:* These groups aim to decrease isolation, prevent child abuse and neglect, and strengthen families through free monthly caregiver support groups.
- *Medical Home Portal:* A user friendly one-stop-shop that provides diagnosis information, treatment options, and a statewide services directory.
- *Consumer Advisory Council:* Maintains and disseminates a health care transition (HCT) guide; develops evidence-based/informed HCT training and resource materials; conducts distance learning opportunities; maintains a transition website; and provides technical assistance to other initiatives related to HCT.
- *CSHS Financial Assistance Program (FAP):* Families with out-of-pocket expenses for medical and enabling services i.e., occupational therapy items; adaptive equipment; and respite care, may be eligible for the FAP.

CSHS is working towards implementing the HRSA framework to advance MH by prioritizing family engagement, provider engagement, coordinated care, and systems building. These priority areas are all framed and guided by a family-centered approach, diversity, equity, and inclusion, and evidence-based practices. These priority areas are the basis of the strategic plan and will continue to guide this section during the remainder of FFY24, and for FFY25.

Cross-Cutting/Systems-Building:

Access to Care & Public Health Services *(SPM 1):*

SPM 1 allows flexibility to CPHDs in low-population counties to supply critical safety-net services and to address multiple priority needs for their maternal and child residents. In FFY 2023, 49% of participating CPHDs chose SPM 1. As an indicator of their percentage of the total population, they received only 13.7% of the total funding allocation. The number of CPHDs working on SPM 1 in FFY24 is 33. Characteristics of these CPHD's include: low population density; one or less FTE, some open less than 40 hours a week; services such as WIC may only be provided once a quarter; and no economy of scale for fixed expenses.

Family Support & Health Education *(SPM 2):*

SPM 2 was created for CPHDs to 1) refer vulnerable families to community services, with follow-up; and 2) provide basic health education, especially in caring for infants and children.
FFY23 marks the eight year CPHDs could select SPM 2. It has proven to be a flexible performance measure, helping to meet the needs of CPHDs seeking to address the social determinant of health and health equity needs in their communities.

In FFY 2023, nine County Public Health Departments (CPHDs) focused activities on this measure. Examples of referrals include: healthcare providers, economic and food assistance, housing, home visiting, WIC, dental services, and Medicaid. Health education topics included: Pre-Natal/Post-Partum Care, Breastfeeding, Infant and Child Development and Safety,

Family Planning, Infant Safe Sleep, Mental Health and Substance Abuse, Parenting, and Oral Health.

In FFY24, the main activities of the thirteen CPHDs working on SPM 2 are: 1) screening clients for social support needs, and 2) topic-specific health education. Some of these activities focus on emerging needs in their communities, including: Medicaid enrollment support; pre-natal education; and STD/STI case management.

At the state-level, the Fetal, Infant, Child, and Maternal Mortality Review (FICMMR) program in Montana receives MCHBG funding. FICMMR review teams are county-based, and the program requirements are included in the MCHBG contracts with the CPHDs. Each CPHD participating in the MCHBG is required to implement one FICMMR injury-prevention activity. This is in addition to the activities associated with their MCHBG performance measure. The main purpose of FICMMR is to identify which deaths were preventable, and to consider how to reduce those types of death in the future. The top three activities in FFY24 are 1) Car Seat Safety, 2) Home Environment Safety, and 3) Suicide Prevention.

Closing

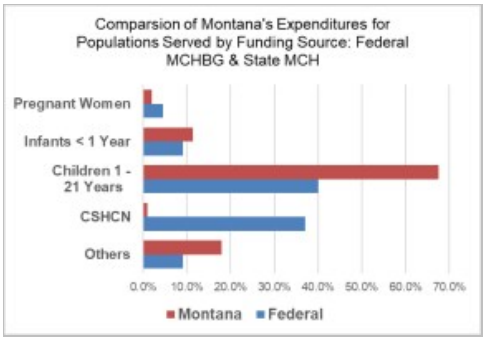
MT's MCHBG program is working diligently to maximize the health of the State's maternal and child population. It relies on strong partnerships and collaborations, ongoing quality improvement efforts, and using evidence-based programs with an emphasis on the priorities identified in the 2020 NA.

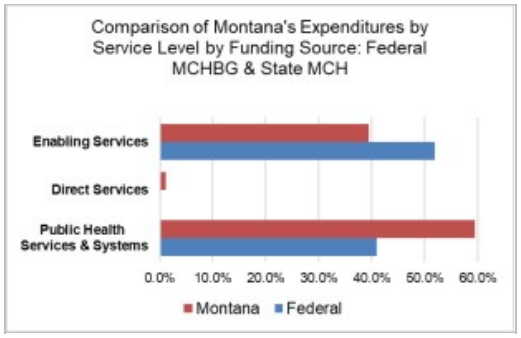
III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

Montana's public health system is decentralized, and County Public Health Departments (CPHDs) have primary responsibility for providing population-based maternal and child health services at the local level. Montana's Title V Maternal & Child Health Block Grant (MCHBG) services are offered to everyone in the maternal and child population living in one of Montana's 56 counties. Federal MCHBG funding is critical to this effort, by matching four dollars of MCHBG funding to every three dollars of funding from participating counties. CPHDs use MCHBG funding to support addressing their priority MCH needs. This system also contributes to strengthening the public health infrastructure serving MCH statewide.

The Maternal & Child Health Coordination (MCHC) Section works directly with the CPHDs, and also oversees state-level projects and partnerships related to MCH. The Children's Special Health Services Section (CSHS) focuses on meeting the statewide needs of Montana's children and youth with special health care needs (CYSHCN). The *2023 Annual Report & 2025 Application* narratives and forms provide a more in-depth picture of how federal MCHBG funding supports the health needs Montana's maternal and child population.

The following two charts show a comparison of Montana's expenditures by funding source: federal MCHBG, and state MCH. One chart shows the difference by populations served, and the other by service category. These provide a visual representation of how federal MCHBG funding compliments state-led efforts. For "Populations Served" federal funding especially helps to provide gap-filling and specialty services to pregnant women and CYSHCN. A breakdown by "Service Level", reveals that Montana, as per federal guidance, spends very little funding on "Direct Services." The amount shown supports the CYSHCN population.





Federal MCHBG funding supports 4.35 full time equivalent (FTE) state-level positions, with 1.75 of these at the management level. The 10% of federal MCHBG funding allowed for administrative expenses is foundational to the work of the MCHC and CSHS Sections.

Federal MCHBG funding has been critical to securing the services of the *University of Montana Rural Institute for Inclusive Communities*, for work on the upcoming 5-Year Statewide Needs Assessment; and for state MCH epidemiologist's work in support of performance measure strategies. Additionally, it supports CYSHCN family partnership and navigator services through: Montana Peer Network; CANVAS Circle of Parents; and the Family Delegate.

III.A.3. MCH Success Story

In FFY 2023, Missoula County Public Health Department (MCPHD) implemented MCHBG activities related to cross-cutting *State Performance Measure 2: Family Support and Health Education*. These three MCPHD success stories were all made possible by MCHBG funding.

A Service for Every Step of Parenthood

A mother engaged with *Welcome Home Baby RN (WHB)* following birth of her first baby for breastfeeding/pumping support. Similarly, the home visiting RDN also engaged with family and provided support around transitioning from exclusively breastfeeding to solids. This mother, due to engagement with *WHB*, started to attend *Baby Bistro* regularly. During the 2023 Woman's Fair, the mother completed an outreach form at the MCPHD table, requesting additional parenting support, as her 11-month-old was starting to have bigger feelings and behaviors.

Committed Clients

MCPHD staff met with a mom, dad, and child who completed the full *Healthy Missoula Families Screening Tool.* Staff decided that *Circle of Security (CoS)* would be a great resource for the family. Both parents expressed nervousness about having the right tools and techniques for parenting the way they wanted. They hoped to be more gentle parents as they were both raised in families who had difficulty supporting them in a healthy manner, and where spanking was regular. They met with staff weekly while completing *CoS* and reflected with clarity about the growth of their daughter due to their dedication and implementation of secure attachment-based parenting. The mom has continued to attend *Baby Bistro* and passes along the knowledge of *CoS* to other mothers, who have then also reached out to for *Missoula Healthy Families* for services. After finishing *CoS*, the family stayed on the MCPHD caseload for additional parenting support and recently requested to do the *Love and Logic Parenting Program*.

Coordinating Important Services

MCPHD staff was able to work with a postpartum client whose child is now 12 months old. She has received nine MCHBG-funded home visits over the course of seven months, since bringing baby home from the hospital. Staff continues to check-in with the client and coordinate with the local WIC program in providing her with pumping supplies and educational materials.

This client requested assistance three days postpartum and expressed appreciation for MCPHD’s in-home services, as a mother of eight children. This was her second biological child she struggled with infant feeding and weight gain. The pediatrician had initially diagnosed the infant with failure to thrive and recommended supplementation with formula. The client was counseled by the pediatrician that it would be difficult to continue breastfeeding once starting supplementation. After engaging in MCPHD’s program this mother stated that her goal was to continue to breastfeed her infant for as long as she could. At six months postpartum the client sent a message stating, “She is 6 months old today and I would not be breastfeeding her if you had not come to my home and supported me. I am so thankful for you!” MCPHD staff has also assisted her with managing thrush, a nursing strike, biting, and maintaining a milk supply while returning to the workforce. This client continues to breastfeed her child and expresses deep gratitude for the services offered.

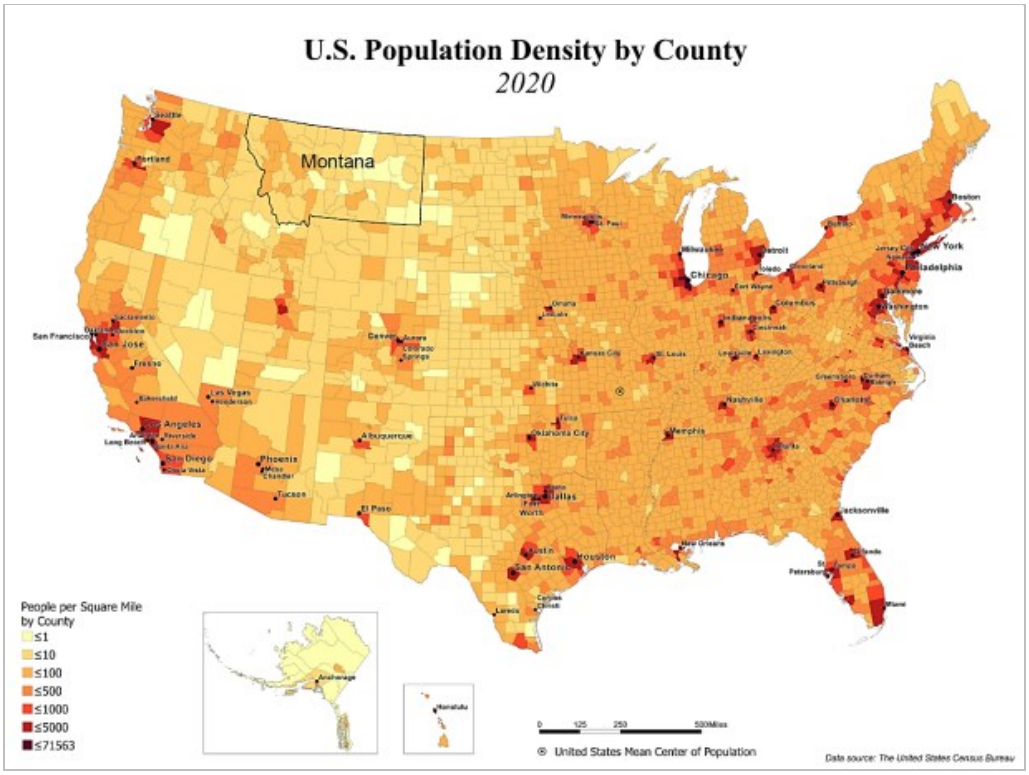
III.B. Overview of the State

Geography, Demographics, Economy, Income

The context for delivery of health care services in Montana is first formed by understanding its vast size, and second by its small population. These factors are inverse to the realities of providing health care in most of the nation. The population's racial composition is another characteristic that very few states share, with American Indians being the principal minority. This overview starts with basic information on these elements and then provides additional details on factors impacting Title V MCHBG services.

Montana is the fourth largest state in size, at 145,546 square miles. As of July 2023, Montana's population was 1,132,812 – which averages to a population density of 7.8 people per square mile. Figure 1. shows U.S. population density by county in 2020, with Montana outlined:

Figure 1.



Thirty-three percent of Montana's population lives in rural or frontier areas, characterized, in part, by limited access to health care in local communities. The remainder are concentrated in only ten of the fifty-six counties (U.S. Census 2020). Agriculture, tourism, logging, and natural resource extraction are major industries. Economic growth is increasing in the high-tech sector; manufacturing; pulse crops such as chickpeas and lentils; and small business startups. The healthcare industry is Montana's largest economic sector by employment. The growth in health care has been steady over the past decade and is expected to experience rapid job growth as Montana's aging population requires more healthcare services. In 2023, the unemployment rate was 2.5%.

Montana's racial make-up is predominately white, with a U.S. Census American Community Survey 2017-2021 estimate at 84.5% of the population. American Indians make up the largest minority, at approximately 6.6% (see Table 1). The ethnic Hispanic or Latino population is 4.2%, compared to 18.7% nationwide.

Table 1: ACS 2017-2021 Estimate of Resident Population by Race for Montana		
Race	**Population Count**	**Population Percent**
White	916,524	88.7%
American Indian and Alaska Native	67,612	6.6%
Asian	8,300	1.0%
Black or African American	5,484	0.6%
Native Hawaiian and Other Pacific Islander	941	0.1%
Other Race	14,089	1.3%
Two or More Races	71,275	3.0%

Montana's seven American Indian reservations and the Little Shell Chippewa, a federally recognized landless tribe, are each unique in their demographics and cultures. The seven reservations are as follows: Blackfeet, Crow, Flathead (Confederated Salish, Pend d'Oreille and Kootenai), Fort Belknap (Gros Ventre and Assiniboine), Fort Peck (Assiniboine and Sioux), Northern Cheyenne, and Rocky Boy's (Chippewa and Cree). For more information, see http://tribalnations.mt.gov.

State law recognizes a unique government-to-government relationship between the state government and the eight tribal governments. According to the U.S. Census American Community Survey 2017-2021 estimate, American Indians equal 6.6% of Montana's population, or approximately 67,612 in number, of which 59.5% live on tribal lands. Information on culturally responsive delivery of maternal and child services is detailed in the Needs Assessment Summary.

The Little Shell Chippewa Tribe, which received federal recognition in December 2019, is without a reservation or land base. With approximately 5,400 members, there are population concentrations in numerous cities and towns across Montana and in other states. Many changes are expected during the next decade as federal recognition is implemented. The legislation included an accommodation for the purchase of 200 acres. The site currently hosts a tribal health clinic, which opened in April 2022. In the future, the site will include buildings for tribal government, and college-level and vocational instruction.

The following table compares some of the MCHBG demographic profile information for the geographic area of each reservation, using 2021 American Community Survey (ACS) 5-year estimates. The median age for the whole state in 2021 was 40 years.

U.S. Census: American Community Survey 2021 Estimates

Montana's American Indian Reservations - Geographic Area Demographics

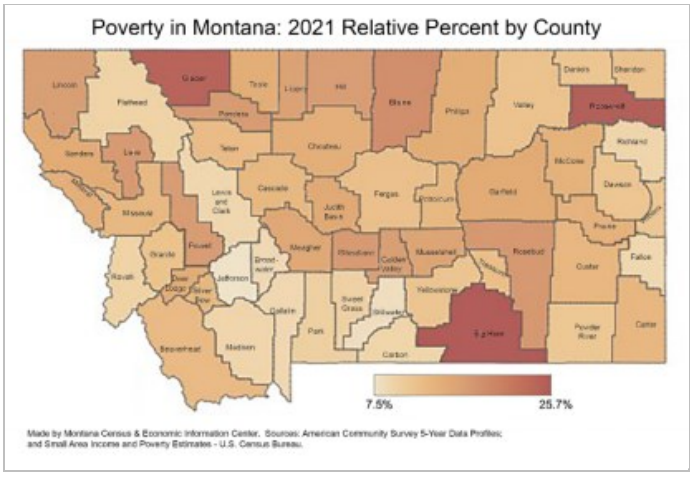
Selected Race and Maternal & Child Health Block Grant Population Categories

Category	Blackfeet	Crow	Flathead	Fort Belknap	Fort Peck	Northern Cheyenne	Rocky Boy's
Total Population	10,706	7,351	31,631	3,627	10,366	4,749	2,341
Median Age*	30.6	28.3	41.0	26.8	30.0	23.0	22.4
Count A.I./A.N.	9,058	5,450	7,673	3,142	6,596	4,040	1,947
Percent A.I./A.N.	**84.6%**	**74.1%**	**24.3%**	**86.6%**	**63.6%**	**85.1%**	**83.2%**
Count White	1,195	1,228	19,507	132	2,558	222	29
Percent White	11.2%	16.7%	61.7%	3.6%	24.7%	4.7%	1.2%
Age Under 5 Years	900	680	1,823	327	1,051	558	320
Age 5-19 Years	2,735	2,222	6,641	1,126	2,786	1,576	684
Females Ages 15-44	2,215	1,425	5,306	801	1,984	1,048	562

A.I./A.N. = American Indian / Alaska Native

* Median Age in U.S. is 38.4, and in MT 40.0

The 2021 ACS 5-year estimated average median household income in Montana was $60,560 compared to the U.S. total average of $69,021. Under the same survey: Montana's per capita income was $34,423, compared to the U.S. average of $37,638; 15.2% of MT's children under age 18 were living below the federal poverty level compared to the US rate of 17%, and 17.7% of MT's children under the age of 5, compared to the US rate of 18.5%. Poverty rates vary greatly by county, from a high of 25.7% in Big Horn to a low of 7.5% in Jefferson. This is shown in detail on the following map.



According to Montana's Office of Public Instruction, the high school graduation rate in the 2022-2023 school year was 85.6%, and the overall dropout rate 2.65%. However, the graduation rate for the American Indian population over the same

timeframe was 66%. The ACS 2021 5-year estimate for ages 25-plus in Montana with a bachelor's degree or higher was 35.7%, very similar to the U.S. rate of 35.4%.

Health Services Infrastructure

All of Montana's counties are designated as medically underserved in at least one of the three disciplines: Primary Care, Mental Health, and Dental Health. According to the 2021 Montana Behavioral Risk Factor Surveillance System (BRFSS) Annual Report, the prevalence of no personal health care provider among Montanans ages 18 and older was 19.1%, compared to the U.S. percentage of 16.0%.

Up until 2023, there were no medical schools in Montana. However, there are now two medical schools in the state: a satellite campus of the for-profit Rocky Vista University College of Osteopathic Medicine in Billings accepted its first class of students in July 2023; and a non-profit school in Great Falls, anchored by the Touro College and University System opened in September.

Since 1971, Montana has been a part of a cooperative program between the University of Washington School of Medicine and the Montana University System. Known as the WWAMI Medical Education Program, it makes it possible for thirty Montana students per year to enter the University of Washington School of Medicine. The Montana students who are admitted to this program complete the first one and a half years of medical school at Montana State University and the final two and a half years at the University of Washington in Seattle, Washington. During their third and fourth years students work in hospitals and clinics rather than classrooms. Students in the WWAMI Program can take third and fourth year courses not only in the Seattle area but also in a number of other sites in the states of Washington, Wyoming, Alaska, Montana, and Idaho.

Montana's Graduate Medical Education Council is currently sponsoring the following residency programs in the state:

Residency Programs in Montana

Residency Program	Location	Established	Number of Residents
Montana Family Medicine Residency	Billings	1995	24 residents / 8 per class
Family Medicine Residency of Western Montana	Missoula & Kalispell	2013	30 residents / 10 per class
Billings Clinic Internal Medicine Residency	Billings	2014	24 residents / 8 per class
University of Washington Psychiatry Residency Program, Montana Track at Billings Clinic	Billings	2019	12 residents / 3 per class

Of Montana's 56 counties, there are twelve with less than 2,000 residents and twenty-two with less than 5,000 residents. A county's population is one variable for determining its Health Professional Shortage Area (HPSA) designation score for access to primary care, mental health, and dental health services. The Primary Care Office (PCO) annually reviews the 56 counties' HPSA scores. Currently, 51 are a mental health HPSA, 49 are a primary care HPSA, and 38 are a dental health HPSA, which indicates that the county experience challenges to access healthcare.

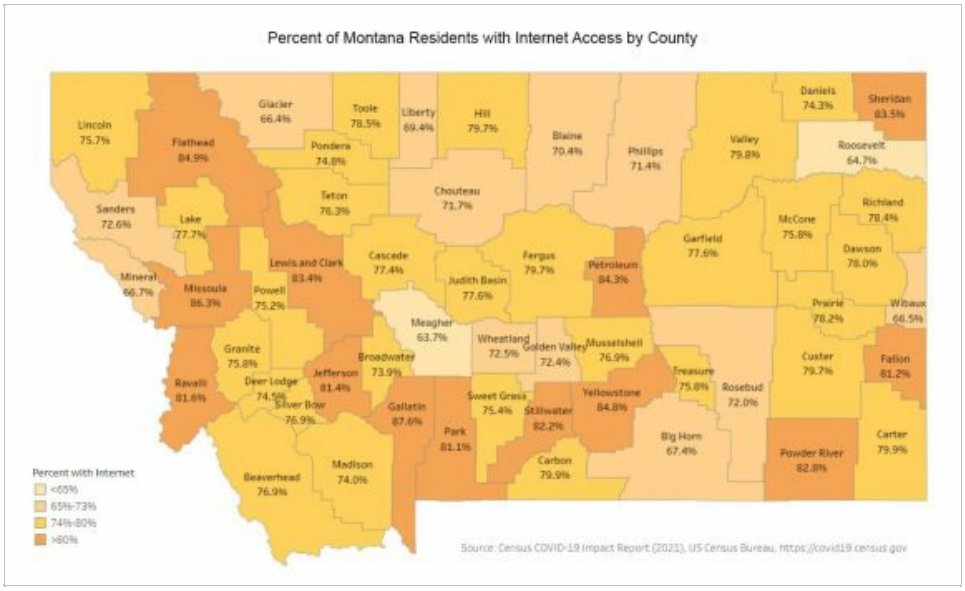
Since 2013, the Oral Health Program has used Dental HPSA scores to determine the locations where University of Washington-School of Dentistry (UWSOD) students go to complete their dental rotations. During FFYs 2018-2023, the UWSOD blended their *HRSA Grants to States to Support Oral Health Workforce Activities* funding to support 61 student rotations in 17 HPSA sites. These students reported serving 2,844 patients, who received one or several of the 4,846 preventive oral health procedures.

Healthcare specialties may be available in more populous areas of the state, or out-of-state travel may be required to access appropriate care. For example: a child living in Plentywood (the star on the following map) has an asthma attack and requires specialized medical attention. Their access options are to either drive 353 road miles or fly 220 aeronautical miles to the closest provider and level IV NICU in Billings. The nearest FQHC is in Glendive, 137 miles away. The numbers on the map represent counties with less than 2,000 residents: from 496 in Petroleum (#1) to 1,959 in Liberty (#12).

Montana's shortage of providers extends beyond rural areas into more populated settings, with no guarantee there will be a specialist to care for more complex needs. The Primary Care Office (PCO) reviews Conrad 30 J-1 visa waiver requests for foreign medical graduates willing to work in Health Professional Shortage Areas (HPSAs). In 2023, the PCO recommended seven visa waivers for specialists. So far in 2024, the PCO has recommended four specialists practicing in endocrinology, obstetrics and gynecology, oncology, and neurology as well as three primary care providers practicing in internal medicine. All providers are serving in urban HPSAs in Great Falls and Billings.

Families in rural areas have many healthcare challenges, including distance to the closest medical care of any kind; specialist and healthcare facility locations; location of supplemental services; and, access to critical care. They also have secondary considerations such as: are there any school-based services; what is the level of community and support services; is there any system of care for Children & Youth with Special Health Care Needs; what is the availability of telehealth services; is internet and cell phone coverage adequate; and, how built environment, which looks quite different in rural towns, impacts their family?

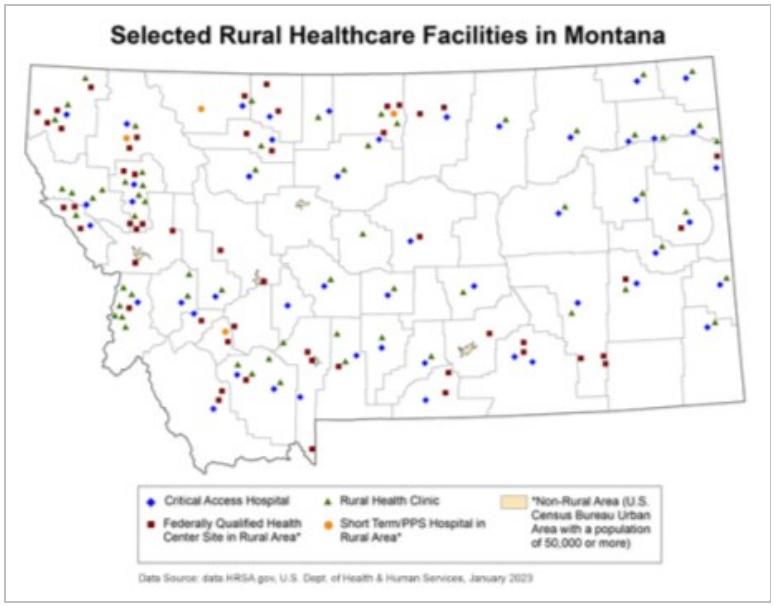
The following map shows the 2021 percentage of residents who have internet access by county for the state. It ranges from a high of 87.6% in Gallatin, to a low of 63.7% in Meagher.



While Montana's larger rural communities are served by hospitals, most of rural Montana is served by Critical Access Hospitals (CAH). According to the 2021 Montana Rural Health Plan, there are 66 licensed hospitals, of which 49 are designated as Critical Access Hospitals (CAH) which have a 25-bed limit, and even among those communities with CAHs there is great disparity in the services offered, and the depth of the medical delivery system.

Montanans can also access services at one of the 61 rural health clinics; four Short Term/Prospective Payment System (PPS) hospitals; one of the 15 Federally Qualified Health Centers and their Satellites, Seasonal and Migrant Clinics; American Indians are able to access care at their Reservation's Indian Health Services and Tribal Health Departments, and at Urban Indian Health Centers located in Billings, Butte, Missoula, Helena, and Great Falls.

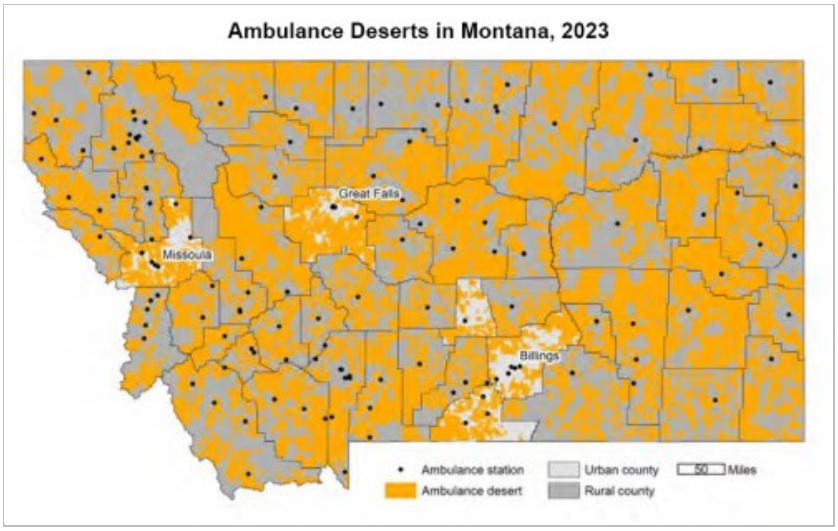
However, the following map shows the maldistribution of these services, and lack of options in the eastern third of the state:



School nurses are not mandated by Montana Law. Montana has one of the highest school nurse to student ratios in the country: 1 school nurse to nearly 2,000 students. Twenty-six of 56 counties have no school nurse at all, and 98% of

Montana students have no registered professional school nurse or too few school nurses in their county. Many school nurses serve more than one school and spend precious time travelling between campuses.

Montana is also subject to geographic disparities in the provision of ambulance services, with fewer than three ambulances covering every 1,000 square miles of land area. According to the Montana Ambulance Association, the industry is experiencing funding gaps and workforce shortages, leading to ambulance service closures across the state. Ambulance deserts are defined as places and people that are more than 25 minutes from an ambulance station. This may be due to terrain and road conditions, as well as distance. The following map shows the extent of the problem, with ambulance deserts showing in yellow (Federal Office of Rural Health Policy, 2023):



In FFY 2023, eighteen County Public Health Departments (CPHDs) that selected SPM 1 implemented activities for services that their nurses provided in local schools. These helped to bridge gaps in care, such as: administering medication; vaccinations; hearing and vision screening; disease surveillance; and health education. CPHDs also provide services such as immunizations, and family planning to county residents, as well as providing education and referrals to social services.

Detailed characteristics of Montana's maternal and child population groups are described in the 2020 Statewide 5-Year MCH Needs Assessment Summary and 2024 Needs Assessment Update. This includes: health status; needs; and emerging issues and factors impacting service delivery. Seven priority areas were identified, listed here by population domain:

- Perinatal & Infant: *Infant Mortality*
- Children: *Oral Health*
- Adolescent: *Bullying Prevention*
- Women & Maternal: *Annual Preventive Healthcare Visit*
- Children and Youth with Special Health Care Needs: *Medical Home*
- Cross-Cutting & Systems Building: *Access to Public Health Services*
- Cross-Cutting & Systems Building: *Family Support Services and Health Education*

State Health Agency: Title V Maternal & Child Health Block Grant (MCHBG) Service Delivery

Montana's MCHBG program is housed in the Department of Public Health & Human Services (DPHHS), the largest state agency in Montana. DPHHS seeks to promote and protect the health, well-being, and self-sufficiency of all Montanans by offering programs to address Montanans' needs for social services, medical, physical, and behavioral/mental health care. Details on all services and programs can be found at: https://dphhs.mt.gov/.

Montana is considered a "decentralized" system for providing public health services

(https://www.cdc.gov/publichealthgateway/sitesgovernance/index.html), which are provided at the local level through the CPHDs. DPHHS has contracts with all 56 CPHDs, and much of its funding is passed through to support their work. Montana's MCHBG Program provides leadership and direction to state, local, and non-governmental programs; and partners for issues affecting the health of the maternal and child population. For example, by connecting state and national performance measure strategies with local efforts.

In addition to the priority maternal and child health needs, several overarching issues pose unique challenges to health care delivery: the aging population; geographic disparities; and access to health care. Some CPHDs are the sole source of certain maternal and child health care services, such as immunizations, for the surrounding population. Montana's MCHBG funding is directly supporting CPHDs in 51 counties in FFY 2024 and is critical to meeting the public health needs of the maternal and child population across the state.

Statutory authority for maternal and child health services is found in the Montana Code Annotated (MCA) Title 50, Health and Safety. 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; 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. Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) is authorized in MCA 50-19-401, and Fetal, Infant, Child and Maternal Mortality Review (FICMMR) is authorized in MCA 50-19-301.

Financing of Health Services

Montana's MCHBG allocation to CPHDs is based on: the total numbers of women of childbearing age (15 to 44 years); infants and children ages 0 through 18; and the number of those individuals living in poverty. The funds are allocated as required by Section 501 to 510 [42 U.S.C. 701 to 710]; and ARM 37.57.1001 governing the MCHBG. In FFY 2023, Montana received a total of $2,363,404.

Historically, based on the funding formula, the CPHDs have received 44% of the state's total. In FFY 2023, the counties received $996,000 in MCHBG funding to provide services to their county's maternal and child population. Other expenditure categories were as follows: the CSHS section expended $776,628 providing services to *Children & Youth with Special Health Care Needs (CYSHCN);* $183,628 was spent on state-level administrative costs; and $410,214 was spent on state-level MCH programs.

DPHHS administers the Montana Medicaid Program (MMP) through several divisions including but not limited to: Human and Community Services Division for eligibility determination; Health Resources Division; and, Behavioral Health and Developmental Disabilities Division, authorized under 53-6-101, Montana Code Annotated (MCA), and Article XII, Section XII of the Montana Constitution. The MMP complies with its state plan and waiver authorities, thus meeting the unique healthcare needs of Montanans. With multiple divisions focused on Medicaid services, DPHHS partners with various providers and stakeholders to address social determinants of health on many levels.

In 2015, MT's biennial legislative body passed Senate Bill (SB) 405, Montana Health and Economic Livelihood Plan, which expanded Medicaid effective January 1, 2016. House Bill (HB) 658, the Medicaid Reform and Integrity Act, passed by the 2019 Legislature, continued SB 405 through June 2025. HB 658 included a work requirement, an 80-hour monthly work or community engagement requirement for the enrollee, which was planned to be effective January 2020. The state submitted an 1115 waiver to CMS in August 2019; which was denied in 2021.

On March 31, 2023, the Medicaid waivers ended which were put into place during the COVID-19 pandemic to make sure people had Medicaid or CHIP coverage. States then began determining current eligibility for coverage. Beginning in April 2023, DPHHS is evaluated Medicaid and HMK members' eligibility for continued coverage and renewed or terminated coverage as appropriate.

Montana Medicaid includes the following coverage groups that all have different eligibility requirements: Infants and Children including Newborn Coverage, Healthy Montana Kids Plus (Children's Medicaid), Healthy Montana Kids (Children's Health Insurance Program), Subsidized Adoptions, Subsidized Guardianship and Foster Care; Pregnant Women; Low Income Adults with a Severe Disabling Mental Illness (SDMI); Aged, Blind/Disabled and/or receiving Supplemental Security Income; Breast and Cervical Cancer Treatment; Medically Needy or Categorically Needy; Low Income Montanans Including Medicaid and Medicaid Expansion and Montana Medicaid for Workers with Disabilities.

As of February 2024, 31,775 adult women were enrolled in traditional Medicaid programs, and 43,552 in Medicaid Expansion. Additionally, 1,520 women were enrolled in Pregnant Women Medicaid. The number of pregnant women covered by other types of Medicaid cannot be pulled accurately because Medicaid is not aware of most other pregnancies until receiving the global pregnancy bill after the baby is delivered.

The 2023 Montana Legislature voted for a state budget that contained $6.2 million in state and federal funds over the next two years to extend continuous postpartum eligibility from 60 days to 12 months after pregnancy. That ensured coverage for between 1,000 and 2,000 additional parents in the state each year, according to federal and state estimates.

As of February 2024, there were 15,357 children enrolled in the Healthy Montana Kids (HMK) Children's Health Insurance Program (CHIP), 85,862 children ages 0-20 enrolled in traditional Children's Medicaid (HMK Plus), and 6,418 children ages 0-20 in HMK Plus Expansion.

In addition to public insurance options, private insurance also covers much of the population. The ACA Federally Facilitated Marketplace enrollment for 2023 was 53,860. Table 3. outlines sources of health insurance for Montana, as reported by the Montana Healthcare Foundation:

Table 3: 2021 Estimates of Resident Population by Insurance Coverage Type for Montana

Insurance Coverage Type	Population Count	Population Percent
Employer-Based Alone	440,313	40.45%
Direct-Purchase Alone	86,382	7.94%
Medicare Alone	79,102	7.27%
Medicaid Alone	158,456	14.56%
TRICARE / Military Alone	16,224	1.49%
VA Care Alone	4,133	.38%
Two or More Types of Health Insurance	214,454	19.7%
No Health Insurance Coverage	89,432	8.22%
Total Noninstitutionalized Population	1,088,496	100.00%

III.C. Needs Assessment
FY 2025 Application/FY 2023 Annual Report Update

Title V MCHBG: Current Needs Assessment Activities

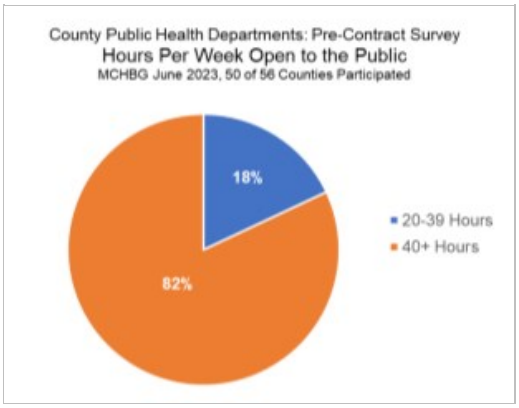
County Public Health Departments: Ongoing MCHBG Assessment Activities

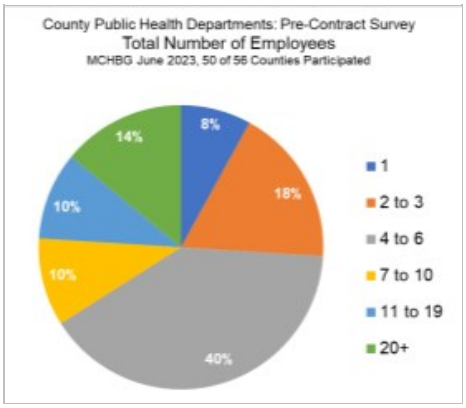
In Montana, County Public Health Departments (CPHDs) are the primary providers of Title V MCHBG services to their residents. Every year, the CPHDs complete an extensive MCHBG Pre-Contract Survey. The survey gathers information on:

- Department and program capacity;
- MCH services provided;
- Staff changes;
- Priorities needs for MCHBG funding and activities; and,
- Feedback on the quality of services and support from state MCHBG staff

Information gathered from the CPHDs on the FFY 2024 CPHD Pre-Contract Survey indicated the on-going priorities of access to public health services, family support, and health education. Thirty-one counties choose *SPM 1: Access to Public Health Services* for their performance measure, and 12 choose *SPM 2: Family Support & Health Education*, which addresses social determinants of health.

The following graphs illustrate results on “Hours Per Week Open to the Public” and “Total Number of Employees:”





The CPHDs also provide qualitative information on their MCHBG activities on two semi-annual narrative reports. These reports ask for a description of any activities or planning efforts undertaken during the six-month timeframe, pertaining to the county's chosen performance measure. This might include progress or challenges pertaining to activity goals, using the evaluation strategies described on their Pre-Contract Survey, and any collaborative efforts with other organizations.

The MCHBG Program Specialist conducts in-person site visits to CPHDs on a rotating three-year basis. This schedule equates to approximately 17 visits a year. These visits are an opportunity to conduct key informant interviews, solicit individual feedback, and conduct personalized performance monitoring and assessment.

One of the MCHBG contract requirements for CPHDs is that they conduct their own client satisfaction surveys, and report a summary of the results to the state program. Examples of the information CPHDs collect include: demographics; preferred methods of communication; how to improve services; sources of information on health topics; client experience with staff, and suggestions for improvement, including hours open to the public.

Medicaid Data Query: Women’s Annual Preventive Healthcare Visit

Objective: The objective of this analysis was to find the percent of Montana adult (18+) women who were covered by Medicaid and received a preventative healthcare visit during the calendar year of 2022.

Methods: Through the Medicaid claims database, all adult women (sex coded as female) who were 18+ for at least one day in the 2022 calendar year were identified. Additionally, county of residence, race, and iCD-10 codes were also obtained.

For the women who met these criteria, they also had to have at least one paid claim with a well-woman visit CPT code. These CPT codes not only encompassed preventative medicine services, but also substance use visits, mental health, blood pressure, diabetes, healthy diet, domestic violence, lipid, obesity, tobacco use, STI, HIV, Hepatitis, cancer, and bacteriuria screenings, as well as other preventative care such as contraceptive care, folic acid supplementation, breastfeeding services, Rh(D) blood typing, and immunizations, which all have unique CPT codes beyond the standard preventative medicine services. All claims with CPT codes pulled were finalized claims. All statistical evaluations were performed in SAS 9.4.

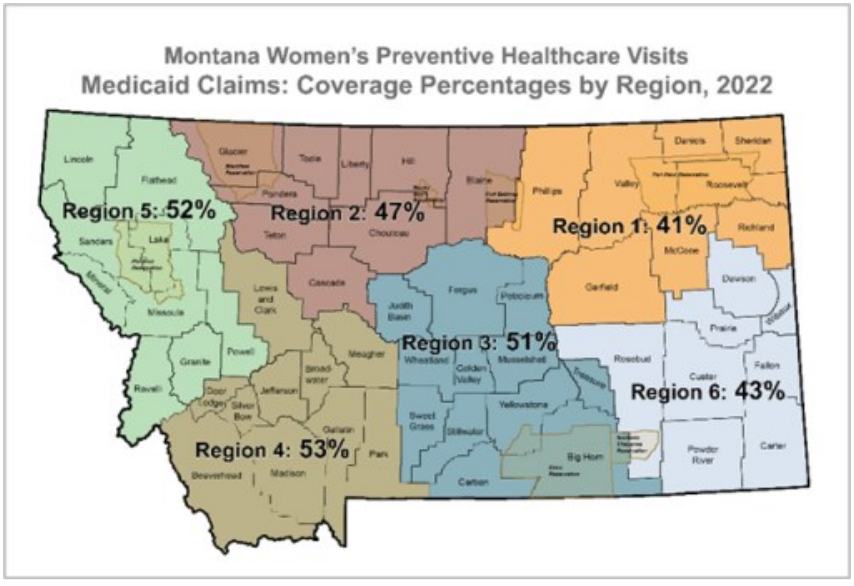
Results: In 2022, there were 91,894 adult (18+) women enrolled in Montana Medicaid. This number was derived from the 279,401 people enrolled in Medicaid, 148,217 (53%) were women, and 172,697 (62%) of Medicaid enrollees were adults. These percentages were used to calculate the number of adult female Medicaid enrollees. Of these women, 46,577 (51%) received some form of preventative care.

These 46,577 women were then divided into six healthcare regions. County-level data was not available due to low counts in some counties. The percentage of Medicaid recipients with well-woman visits as divided into healthcare regions is shown in Table 1 below.

Table 1: Percentage and Rate per 1,000 of Adult Medicaid Recipients with a Well Woman Visit, Montana Medicaid, 2022

Regions	Percentage	Rate per 1,000
Region 1	41%	409 / 1,000
Region 2	47%	467 / 1,000
Region 3	51%	514 / 1,000
Region 4	53%	534 / 1,000
Region 5	52%	522 / 1,000
Region 6	43%	425 / 1,000

Regions 3, 4, and 5 all had the highest percentage of well-woman visits, all of which are over 50%. Regions 1, 2, and 6 were the lowest with 41%, 47%, and 43%. However, the range between the lowest region (Region 1, 41%) and the highest (Region 4, 53%) was only 12%.



The women were also divided into race by American Indian/Alaskan Native and other races. These categories were chosen due to the enrollment categories available on the Montana Medicaid website. The percentage of American/Indian Alaskan Native Medicaid recipients was 14% lower than the other Medicaid recipients, at 58% compared to 72% (Table 2).

Table 2: Percentage and Rate per 1,000 of Adult Medicaid Recipients with a Well Woman Visit by Race, Montana Medicaid, 2022

Race	Percentage	Rate per 1,000
American Indian/Alaskan Native	58%	582 / 1,000
Other	72%	725 / 1,000

The Medicaid recipients were also divided into three age categories: late teens (19 – 20 years old), adults (21 – 64), and elderly (65+). Like the racial categories, the age groups were chosen based on available data on the Montana Medicaid website. While the adult and elderly populations had about the same percentage of recipients with well-woman visits (53% and 51%, respectively), the late teenagers had about a 10% reduction in visits at 42% (Table 3).

Table 3: Percentage and Rate per 1,000 of Adult Medicaid Recipients with a Well Woman Visit by Age Group, Montana Medicaid, 2022

Age	Percentage	Rate per 1,000
19 – 20 Years Old	42%	416 / 1,000
21 – 64 Years Old	53%	534 / 1,000
65+ Years Old	51%	514 / 1,000

Discussion: While the percentage of Medicaid recipients with well-woman visits across the six regions varies from 41% - 53%, it does show that only about half of women with Medicaid are receiving preventative healthcare. Additionally, as Tables 2 and 3 show, American Indians and Alaskan Native women are receiving less preventative care than other races, and women in their late teens receive less than adult or elderly women.

However, there are limitations to using Medicaid claims for analysis purposes. Medicaid claims are used for billing purposes, so they are coded as such and are not coded for research or public health purposes. Additionally, these claims are limited to the CPT codes used to pull the data. If a CPT code was overlooked or missing from the claim, it was not included. Finally, Medicaid can be used with other insurances such as Medicare, private insurance, or Indian Health Service (IHS) insurance. The other insurances could be used to pay for preventative healthcare, as Medicaid is a payor of last resort.

Even with these limitations, it is clear that women are not receiving necessary preventative care. Steps such as advertising preventative services, physicians sending reminders, and providing education on the important of screenings are all common recommendations to improve preventative care rates.

Statewide 5-Year 2025 Needs Assessment: Activities and Purpose

In January 2023, Montana's Title V MCHBG Program began discussion with the *University of Montana Rural Institute for Inclusive Communities* (UMRIIC) on Phase 1 of work for the Statewide 5-Year 2025 Needs Assessment. The purpose of Phase 1 was to collect primary data from parents and caregivers on maternal and child health in Montana through a statewide survey. It is also to helped improve the representation and inclusion of service recipients in the MCHBG needs assessment process.

UMRIIC created a draft survey based on the Minnesota Department of Health and Human Services Discovery Survey. In May 2023, UMRIIC hosted listening sessions to engage parents/caregivers in further designing the survey questions and recruitment plan. UMRIIC and MCHBG staff then integrated the feedback into a revised version. This team included the American Indian Health Director for Montana's Department of Public Health & Human Services. The Parent/Caregiver Survey data collection occurred from October through December 2023, with 558 participants.

Phase II of work on the needs assessment began in October 2023, and will continue through September 2024. It's emphasis is on primary data collection from key groups such as maternal and child health stakeholders and tribal communities. The main methods are surveys and qualitative key informant interviews. Federal Fiscal Year (FFY) 2024 is also the main timeframe for quantitative data analysis.

Phase III begins in FFY25, with the following workplan:

- 10/1/24 – 12/21/24: Complete data analysis from surveys and interviews. Review findings with the needs assessment team to clarify key issues and priority concerns.
- 1/1/25 – 3/31/25: State staff will finalize performance measure choices for FFY 2026, with consideration for federal requirements and capacity.
- 4/1/25 – 7/15/25: Complete Needs Assessment Summary Report and submit to HRSA.

Family & Community Health Bureau-Affiliated Programs: Needs Assessment Activities

Healthy Montana Families Home Visiting: Ongoing Risks Identification

Montana's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is called Healthy Montana Families (HMF). HMF is currently contracting with 18 Local Implementing Agencies (LIAs). In FFY 2023, the LIAs served 1,837 participants, in 931 households, with 11,805 home visits. In 2023, the LIAs were asked to identify ongoing risks. By far, the top three were: Housing (n=18), Behavioral Health (n=14), and Transportation (n=14).

HMF's Demographic Service Utilization FFY 2023 Report presented the following statistics on LIA households served (percentages based on the total of 931):

- 51.8% were *low-income*;
- 43.9% had a *history of child abuse or neglect,* or had interactions with child welfare services;
- 37.4% included a member who used *tobacco products* in the home;
- 32.7% included a member with *low student achievement* or has a child with low student achievement;
- 31.5% had a history of *substance abuse* or had a member who needed substance abuse treatment;
- 21.8% included a *child with developmental delays or disabilities*;
- 10.1% included a member who was serving or had formerly *served in the U.S. Armed Forces*.
- 2.6% included an enrolled participant who was *pregnant and under age 21*;

Oral Health Program

During 2023, the Montana Oral Health Program conducted an assessment of the oral health workforce. The goal of the 2023 Oral Health Workforce Assessment was to examine the distribution, workforce capacity, and demographic characteristics of the current dental workforce in Montana. This examination is a platform to increase access for populations that experience disparities, and identify opportunities and challenges for health equity in dental care.

Stakeholder input was collected during three stakeholder meetings that included representation from: the dental health workforce; those in education settings; and representatives of Montana communities that experience oral health disparities. Kick-off and mid-point meetings were used to: formulate assessment needs and data sources; identify key informants; set partner expectations; and inform future involvement in the assessment.

Surveys were developed and disseminated to dentist and dental hygiene professional networks, and a key informant survey was conducted to collect qualitative data. Analysis of survey data was used in combination with other workforce data sets, and dental care utilization data, to create a comprehensive view of the oral health workforce in Montana. Here are the key findings of the assessment:

Understanding the Workforce:

- Montana authorizes the practice of dental health aides (DHA) and dental health aide therapists (DHATs) within tribal health, Indian Health Services and Urban Indian Health Centers. However, performing dental extractions or invasive procedures to teeth and gums is prohibited. Although authorized by law, the functions of a DHAT in Montana do not align with what is nationally recognized in dental therapy.
- Dental hygienists provide care under general supervision with the intent and knowledge of the supervising dentist, which does not require the dentist to be on the premises. Dental hygienists practicing with a limited access permit (LAP) may practice under public health supervision in specific public health settings.

Supply and Demand:

- In 2023, 1,055 dental hygienists held a professional license; 914 of those license holders had a Montana address on file.
- In 2022, Montana Occupational Employment Statistics estimated 1,420 dental assistants to be working in Montana.
- Dentist survey respondents reported employing an average of 2.5 dental hygienists yet reported needing an average of 3.1 dental hygienists. Similarly, dentists reported a need for more dental assistants, with an average of 3.9 currently employed and a need for 4.2. Results indicate dental clinics across Montana are understaffed.
- The American Dental Association Health Policy Institute estimates there are 640 active dentists in the State or 56.5 dentists per 100,000 population. This is below the national average of 60.4 per 100,000 population, ranking Montana

30th in the nation.

Recruitment and Retention:
- Employers in Western and South Central Montana report more difficulty recruiting dental hygienists compared to Eastern and North Central Montana.
- Dentists in North Central Montana reported 7-9% lower hourly pay for dental hygienists compared to those in Western, South Central, and Eastern Montana.
- Benefits are important to dental hygienists; 87% rated them as either extremely or very important.
- On average, dentists who participate in the National Health Service Corp within rural Montana intend to continue in rural practice for 18.6 years.

Educational Pipeline:
- 66% of Montana dental hygienists reported they obtained their high school diploma or GED in Montana.
- Many of Montana's current dental hygienists reported starting their career as a dental assistant.
- 47% of Montana dentist survey respondents reported graduating from high school in Montana; 34% were trained through either the University of Washington School of Dentistry, Oregon Health and Science University School of Dentistry, or the University of Minnesota School of Dentistry.
- Many dentists, 50%, decide to become a dentist before going to college.
- Career interest among high school students is low; 5% of students in healthcare pipeline programs report an interest in pursuing a dental career.
- 15-25% of Carroll College Pre-Dental Pathway students matriculate to dental school.
- 42.2% of WICHE Dental Exchange Program graduates are estimated to be working in Montana.
- 44.6% of Minnesota Dental Exchange Program graduates are estimated to be working in Montana.
- Great Falls College Dental Hygienist Program estimates 89% of their 2022 graduates are employed in Montana.
- Salish Kootenai College Dental Assisting Program staff reported 100% of graduates work in Montana.
- Both the Great Falls College and Salish Kootenai College Dental Assisting Programs have experienced a decline in enrollment in recent years.

Underserved Populations:
- Barriers to care for historically underserved populations include financial constraints, geographical limitations, healthcare system complexities, and specific population challenges.
- In 2022, 77.5% of general and pediatric dentists served Medicaid-enrolled Montanans; 13% of dentists accounted for 63% of Medicaid services billed.
- Just 36% of Montana dentist survey respondents reported they are accepting new adult Medicaid patients and 57% reported they are accepting new child Medicaid patients.
- In 2023, 103 hygienists held a LAP, which is 9.8% of all dental hygiene license holders.
- HRSA estimates 33.5 dentists are needed to meet the needs of Montana's underserved communities. Missoula, Cascade, Ravalli, and Gallatin counties have the greatest needs.
- Workforce needs reported by Montana's Indian Health Services and Tribal Health Clinics in the fall of 2023 included 11 dentists, 4 dental hygienists, and 17 dental assistants.
- In 2022, 4,264 nontraumatic dental care visits were made to an emergency room in Montana.

Innovative Initiatives:
- 22% of dentists surveyed report they utilize teledentistry.
- Montana promotes the use of primary care medical providers who are trained in preventive oral healthcare such as risk assessment, referral to dental care, and fluoride varnish application.

Early Childhood & Family Support Division: Bright Futures Birth-5 Grant, Early Childhood Needs Assessment

Montana had 57,646 children under the age of five in 2022, according to the U.S. Census. Getting the best start in these years has life-long impacts on everything from educational outcomes to life expectancy. Each child and family has a unique mix of needs and assets. In Montana, services to help children and families thrive are delivered through many coalitions, organizations, businesses, programs, agencies, and individual professionals. Together, families and these organizations make up the early childhood system.

The system-level needs assessment was designed to do three things:
- Characterize the current state of young children and their families and the services that support their needs and goals
- Identify opportunities and challenges within the early childhood system
- Provide system-level recommendations that will help inform strategic planning to address challenges and build on successes

The needs assessment drew on public data sources, 50 family and service provider interviews, and a family and service

provider survey that was answered by 1,734 total respondents including 990 families from every county in Montana.

Preliminary results show gaps in service capacity, provision, and access. Gaps in data, communication, coordination, and state-local early childhood system governance also show needed areas for further improvement. Additionally, there is widespread recognition of the need to work as a system. It was also noted, however, that there have been significant advancements since 2019. These advances include: consolidation of early childhood functions in state government; and increased coordination and recognition of the valuable functions that early childhood coalitions and other organizations provide in Montana. A final report will be released in August of 2024.

Click on the links below to view the previous years' needs assessment narrative content:

2024 Application/2022 Annual Report – Needs Assessment Update

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,300,122	$2,281,008	$2,323,181	$2,315,433
State Funds	$3,013,111	$2,731,810	$3,170,955	$2,854,070
Local Funds	$11,133,625	$3,441,756	$5,644,793	$5,996,450
Other Funds	$0	$0	$0	$0
Program Funds	$6,574,458	$5,304,745	$6,548,111	$3,156,546
SubTotal	$23,021,316	$13,759,319	$17,687,040	$14,322,499
Other Federal Funds	$24,660,140	$28,037,700	$25,867,305	$27,370,474
Total	$47,681,456	$41,797,019	$43,554,345	$41,692,973

	2023		2024	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,323,181	$2,366,470	$2,323,181	
State Funds	$3,343,517	$2,634,577	$3,343,153	
Local Funds	$3,441,756	$3,164,626	$5,996,450	
Other Funds	$0	$0	$0	
Program Funds	$3,391,241	$2,888,530	$3,076,215	
SubTotal	$12,499,695	$11,054,203	$14,738,999	
Other Federal Funds	$24,009,736	$28,089,518	$24,076,318	
Total	$36,509,431	$39,143,721	$38,815,317	

	2025	
	Budgeted	Expended
Federal Allocation	$2,323,181	
State Funds	$3,082,402	
Local Funds	$3,164,626	
Other Funds	$0	
Program Funds	$2,834,159	
SubTotal	$11,404,368	
Other Federal Funds	$27,137,314	
Total	$38,541,682	

III.D.1. Expenditures

Montana's Department of Public Health and Human Services (DPHHS) relies on federal funding, which provides a significant number of public health services to the 1.1 million plus citizens living in one of the state's 56 counties. In FFY 23, the state's Title V Maternal & Child Health Block Grant (MCHBG) expended $2,366,470. This spending provided Direct and Enabling Services to 19,188 pregnant women, infants, children, adolescents, children and youth with special health care needs (CYSHCN) and women of childbearing age (Form 5a). This number increases to 47,783 for the same group, when including Public Health Services and Systems (Form 5b).

The MCHBG, housed within the Family and Community Health Bureau (FCHB) in DPHHS, relied on partnerships with private clinics, hospitals, community based-organizations, non-profits, Tribal Health Departments, colleges and universities, high schools, and County Public Health Departments (CPHDs) to serve these Montanans in FFY 23. These partnerships, as well as the FCHB's other maternal and child health programs, focused on addressing Montana's FFYs 2021-2025 priority needs:

- Access to Public Health Services
- Bullying Prevention
- Family Support & Health Education
- Infant Safe Sleep
- Medical Home
- Children's Oral Health
- Women's Preventive Healthcare

Montana's methodology used the ratios of the total maternal and child population as a factor for determining state-level budget amounts for the MCHBG demographic categories, to ensure that the 30%-30%-10% requirements are met for Preventive and Primary Care for Children; CYSHCN, and administrative expenditures. In FFY 23:

- $965,523 was expended on Preventive & Primary Care for Children, which was higher than the budgeted amount of $832,857
- $776,628 was expended on Children with Special Health Care Needs, which was slightly more than the budgeted amount of $765,410
- $183,628 was expended on Administrative costs, which was less than the budgeted amount of $232,318

Funds are distributed to the CPHDs using a formula which considers the size of their maternal and child populations, along with oversampling for those who are at or below the federal poverty level. These CPHDs are often the only source for enabling and public health services for their community. In FFY 23, $996,000 was distributed to 49 CPHDs to address their selected National/State Performance (N/SPM).

In FFY 23, CPHDs served 2,889 American Indian (AI) residents in the MCH population categories (unduplicated numbers). Statewide, this was 9% of their total MCH clients served. For CPHDs which share a geographic area with a reservation, the AI percentage of unduplicated numbers served rose as high as 64%.

The CPHDs reported $3,164,626 for their FFY 23 match amount. The CPHD's match, combined with the State's MCH funds of $2,634,577 and program income of $2,888,530, made the MCHBG total match far exceeded the $3 to $4 requirement. The state match was slightly over 24 times the required 1989 Maintenance of Effort of $485,480.

Estimating the FFY 23 budget relied on financial information and programmatic data previously collected and reported to complete Forms 3a, 3b, 5a, and 5b. The differences between budgeted and expended amounts were largely created by fluxuations in the numbers per populations served by the CPHDs.

Form 3a. Types of Individuals Served: Title V MCHBG		
Population	**Budgeted**	**Expended**
Pregnant Women	$93,466	$90,003
Infants < 1 year	$200,192	$192,358
Children 1 – 21 years	$957,134	$965,523
CSHCN	$697,267	$776,628
Others	$163,372	$158,330
Total	$2,111,431	$2,182,842
Form 3a. Types of Individuals Served: Non-Federal MCHBG Funds		
Pregnant Women	$207,010	$202,498
Infants < 1 year	$3,762,219	$3,669,887
Children 1 – 21 years	$3,007,821	$2,816,665
CSHCN	$426,602	$114,614
Others	$1,723,576	$1,795,653
Non-Federal Total	$9,127,228	$8,599,307
Federal/State Partnership Total	$11,238,659	$10,782,149

Form 3b: Types of Services: Title V MCHBG	Budgeted	Expended
Direct: Preventive/Primary Care Women, Mothers, Infants < 1	0	0
Direct: Preventive/Primary Care	0	0
Direct: CSHCN	$50,000	0
Enabling	$1,383,804	$1,440,594
Public Health Services & Systems	$889,377	$925,876
Form 3b: Types of Services: Non-Federal MCHBG Funds		
Direct: Preventive/Primary Care Women, Mothers, Infants < 1	0	0
Direct: Preventive/Primary Care	0	0
Direct Services CSHCN: Physician/Office Services	0	0
Direct Services CSHCN: Laboratory Services	$315,000	$4,149
Direct Services CSHCN: Other Therapies	0	0
Enabling	$4,574,571	$4,533,269
Public Health Services & Systems	$4,191,616	$4,150,314
Non-Federal Total	$9,081,187	$8,687,732

The CPHDs FFY 23 Financial & Data Reports stated:

- 30,004 Group Encounters (some duplicated count)

- Unduplicated Number of Persons Served:
  - Pregnant Women 1,379
  - Infants 4,228
  - Children 1 through 21 18,021
  - CYSHCN 886
  - Others MCH 7,024

  Total 31,538

- Racial demographics (self-identified):
  - White: 23,748
  - American Indian: 2,889
  - More than one Race 883
  - Other/Unknown 3,731

In addition to MCHBG funding, the federal and state funds awarded in FFY 23 supported other FCHB programs focused on the maternal and child population. This is illustrated in the following paragraphs and reported on Form 2. Additional details and specifics are in the FFY23 Annual Report N/SPM narratives.

The Childrens Special HealthServices (CSHS) Section's MCHBG FFY 23 expenditures supported these activities for NPM 11: Medical Home:

- Contracted with the HALI Project: Montana Parent Partner Program to provide peer services to families
- Collaborated with the *University of Montana Rural Institute for Inclusive Communities* (UMRIIC) to host the Montana team's participation in the National Care Coordination Academy.
- Butte 4-C's facilitated the Circle of Parents (COP) peer support meetings
- UMRIIC continued to:
  - Provide the Consumer Advisory Council (CAC) with evidence-based transition resources for their quarterly meetings and distribution to the CAC interested parties.
  - Assist with the Montana Youth Transitions Conference.
- Collaborated with the Family to Family Health Information Resource Center (F2F) on a resource guide for families of CYSHCN moving to Montana.
- Financial Assistance Program (FAP), which covered items that were not covered by Medicaid, Part C, or private insurance, such as: an adaptive backpack for a child to participate in family outdoor activities; and a mobility harness.

In addition to focusing on MH/NPM 11, CSHS staff administered these Federal (F) and State (S) funded programs:

- Genetics, CSHS Cleft/Craniofacial Clinics, and Newborn Screening Programs: $1,609,775 (S)
  - Supported Cleft/Craniofacial clinics in four regional locations.
  - Blood spot specimen is collected 24-48 hours from birth and sent to the DPHHS Public Health Laboratory within 3 days.
    - Children and families in need of follow up worked with Shodair Children's Hospital.
- MAPP-Net: $850,000 (F)
  - Sponsored the third annual Symposium of Pediatric Mental Health.
  - Promoted and facilitated mental and behavioral health screening and follow-up through trainings, resulting in 181 inter-disciplinary providers were trained through MAPP-Net programming.
- Newborn Hearing: $310,000 (F)
  - Ensured that all newborns had their hearing screened by 1 month, diagnosed by 3 months, and enrolled in early intervention by 6 months.

The Maternal Child Health Coordination (MCHC)CHC Section ensured that the CPHD's expended their allocation on their selected N/SPM, and required Fetal, Infant, Child, and Maternal Mortality Review (FICMMR) Program injury prevention activities. Explained in detail in the Overview of the State, Montana has a "decentralized" system for providing public health services whereby local CPHDs are on the frontline for providing public health services.

The MCHBG and FICMMR Program Specialists (PS), both supported 100% with MCHBG funds, completed data quality reviews of the CPHD's reports: Quarterly; Annual Compliance & Activities; and Annual Financial & Data. The CPHDs'

approved reports generated their MCHBG payments, with final authorization by the Title V MCHBG Director/MCHC Supervisor.

The MCHBG PS: worked directly with the 25 CPHDs that selected *SPM 1: Access to Care and Public Health Services,* and the13 CPHDs that selected *SPM 2: Family Support and Health Education*; provided technical assistance (TA) as needed to all the CPHDs, i.e. completing their required reporting; training on evidence-based/informed activities; and was the Project Manager for the FFY 22 Annual Report & FFY 24 Application. The FICMMR PS: worked directly with the 6 CPHDs that selected NPM 5: Safe Sleep; completed Quality Assurance on the Child Death Review (CDR) reports submitted by the CPHD FICMMR Teams; ensured that the CPHD's injury prevention activity was evidence-based or evidence-informed; and throughout the year, provided feedback on their quarterly reports.

In addition to administrative oversight of the MCHBG funding, the Title V MCHBG Director/ MCHC Section Supervisor supervised staff responsible for additional federal and state funds that supported the maternal and child population. These funds created the following programs and focus:

- Montana Obstetrics and Maternal Support (MOMS): $2,168,159 (F)
  - NPM 1: Well Woman Visit TA.
  - Raise and elevate the importance of woman's health.
  - Innovative approaches for accessing pre/post-natal care and substance abuse treatment for pregnant women.
- Grants to States to Support Oral Health Workforce: $400,000 (F) & $100,000 (S)
  - NPM 13.2: Children's Oral Health TA
  - Dental students provided oral health services in Dental Health Professional Shortage Areas (HPSA).
  - Graduate nursing students provided education, screenings, and referrals to American Indian Head Start Programs.
  - Pre-Professional Oral Health student pipeline programs
  - Tribal pediatric oral health messaging campaign
- Maternal Mortality Review and Prevention: $370,000 (F)
  - Data analysis and reporting can be used to support MOMS's activities and MCHBG 2025 Statewide Needs Assessment priority selection.
- Primary Care Office: $159,613 (F)
  - All the N/SPM.
  - Data analysis determined the Primary Care, Dental, and Mental HPSA designations.
- State Loan Repayment Program: $174,190 (F) & $100,000 (S)
  - All the N/SPM.
  - Student loan repayment assistance for certain healthcare providers practicing in a HPSA

The Adolescent Health PS expended $850,887 in federal funds by partnering with high schools, colleges and universities, non-profits, UMRIIC, and Yarrow, Inc. The funding streams were the Pregnancy Risk Education Program (PREP), thePreventive Health & Health Services Block Grant, and Rape Prevention Education (RPE), and Sexual Risk Avoidance Program (SRAE).

Referrals to, and providing educational materials about, the FCHB's Healthy Montana Families (HMF) and WIC Programs were often mentioned in the CPHDs' performance measure reports. HMF and WIC also distributed FCHB and ECFSD specific programmatic resources, such as: suicide prevention, safe sleep, bullying prevention, Healthy Montana Mouths, childcare locations, and FAP information to their consumers. In FFY 23, WIC funding totaled $17,629,922 (F) and $7,627 (S) and HMF received $4,349,780 (F) and $592,329 (S).

III.D.2. Budget

For FFY 2025, Montana's Title V MCHBG Program (MCHBG), housed in the Family and Community Health Bureau (FCHB), is requesting $2,323.181. Administrative oversight of the FFY 25 budget is a collaborative effort by the Fiscal Bureau Analyst (FAB), and staff in the Maternal and Child Health Coordination (MCHC) and Children's Special Health Services (CSHS) Sections. The MCHC and CSHS MCHBG Program Specialists (PS), the Title V MCHBG and CYSHCN Directors, and FAB have monthly budget meetings which ensure the required 30%-30%-10% requirements will be met for: Preventive and Primary Care for Children; CYSHCN; and Administration. The FFY24 budgeted expenditures are as follows:

- Preventive and Primary Care for Children: $832,857 (35.8%)
- Children with Special Health Care Needs: $765,410 (32.9%)
- Title V Administrative Costs: $232,318 (10%)

Montana (MT) has always contributed the 1989 Maintenance of Effort amount of $485,480. The State Legislature establishes the biennial budget support for programs' state revenues. For FFY20 through FFY24, the state funding average was $3,210,553. For FFY25, FCHB programs will receive $3,082,402 state funds. Certain state funds are tied to legislative rules, and are restricted in their expenditure, i.e., can only support state staff or be expended on contracted services. State funds will help support programs administered by FCHB, CSHS, MCHC; Healthy MT Families (HMF); WIC; and Adolescent Health (AH) staff. The state funds, when combined with the estimated $3,164,626 in matching funds from the 50 County Public Health Departments (CPHDs), and $2,834,159 in program income, will exceed the required $1,742,386 needed to meet the $3 match in non-federal funds for every $4 in MCHBG funding.

The CPHDs will receive $1,037,445 from the MCHBG, distributed per the funding formula as required by MCA Section 501 to 510 [42 U.S.C. 701 to 710]; and ARM 37.57.1001. CPHDs will utilize the funds in accordance with details submitted in their FFY25 Operational Plans (OP). The OP includes activities and evaluation plans to address their chosen National/State Performance Measure (N/SPM). The MCHBG funding also supports the CPHD's required *Fetal, Infant, Child, & Maternal Mortality Review* (FICMMR) injury-prevention activity. To ensure that the CPHDs' fiscal reporting accurately reflects their MCHBG expenditures, the MCHBG PS provides annual fiscal reporting training.

The Children's Special Health Services (CSHS) Section will provide services to all children with and without special health care needs, from their FFY25 budget of $3,723,103, which includes these funding streams: MCHBG: $697,267 State funds: $1,940,836; and Federal funds: $1,085,000.

The CSHS Section will continue their contractual oversight and partnerships, which provide gap-filling services, such as peer support and resource coordination, to address and ensure that CYSHCN have access to a medical home (MH / previously NPM 11). In the coming year, MCHBG funding will support:

- Peer Support Services: offered by MT Peer Network (MPN) and the Early Childhood Coalition of Beaverhead County (ECCBC) Canvas Early Learning Center.
- Youth Peer Support: new partnership with the Great Falls Area Chamber of Commerce (GFACC) Leadership High School (LHS) program
- Transitions Project and program evaluation: University MT Rural Institute for Inclusive Communities (UMRIIC).
- Financial Assistance Program: for qualifying families of CYSCHN or foster care child, will provide assistance for services outside the scope of Medicaid, CHIP, or private insurance.
- Title V MCHBG Family Delegate role.
- Purchase of assistive equipment and adaptive technology for Mon-Tech's lending library
- Sponsorship of the half-day conference organized by the MT Chapter of the American Academy of Pediatrics.

MCHBG funding will support the CSHS PS (100%) and the CSHCN Title V Director/Section Supervisor (75%). In FFY24, the CYSHCN-focused programs listed in the following bullet points will receive support from the remaining CSHS state and federal funds. They will receive contract oversight and technical assistance from: the CSHS Nurse Consultant; the MT Access to Pediatric Psychiatry Network (MAPP-Net) PS and the Newborn Hearing Screening (NBHS) PS:

- Cleft/Craniofacial Clinics: An interdisciplinary care team was selected based on their Request for Proposal (RFP) application to provide services to children and their families. Contract executed in December 2023.
- MT Statewide Genetics Program: Genetic testing and counseling services, provider consultations, and education on genetic conditions through a contract with Shodair Children's Hospital.
- Metabolic Services: Shodair Children's Hospital is contracted to offer metabolic clinics and long term follow-up services for families identified by the Newborn Bloodspot Screening (NBS) program.
- CSHS and the DPHHS Public Health Laboratory collaborate on ensuring an infant and their family receive additional

services based on NBS test results.
- Resource navigation projects, such as a resource tool for families who are considering moving to MT.
- MAPP-Net: Primary care providers and behavioral health specialists will be connected to education and consultation services to meet the mental health needs of the children and youth they serve.
- NBHS: All infants are provided with NBHS and resources, following the 1-3-6 Early Hearing Detection and Intervention guidelines established by the Joint Committee on Infant Hearing.
- The Newborn Screening Committee, which is charged with reviewing the panel of required screenings and recommending any additions or removals.

In FFY25, the MCHC Section will be supported with $200,000 in state, and $ 3,300,395 in federal funding. The Title V MCHBG Director/MCHC Section Supervisor will oversee the three following programs:

The *MCHBG* PS serves as the primary contact for the 50 participating CPHDs, which includes: providing training, technical assistance (TA), and resources on: their selected National and State Performance Measures (N/SPMs); Operational Plans; Contracts, Semi-Annual Reports; Annual Compliance & Activities Reports; and Annual Financial & Data Reports. The MCHBG PS will be the subject matter expert for 30 CPHD's working on SPM 1, and 13 CPHD's working on SPM 2; and refer the CPHDs to FCHB/MCHC staff who are positioned to address specific inquiries regarding NPMs for: Well-Woman Visit; Infant Safe Sleep; Bullying Prevention; and Preventive Dental Visit – Child (previously 1, 5, 9, and 13.2). In FFY24, the MCHBG PS is scheduling approximately 17 CPHD in-person site visits. These visits help to build working relationships, and increase understanding of local environments and challenges.

The MCHBG PS, who is 100% MCHBG-funded, is the Project Manager for the *FFY25 Application & FFY23 Annual Report*. The PS is also the MCHBG 2025 Statewide Needs Assessment contract liaison with UMRIIC. The MCHBG and FICMMR PSs will provide their contractually required Annual MCHBG and Quarterly FICMMR Trainings, and offer new CPHD staff trainings on an as-needed basis.

The *FICMMR* PS will ensure that the required CPHDs' annual FICMMR injury-prevention activity has an evidence-based or informed foundation, and their Semi-Annual Reports and Annual Compliance & Activities Reports reflect their stated activity and evaluation plan. In FFY24, the FICMMR PS, who is 100% MCHBG-funded, is fulfilling the following duties: subject matter expert to the seven CPHDs that opted for Safe Sleep / NPM 5; collaborate with the Department of Justice's Coroner Liaison upcoming local coroner's infant safe sleep training; and be a resource to the Maternal Mortality Review Program Nurse Consultant/Grant Administrator.

The *MT Obstetric and Maternal Support* (MOMS) Program is in its fifth year, focusing on raising awareness about the importance of maternal health. The program's aim is to decrease the state's maternal mortality and severe maternal morbidity rates, by implementing and evaluating maternal health innovations. The funding supports the MOMS PS, who provides: TA to the one CPHD that selected Well-Woman Visit / NPM 1, and two CPHDs that are focusing on women's preventive healthcare activities for SPM 1; and will continue to collaborate with the Public Health and Safety Division STD/HIV/Viral Hepatitis Section's effort to increase awareness on how to prevent syphilis. MOMS will continue to contract with the *University of Montana Rural Institute for Inclusive Communities* (UMRIIC) staff to conduct evaluation analysis of the Billings Clinic's (BC) MOMS-funded programs. In FFY25, BC will continue to offer ECHO clinics; Empaths Perinatal Substance Treatment System; and Cuddling Cubs, a virtual postpartum support group.

The MT Maternal Mortality Review and Prevention (MMRP) Program, funded by the *CDC Enhancing Reviews and Surveillance to Eliminate Maternal Mortality* (ERASE MM) *Initiative*. The Nurse Consultant/Grant Director has completed abstracting all the available records for the Calendar Year 2020 maternal deaths. The MT Maternal Mortality Review Committee (MMRC) has discussed and provided prevention recommendations for the maternal deaths and a published recommendation report will be finalized in summer 2024. The MMRC results have been documented in the CDC MMRIA data system.

UMRIIC's contract, to provide MMRC meeting facilitation and technical assistance, was amended to include completing family member interviews, to further gauge the preventability of the maternal death. UMRIIC will utilize the report on the prevention recommendations as an additional tool to raise awareness on the importance and contributing effects social determinants of health have on optimal maternal health.

The MMRP and MOMS staff began collaborating with the DPHHS Director of the Office of American Indian Health to establish a formal data sharing agreement with each Tribal Government. A letter signed by the DPHHS Director was sent to the Chairman/woman of each tribe, requesting they ratify a resolution to recognize a partnership in reviewing tribal maternal deaths and sharing recommendations.

The FCHB also includes: Healthy MT Families (HMF) Home Visiting; the Supplemental Nutrition for Women, Infants, and Children (WIC) program; and two Adolescent Health PSs, who are supervised by the Community Health Section

Supervisor.

The *Healthy MT Families (HMF) Home Visiting* services will support maternal, infant, child, and CYSHCN populations by funding four evidence-based home visiting models: Parents as Teachers; Nurse-Family Partnership; SafeCare; and Family Spirit. In FFY25, state ($692,980) and federal MIECHV ($5,055,000) funding will support the HMF Supervisor and three PSs. The HMF staff will oversee 18 home visiting programs in 16 counties, three within tribal agencies.

The *WIC* Program will have 34 local WIC Agencies, which includes seven Tribal Agencies, and about 120 farmers participating in the WIC Farmer's Market Program. WIC's estimated $17M in federal funds, and $9K Farmer's Market match, also support: the WIC State Director; Nutrition Coordinator; two Public Health Nutritionists, one who is the Breastfeeding Coordinator; Marketing and Continuous Quality Improvement PS; Farmer's Market PS; Vendor Lead PS; and two Information Technology positions. Families will have access to WIC's: nutritional education; food packages; breastfeeding consultations; and fresh fruits and vegetables from Farmer's Markets.

Adolescent Health (AH) will continue their partnerships with: community-based organizations; schools; Tribal Public Health Departments; and colleges. These partners will be contracted to provide services to ensure that Montana youth have optimal physical, mental, social, and reproductive health. Adolescent health is solely funded by federal grants that will total $850,887 in FFY25. The federal grant funds include Title V/Sexual Risk Avoidance Education (SRAE); Rape Prevention and Education (RPE); Personal Responsibility Education Program (PREP); and, by collaborating with the Public Health System Improvement Office, funds from the Preventive Health & Health Services Block Grant.
As an example of AH partnerships, RPE's contracted partners include: 8 Colleges; 27 Middle Schools; The Montana Coalition Against Sexual and Domestic Violence; 1 non-profit organization (Domestic and Sexual Violence Services); and 2 private for-profit partners (Yarrow LLC., and Windfall, Inc.). Missoula CPHD is a non-contracted partner. The RPE PS serves as the liaison with Yarrow, LLC for completing the Adolescent Health Needs Assessment.

The new Early Childhood & Family Support Division structure moved the State System Data Initiative, and Pregnancy Risk Assessment Monitoring System programs into the Business Systems/Operations Bureau. These programs are crucial for all of FCHB's federal reporting requirements. In FFY25, SSDI will receive $100K (federal only) and PRAMS $175,000-federal and $4,694-state special revenue.

For FFY25, the MCHBG, along with state and local partnerships, is budgeting $38,541,682 for maternal and child health-focused programs. These programs seek to improve the lives of all women, infants, children, CYSHCN, and adolescents living in MT.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Montana

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

Montana's Title V Maternal & Child Health Block Grant (MCHBG) is housed in the Early Childhood and Family Support Division (ECFSD). Established in January 2020, ECFSD is one of 12 divisions in the Department of Public Health and Human Services (DPHHS). As it continues to evolve, its programs focus on early care and education, food security and nutrition education, violence and neglect prevention, family support, and preventative health care.

The ECFSD mission: "*provides coordinated services and resources to promote well-being and support the health and development of children, Individuals, families and communities*" aligns with the DPHHS mission of "*servicing Montanans in their communities to improve health, safety, well-being, and empower independence.*" To learn more about DPHHS go to: https://dphhs.mt.gove/AboutUs/index

Strategic planning by ECFSD leadership recognized the importance of data collection and analysis, and the connection to fiscal accountability for its family-focused programs. These programs garnered over 159 million dollars from state general fund, state special revenue, and federal funds in FY24. ECFSD leadership recommendations approved by DPHHS leadership resulted in the creation of the new Business Systems & Operation Bureau (BSOB). This bureau now supports data collection, GIS mapping, data systems creation and maintenance, and data evaluation and analysis.

ECFSD leadership acknowledges that family-focused programs need assistance with data collection and analysis, to make data-driven decisions for programmatic intervention and prevention services. Program staff within the BSOB are now well-positioned to implement evidence-based interventions, and to market and promote programs to target populations. Fiscal Bureau staff work closely with ECFSD program staff on the division's over 1,000 contracts and agreements, for services with various organizations and businesses throughout the state.

Montana's Title V Maternal & Child Health Block Grant (MCHBG) is in the Family and Community Health Bureau (FCHB), one of five ECFSD bureaus. As the name indicates, the FCHB administers programs that provide services to the state's maternal and child health population and their families. Direct MCHBG administrative oversight is shared by the Title V MCHBG Director and CSHS Director, who are also Section Supervisors for the Maternal and Child Health Coordination (MCHC) and Children's Special Health Services (CSHS) sections. The FCHB also includes the Supplemental Nutrition for Women, Infants, and Children (WIC) Program, the Healthy Montana Families Home Visiting Section, and the Community Health Section.

The CYSHCN Title V Director and the CSHS staff members are focusing their *NPM 11: Medical Home* population strategies by prioritizing: family engagement; provider engagement; coordinated care; and systems building into their activities. The activities are provided through partnerships, both longstanding and new, to ensure that the 30% allocation CSHS receives from the MCHBG provides services to Montana's CYSHCN population and their families.

The NPM 11 narratives offer insight into the long-standing partnerships with the University of Montana Rural Institute of Inclusive Communities (UMRIIC), the University of Montana Family-to-Family Health Information Center (F2FHIC) and the Montana School for the Deaf and Blind. New partnerships have been established in response to CSHS seeking entities to provide Peer Support Services, these include: the Montana Peer Network (MPN), and the Early Childhood Coalition of Beaverhead County (ECCBC)-Canvas Early Learning Center.

CSHS Family Peer Support Program is in the final year of the RFP that was issued in FFY23. CSHS will release another RFP in FFY24, to provide funding for family-centered peer support services. These peer support services are designed to improve access to a medical home, and to support CYSHCN families in navigating the system of care. The ECCBC has continued the role of using the Circle of Parents model as an option for CYSHCH families. Applying lessons learned from the previous Peer Support Services providers, CSHS staff meet quarterly with MPN and ECCBC to provide technical assistance and to ensure their expansion plans are met. Data indicates that both service providers are on track to meet or exceed the agreed upon number of families to receive services.

According to the American Academy of Pediatrics, challenges can occur if parents of children with disabilities lack respite, coping skills, or adequate social and community support. Education and support by peers for families of CYSHCN, related to a child or youth's medical condition, may increase coping and resilience in some families. The core values of support include building on the strengths and needs of the youth and family. This approach has resulted in improvement in multiple domains of individual and family functioning, including: the reduction of family stress and strain and increased behavioral and emotion strengths in children.

The CSHS' focus on Youth Peer Support has generated a partnership with the Great Falls Chamber of Commerce (GFACC) Leadership High School (LHS) program. By pairing a LHS student with a special education student, both students benefit from the relationship. The evaluation plans provided data that determined the special education student met their transition goals and impacted the understanding from the LHS of students with special needs. Data-aided determinations continue the expansion of the Youth Peer Support program.

Over many years, the CYSHCN Title V Director has been promoting the integration of the Title V MCHBG Family delegate as a paid position. In July 2022, the Family Delegate became a F2FHIC staff member. They have supported and advised the CSHS on policy and resource navigation and program alignment. Their lived experience, as a parent of a child with special health care needs, has guided program implementation and the program's ability to maneuver through the mental health system of care.

Montana's approach to providing public health services is prescribed in the Montana Code Annotated (MCA). Title 50: Health and Safety. Section 20-1-202: *Public health services in Montana are provided via a decentralized system of care*. The decentralized system equates to each county having their own County Public Health Department (CPHD), which is governed by the elected county commissioners and local boards of health. MCA Rule 37.57.1001 delineates the standards for how Title V MCHBG funds are allocated by CPHDs. "*In distributing MCH block grant funds, the department will give priority to the counties, regions, and communities with the least resources, the largest proportion of underserved families and the most serious maternal and child health problems and will determine who should have priority by utilizing objective health indicators."* The CPHDs are also required to implement an injury-prevention activity, as mandated by the Fetal, Infant, Child and Maternal Mortality Review Program (FICMMR) MCA-50-19-401-406.

In Montana, geographic disparities in rural areas account for a significant percentage of underserved families. In contrast to the relatively small population, the state's large geographic area is a primary challenge for providing services to its maternal and child residents. The MCHBG staff also recognizes that health disparities impact Montana's American Indian population, which, according to the July 2023 U.S. Census estimate for Montana, was 6.5 %.

CPHDS who elect to receive MCHBG funding collect data on the number of county residents they serve, which includes their self-identified race. In FFY 23, the 50 participating CPHDs reported that 9% of their MCH clients identified as American Indian. The MCHBG staff continues to be intentional when looking at the funding distribution plan, and including tribal populations in funding formulas.

Historically 41% of annual MCHBG funding is allocated to the CPHD's, per the MCA Rule: 37.57.1001. As a condition of receiving MCHBG funding, the CPHDs submit details for an annual Operation Plan (OP) for their National or Sate Performance Measures (N/SPM), and an injury-prevention activity. The OP encourages the CPHDs to consider the results of their county health needs assessment to determine which N/SPM would be most beneficial to the residents their county serves.

The CPHDs have been presented with numerous trainings focused on evidence-based/informed or best practice activities, provided by the MCHBG and FICMMR Program Specialists (PS). The CPHDs are tasked to provide details on their planned activities; identify their goals and evaluation plans; and list data sources. Most of the CPHD activities are evidence-based/informed or best practice, but they are allowed the opportunity to innovate on at least one if desired, and pilot new ideas for their unique operational environments. Their results are documented in Annual Compliance and Activities Reports, which capture the outcomes on their approved OP.

The MCHBG PS and FICMMR PS review the semi-annual reports. They provide technical assistance and feedback as needed. After the PS approval of the reporting deliverables, the Title V MCHBG Director authorizes the associated CPHD payment.

Having the Title V MCHBG housed in the ECFSD has been beneficial to the maternal and child health population of Montana. ECFSD leadership hosts monthly meetings for all program section supervisors. These meetings are a platform for the 20+ attendees to learn about new DPHHS or ECFSD resources and programs. This information is shared with the CPHDs and CSHS contractors when applicable, to help increase their knowledge and program collaboration.

Partnerships, which are the foundation for the state-level Title V MCHBG Program, are also important to the CPHDs and their ability to make a difference in the lives of the county residents they serve. The CPHDs report on their successes, challenges, and partnerships that have contributed to their OPs in their semi-annual and annual reports. A sample of the CPHD's FFY 23 partnerships include these state programs: WIC, Immunization, Oral Health, Public Health Emergency Preparedness, Healthy Montana Families, and Child Abuse and Prevention. The DPHHS electronic referral system, CONNECT, was also a partnership for several of the CPHD's that selected SPM 2.

The *Healthy Mothers Healthy Babies* (HMHB) *Linking Infants and Families to Support* (LIFTS) was an online resource tool which continued to be utilized in FFY 23. It helps families seeking services and looking for ways to address social determinants of health needs. The HMHB *Safe Sleep for Baby Program* is also frequently mentioned as an important partnership. In FFY 24 these partnerships, among others, are pivotal for the 32 CPHDs focusing on *SPM1: Access to Public Health Services*. There are also critical to the 13 CPHDs working on *SPM 2: Family Support and Education*, which helps to address social determinants of health.

Progress addressing *NPM 1: Well-Women Visit* relies on the partnership with the Montana Obstetric and Maternal Support (MOMS) Program, funded through the HRSA Maternal Health Innovations Grant. MOMS is entering the 5th year of the grant.

The program partners with Billings Clinic to provide program services, and the University of Montana Rural Institute for Inclusive Communities Program (UMRIIC) to provide program evaluation. The program services that Billings Clinic provides to support NPM 1 include:

- Project ECHO (Extension for Community Healthcare Outcomes) Model: an efficient model to meet maternal health workforce needs. Over 120 unique participants attended the 14 Project ECHO clinics this past year, including healthcare professionals, staff from social service agencies and medical and nursing students.
- Simulation in Motion-Montana (SIM-MT): Simulation training opportunities for non-birthing and birthing facilities for trauma care and dangerous patient events. Four trainings were held in four counties with 40 healthcare professionals attending the trainings. These focused on trauma in pregnancy, postpartum hemorrhage, preeclampsia, and shoulder dystocia.
- Indigenous and Recovery Doula Training: Training was conducted over a four-day period, with sixteen people attending the training. Topics included: grief and loss; pregnancy; traditional teaching tools; labor and birth; postpartum; and caring for the caregiver.

Montana's efforts to raise awareness on the importance of maternal health was heightened with the *CDC Enhancing Review and Surveillance to Eliminate Maternal Mortality Grant* (ERASE MM). The MCHC Program began receiving ERASE MM funding in 2020. This grant formalized the creation of the *Maternal and Mortality Review and Prevention Program* (MMRP) that oversees the work of Montana's *Maternal and Mortality Review Committee* (MMRC). Maternal mortality is a sentinel indicator of population health in Montana. Maternal mortality rates reflect the health of women, children, and families in Montana; rates also reflect the capacity of our systems that support the health and well-being of this population.

The MMRP provides structural support for the MMRC. This committee reviews maternal deaths in Montana that occur during or within the year following pregnancy, to determine pregnancy-related status, preventability, and provide recommendations to prevent future deaths. These recommendations are designed to increase the capacity of Montana's medical, public health, legal, and socioeconomic systems to improve maternal and family health outcomes. The MMRP works closely with communities and partners to disseminate recommendations and develop them into actionable strategies. Additionally, this program analyses maternal deaths to provide epidemiological reports to inform the public and other stakeholders about the state of maternal mortality in Montana. UMRIIC is instrumental in providing the analysis for the MMRC recommendations, and a report for DPHHS is being finalized for distribution.

As noted in the *NPM 5: Infant Safe Sleep* narratives, county coroners around the state have been trained by the State Coroner Liaison on how to use a safe sleep doll for death scene reenactments. This partnership has been very effective in FICMMR coordination efforts. Additionally, the initial creation of an online Safe Sleep Data Dashboard for Montana took place in FFY24 and is being finalized.

The advertising agency Windfall, Inc. continues to be a *NPM 9: Bullying Prevention* partner, and is assisting state-level staff with a MCHBG-funded bullying prevention social media campaign. Yarrow, LLC is an additional NPM 9 partner. The Yarrow staff is finishing up the Adolescent Health Needs Assessment and these results will be incorporated into the MCHBG 2025 Statewide 5-Year Needs Assessment.

The *Grants to States to Support Oral Health Workforce Activities* helps the state to address the oral health care needs of anyone living in counties designated as a Dental Health Professional Shortage Area (HPSA). The Oral Health (OH) program relies heavily on partnerships with the University of Washington School of Dentistry, Montana State University College of Nursing, WIM LLC, Yarrow LLC, and the Montana Office of Rural Health/Area Health Education Center.

In FFY24 the OH program supported the technical assistance provided by Association of State and Territorial Dental Directors (ASTDD) for assessing the health care status of Montana's 3rd grade children. ASTDD determined the random school sample for the Basic Screening Survey (BSS) of 3rd graders, which was funded through the MCHBG. The BSS survey results updated the CDC Oral Health Data and will be used in the upcoming MCHBG 2025 Statewide 5-Year Needs Assessment.

Montana is currently following the national trend of experiencing a significant uptick in the number of syphilis cases among pregnant women, and concurrently an increase in congenital syphilis cases. MCHBG supported a statewide awareness campaign in collaboration with the Public Health and Safety Division's STD/HIV/Viral Hepatitis Section. Recognizing the need for ongoing collaboration to stem the increase in syphilis, the collaboration among state agencies will continue in FFY25.

Moving ahead to FFY 25, Montana's Title V MCHBG Program will continue to support consistency, efficiency, and coordinated services for children and families across the state. This is the context in which Montana's Title V MCHBG Program functions and carries out its purpose.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

Established in January 2020, the Early Childhood and Family Support Division (ECFSD) continues to evolve under the leadership of Tracy Moseman, who began as the Division Administrator (DA) in August 2022. The ECFSD is one of the 12 divisions in the Department of Public Health and Human Services (DPHHS). To learn more about DPHHS go to: https://dphhs.mt.gov/AboutUs/index.

The ECFSD's mission is: "*To better coordinate existing services for children and families.*" It aligns with the overall DPHHS mission of "*Serving Montanans in their communities to improve health, safety, well-being, and empower independence*."

In 2023, ECFSD leadership determined it would be beneficial to split the Early Childhood Services Bureau (ECSB) into two separate bureaus 1) Childcare and 2) Early Childhood Services. The Child Care Bureau is charged with ensuring that all families in need of childcare are aware of the resources to aide in selecting a provider as well as offering financial assistance.

The ECSB focuses on quality childcare service to ensure all children are cared for in an enriching environment that meets their physical, emotional, and social needs. Sections in ECSB include: Prevention & Early Intervention, Early Learning & Family Support, Child & Adult Care Food Program, the Preschool Development Grant Birth though Five Program, and Head Start State Collaboration. The Prevention & Early Intervention Section also includes: the Children's Trust Fund; and the Montana Milestones Part C Early Intervention Program.

In addition to this split, the Fiscal Bureau (FB) within the ECFSD was also divided to create another bureau, the Business Systems & Operations Bureau (BSOB). Now the FB is solely responsible for fiscal operations and oversees more than 30 funding streams, exceeding $84 million, and supporting over 20 programmatic activities through contracts. These contacts include: childcare providers; Head Start programs; universities; County Public Health Departments; healthcare providers; hospitals; community-based organizations; Tribal Health Department; and schools. The BSOB is home to staff responsible for managing ECFSD data systems, data collection, data analysis, and epidemiological support.

The ECFSD continues to have their work guided by the 2020-2025 ECFSD Strategic Plan that was finalized by Bloom Consulting in 2020. The strategic plan provides guiding principles, goals, objectives and strategies to the work being done by all ECFSD programs. In August 2023, Bloom Consulting conducted phase 2 of ECFSD Strategic Planning, which included addressing the guiding principle "*We are committed to staff and workforce development to support professional growth and ensure our programs are administered innovatively and effectively* ." Each Division sponsored their own strategic planning opportunities to prepare for the 2023 Phase 2 planning.

The Family and Community Health Bureau (FCHB) continues to utilize the expertise of Yarrow, LLC to lead them through strategic planning activities. A "Strengths, Weaknesses, Opportunities, and Threats" (SWOT) analysis was conducted to identify the FCHB priority areas of: Programmatic Development; Data Modernization; and Staff Culture and Communications. An additional outcome of the FCHB planning process was to assess the current structure and organization of the bureaus, funding, and staff. From this assessment a new section was created in the FCHB in 2024, the Community Health Section, which now includes: the Primary Care Office/State Loan Repayment Program; the Oral Health Program; Sexual Violence Prevention and Victims Services Program; and Adolescent Health Programs.

The ECFSD Leadership Team created the ECFSD Workforce Development Policy and Procedure (WDPP), which outlines expectations for all ECFSD positions and encourages individualized professional development. The WDPP aligns with TALENT, the State of Montana performance management resources system, which allows for each agency to develop agency-focused goals. The goals serve as a springboard for state employees to develop activities to track in alignment with professional and work-related goals. DPHHS identified these organizational goals:

1. Increase Efficiencies: examples include digitization, workflow improvements, business processes, identifying issues, and continuous improvement;
2. Improve Customer Service: examples include decreasing wait times, decreasing error rates, and customer satisfaction survey results;
3. Support a Strong, Healthy, and Resilient Culture: examples include improved recruitment/retention, employee recognitions, professional development, and continuous improvement;
4. Improving Quality of Care: examples include care coordination, quality measures, and data-drive decisions;
5. Improve the Well-Being, Independence and Self-Reliance of Montanans: examples include increased education and training programs, and increased participation prevention services and programs.

The TALENT expectations have evolved to require all state staff to review their goals twice a year and to have 1 comprehensive progress review with their supervisor. Program work performance is also discussed at reflective supervisor-employee meetings held a minimum of twice per month with immediate supervisor. The one-on-one meetings are viewed as opportunities to identify emerging training needs, troubleshooting challenges, or to provide feedback on areas of focus for quality improvement.

Annually, all employees are required to complete refresher trainings from DPHHS Human Resources (HR) and the Technology Services Division on topics such as: The Health Insurance Portability and Accountability Act (HIPPA); safety in the workplace; and cyber security. All DPHHS Supervisors, Bureau Chiefs, and Division Administrators are provided the opportunity to attend monthly LEAD webinar trainings. Topics have included managing a hybrid workforce, how to conduct employee progress reviews, and new employee onboarding and training.

In 2022 the Department of Administrative (DOA) conducted a statewide Remote and Office Work Study (ROWS) to determine what occupations groups might be eligible for continued telework, after the COVID-19 Pandemic. Results were release in September 2022, which identified the number of remote days employees were eligible for based on their job classification. These classifications and remote days continue to be updated yearly.

The Title V MCHBG Program, housed in the FCHB, is co-led by the Maternal and Child Health Coordination (MCHC) and Children with Special Healthcare Needs (CSHS) Section Supervisors. In their roles as Title V Director and the Title V/CSHS Director, they supervise staff who are responsible for programs that directly support the National and State Performance Measures (N/SPMs) and State Action Plan (SAP).

Partnerships are key to addressing the N/SPMs. As explained in the *Overview of the State* narrative, County Public Health Departments (CPHDs) are a significant partner in providing health and social services to the residents they serve. The MCHBG Program Specialist (PS) helps the CPHDs create an Operation Plan (OP) for their chosen N/SPM. The OP outlines their activities, evaluation plans, and goals. The MCHBG Program Specialist completes a Quality Assurance/Improvement review of each OP, and supports implementation of the CPHD activities as outlined. The MCHBG Program Specialist also oversees CPHD contracts and reporting.

The following table is a snapshot of Lead MCHC or CSHS Staff experts and partners:

NPM	Lead MCHC or CSHS Staff	Partnerships
1	MCHBG PS, MOMS PS, MMRP Nurse Consultant	CPHDs, Billings Clinic (BC), University of MT Rural Institute for Inclusive Communities (UMRIIC), Maternal Mortality Review Committee, DPHHS American Indian Health Director
5	MCHBG PS, FICMMR PS	CPHDs, Cribs for Kids Safe Sleep, Healthy Mothers Healthy Babies, Coroner Liaison from Department of Justice
9	MCHBG PS, FICMMR PS, Adolescent Health PS	CPHDs, high schools, Windfall Inc., DPHHS Suicide Prevention Coordinator, Yarrow, LLC
11	CYSHCN Title V PS, Newborn Screening PS, CSHS Nurse Consultant,	UMRIIC, BC, Great Falls Areas Chamber of Commerce, MT Peer Network, Early Childhood Coalition of Beaverhead County, MT School for the Deaf and Blind
13	MCHBG PS, Oral Health PS	CPHDs, University of Washington School of Dentistry, MT State University College of Nursing, MT Office of Rural Health/Area Health Education Center, Yarrow LLC, Blackfeet and Crow Tribal Headstart Programs

The FCHB programs that work directly with CPHD staff are aware of the need to be flexible in response to the reality of the CPHD work environment. Many staff work under multiple county programs, and recruiting and retention of qualified staff in rural and frontier communities continues to present a challenge. FCHB staff provide one-on-one training for new CPHD

staff as they come into new positions.

III.E.2.b.ii. Family Partnership

The Family & Community Health Bureau's (FCHB's) Children's Special Health Services Section (CSHS) and Maternal and Child Health Coordination Section (MCHC) are primarily responsible for ensuring that Title V Maternal & Child Health Block Grant (MCHBG) input is solicited from Montana's families and consumers. Family and consumer feedback and involvement are sought directly from surveys or participation at meetings. When feasible, their input is included in the State Action Plan objectives, goals, and activities. Family and consumer insights are also received from contractors working with the maternal and child population. CSHS contracts with family-led organizations to provide services and solicits their input on programs and initiatives.

CSHS's vision is to increase family and youth voice in program decisions. CSHS initiated several strategies to increase family voice in programs in FFY23, which have been implemented in FFY24. These strategies include:

- Continuation of a contract with the Family-to-Family Health Information Center (F2F) for the Association of Maternal and Child Health Programs (AMCHP) Family Delegate position. This position is embedded within and supervised by the F2FHIC. Tarra Thomas resigned from the position in April 2024. CSHS, in collaboration with the F2FHIC, hired two new individuals to fulfil this role, Erin Hoch and Kali Stubbs. These two individuals have lived experience and started in this role in February 2024, providing some overlap for Tarra to help provide training.
- Working on special projects in collaboration with F2FHIC to advance the voice of families and address critical needs. One example that was implemented in FFY23 and extended into FFY24, and beyond, includes planning a family panel for a half-day training for providers on quality of care related to complex care patients. The theme for FFY24 was transitions and the theme for FFY25 will be genetics.

Examples of parent engagement across MCHBG/CSHS programming:

- Family and consumer input were received from the Universal Newborn Hearing Screening and Intervention (UNHSI) Coordinator, who is working with two family-based organizations: the Montana School for the Deaf and Blind (MSDB) and MT Hands and Voices (H&V). They are contracted to increase family involvement and outreach to the families with Deaf/Hard of Hearing (D/HH) children.

    - The MSDB contract requires these organizations to offer a Deaf Mentor Program for D/HH children. The Deaf Mentors are trained through the SKI-HI Institute at Utah State University. During 2023, Deaf Mentor services continued to be in-person, with a virtual option available. Throughout 2023, services were provided to 18 families. Deaf Mentors also offered 34 online American Sign Language (ASL) classes, and 22 in-person.

    - In 2023, activities were held by the MT Hands & Voices Chapter. An in-person parent advocacy training was held in March of 2023 and was attended by 17 parents. CSHS is continuing the work of engaging with Deaf/HH families through activities such as: outreach events; support groups; playground days; ASL story times, and gymnastic days.

    - The UNHSI Coordinator also leads the 18-member UNHSI Learning Community (LC), composed of: five parents; a D/HH adult; audiologists; Early Interventionists; an epidemiologist; data manager; nurse consultant; and hospital screening staff. The LC focused on developing family-focused outreach and education materials and identifying strategies to reduce *Loss to Follow-Up* for newborn hearing screenings. Program staff provide outreach to various levels across the healthcare system and directly to families. Training opportunities are provided to program staff, family support specialists, and parents. In 2023, the UNHSI coordinator attended the Hands & Voices Family Leadership Conference in Grand Rapids, MI. In March of 2024, two professionals, the UNHSI Coordinator and the CYSHCN Director attended the national Early Hearing Detection & Intervention (EHDI) conference in Denver, CO.

- In FFY 2022, a Governor-appointed Newborn Screening Advisory Committee began convening on a bi-annual basis (at a minimum). It was created by legislation in the 2021 legislative session and is supported by a partnership between CSHS and the Public Health & Safety Division's (PHSD) Metabolic Newborn Screening (NBS) Program. Committee membership includes two individuals affected by the condition under consideration, or two family members of individuals affected, regarding conditions screened through the Metabolic NBS Program. The committee met three times in 2022, and twice in 2023. The focus of the first two meetings was to onboard the members and decide on by-laws, screening criteria and nomination process. In the following meetings, the committee started reviewing nominated conditions such as Krabbe, Adrenoleukodystrophy (ALD), and Pompe. A fourth condition, Gaucher, is on the fall 2024 agenda. ALD was passed unanimously and added to the Newborn Screening Panel with testing to begin August 2024. Pompe was reviewed in April of 2024 and will be voted on by the committee in late August 2024. The meetings are public and advertised on the DPHHS calendar.

- House Bill 619, passed by the 2023 Montana legislature, was an act to revise laws relating to the assessment of

language development in Deaf/Hard of Hearing (D/HH) children. This bill included the creation of a temporary committee to assist DPHHS and the Office of Public Instruction (OPI) in creating a parent resource on language development and establish language assessment standards. The committee had specific roles, such as: parent using ASL, parent using spoken language, Speech Language Pathologist, and Teacher of the Deaf. Thirteen members were chosen for the committee and the committee met six times from March through May of 2024. The end result was a parent resource tool and recommendation of language assessment standards for DPHHS and OPI.

- In FFY24, a Request for Proposal (RFP) was released to determine who will provide peer services across the state. Current organizations that hold these contracts include Montana's Peer Network and Canvas Early Learning Center. The RFP is aimed toward organizations which could provide individual, group or state-wide resource navigation peer services to CYSHCN families. Family-led organizations will be prioritized in the process to achieve the goals of increasing the delivery of family peer services in the state.

  Montana's Peer Network currently facilitates Family Peer Support, which is an individual direct service peer program for communities across Montana. Family Peer Supporters, who are parents of CYSHCN, work in clinics to support and provide referrals to families - and inform them of CSHS family, clinic, and community resources.

  In FFY23, 328 families across the state received Montana Family Peer Support services from the new contractor, Montana Peer Network. There was a total of 942 encounters. The decrease in encounters was expected with a new contractor taking over the peer support program. The number of families served, and respective encounters, have increased from FFY23 to FFY24 which CSHS understands is due to the project being in year 2 of 2. and Family Peer Supporters being able to continue and uphold relationships built with families in their respective communities.

  Circle of Parents, based on a national model of peer groups, is led by parents and other caregivers, and has a very strong emphasis on Parent Leadership. Circle of Parents groups are held in a variety of urban and rural counties across the state, and the program is led by two Parent Leaders. In FFY23 there were 8 groups across the state. As of June 1, 2024, there are eight groups and Canvas Early Learning/ Early Childhood Coalition of Beaverhead County is anticipating expanding to 11 groups before the end of FFY24.

- The CSHS Stakeholders' Group has not met since August 2022. This is due to full staff turnover in CSHS and the process of re-staffing the section. The next meeting scheduled will occur in-person, in August 2024. CSHS is soliciting feedback on the meeting agenda and format from critical partners, like the Family-to-Family Information Center and the Title V Family Delegates.

- CSHS contracts to fund work with the University of Montana's Rural Institute for Inclusive Communities (UMRIIC), which is a key source of family and stakeholder input. The UMRIIC leads the Consumer Advisory Council (CAC), a group of 15 consumers and family members in transition, and representatives who serve the population. The CAC works with CSHS staff to revise the Healthcare Transitions Guide as needed. UMRIIC and CAC staff raise awareness and provide educational information at venues such as conferences, vendor fairs, and monthly learning webinars. Attendee's feedback is shared with CSHS, integrated into quality improvement efforts, and aids in selecting future topics.

- In FFY24, CSHS continued to work with a committee to assist the CSHS Financial Assistance Program with reviewing applications to the program. The committee is composed of: CSHS staff; Family and Community Health Bureau staff; parent leaders; two staff from the Family-to-Family Information Center; and the Title V Family Delegate. The committee continues to meet on a regular basis to discuss and review financial assistance applications and determine how funding should be allocated.

Client and consumer satisfaction surveys are conducted regularly with the maternal and child population served by DPHHS programs. The results are included for programming decisions in an ongoing basis. Current examples include:

- County Health Public Departments (CPHDs) which accept MCHBG funding conduct a client survey and use the results to help with their program planning and selection of a national or state performance measure. The CPHD survey summary is a required annual deliverable.
- The Supplemental Nutrition Program for Women, Infants, and Children (WIC) conducts an annual client/participant survey.
- MOMS supported the MCHBG with several studies aimed at informing challenges and nuances related to the *NPM1: Well-Woman Visit*. MOMS contracted with UMRIIC to conduct, administer, analyze, and report out the following:
  - *MOMS Postpartum Care and Contraception Study* to improve postpartum access to contraception; provider familiarity and expertise with postpartum contraception provision; and to understand behavioral health screenings provided during postpartum visits.

- *The Provider Survey: Understanding and Improving Barriers to Treatment and Care of Substance Use Disorder* to identify provider bias related to treatment and care of pregnant women with substance use disorder.
- *Facilitators and Barriers to Seeking Treatment and Care of Postpartum Depression* to identify risk and protective factors associated with seeking care for postpartum depression symptoms among Montana women who use substances or those with mental health concerns.
- *Maternal Health Care Experiences Survey – Wellness Visit Survey Module* to gather information on patient access to, and experiences with, the women's wellness visit to contribute to the MCHBG Needs Assessment. The wellness visit survey module gathered information on health care utilization (annual wellness visit, and having a wellness visit the year before pregnancy); services included (physical exam, health history, health screening(s), reproductive life planning); health screenings (cervical cancer, depression and/or anxiety, sexually transmitted infections, substance use, breast cancer, and other screenings); patient satisfaction; and an open-ended question on areas for improvement.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

Within the Early Childhood and Family Support Division (ECFSD), the Maternal and Child Health Epidemiology (MCHE) Staff consists of one Research Analyst Supervisor, two MCH epidemiologists, one Spatial Epidemiologist, one Data Support Specialist and two Program Evaluators. The MCHE Section is staffed by:

- Research Analyst Supervisor, Erin Dobrinen
- Pregnancy Risk Assessment Monitoring System (PRAMS) Coordinator/Epidemiologist, Kara Hughes
- Maternal and Adolescent Health Epidemiologist, Mary Duthie
- Data Support Specialist, Maren Weber
- Spatial Epidemiologist, Ellysse Boughey
- Program Evaluator, Melissa Lavindar
- Program Evaluator, Brittany Cory

Erin Dobrinen, MS, MAS, CPH has fifteen years' experience in laboratory and pharmaceutical research, including serving on an IRB review board, and three years' experience in public health including oral and maternal health epidemiology at a Tribal Epidemiology Center. She has a recent degree in Spatial Analysis for Public Health, and was trained by CityMatCH in maternal health epidemiology. Erin has held the position of Research Analyst supervisor since September 2023. Her designated roles/responsibilities include:

- PRAMS Principal Investigator and Grant Director
- State Systems Development Initiative (SSDI) Grant Director
- Supervision of the MCH Epidemiology Section
- Coverage for MCHE vacancies
- ECFSD projects as assigned

Kara Hughs, BS, CPH, is the Montana Pregnancy Risk Assessment Monitoring System (PRAMS) Coordinator and Epidemiologist Lead. She has worked for MT DPHHS for ten years in the areas of maternal health, teen pregnancy prevention, food access, referral systems, built environment, and chronic disease prevention. She has experience in program management and evaluation, stakeholder engagement, and policy development.

The Data Support Specialist, Maren Weber, BA was hired in November 2021. She has broad expertise in disabilities determinations, records management, and data handling and extraction. Her contributions include: PRAMS operations; Children and Youth with Special Health Care Needs (CYSHCN) Database Administrator for CSHS; the HiTrack data system; and the Child Health Referral Information System (CHRIS).

Ellysse Boughey, BS, is the State of Montana's MCH Spatial Epidemiologist hired December 2022. Ellysse has worked in the public health field since 2018, She has experience in community health assessments and improvement planning, policy analysis and development, commercial tobacco use prevention, and chronic disease prevention. Ellysse uses division data to make geospatial tools, including dashboards and interactive web-hosted maps to display programmatic data for the public.

Mary Duthie, MPH, is the Montana Maternal and Child Health Epidemiologist and Evaluator. She has worked in public health for over five years in the areas of maternal health, assistance, quality insurance, and chronic disease prevention. She has experience in program evaluation, data analysis, and grant writing and reporting. She joined ECFSD in October 2023.

Brittany Cory is the Program Evaluator for the Bright Futures Birth to Five initiative (BFB5), hired Fall 2023. She has previously worked in public health with the Montana Comprehensive Cancer Control program as well as the nonprofit setting. She holds degrees in Public Health and Health Sciences, and has experience in health education, chronic disease prevention, project development, systems evaluation, and policy engagement.

Melissa Lavinder, BS, is the State of Montana's Early Childhood Program Evaluator. Melissa has accumulated over ten years' experience working at DPHHS to support the well-being of children and families. She has experience in program administration, grant allocation processes, and stakeholder engagement. Her exceptional work is evidenced by her receipt of multiple service awards, including the Service to Children and Abby M. Zent Service Recognition awards. Most recently, Melissa served as a member of the CDC/Harvard Evaluation Practicum team for DPHHS, co-developing an evaluation plan for Montana's ARPA Child Care Innovation investments. She serves as the Program Evaluator for Montana's Maternal, Infant, and Early Childhood Home Visiting, and Universally Offered Home Visiting programs.

Montana has experienced fluctuations in MCHE capacity since its creation and has only recently (Fall 2023) become fully staffed.

- In 2017 Montana had 4.0 FTE MCHE positions: PRAMS; Maternal, Infant and Early Childhood and Home Visiting (MIECHV), SSDI, and an MCH generalist (which served as an epidemiologist for all non-MIECHV MCH programs).
- The MCHE Section was formed in October 2018, when the Public Health & Safety Division established state leads for its three main epidemiology subject matter areas: communicable disease, chronic disease, and maternal and child health. In 2018, MCHE capacity grew from 4.0 FTE to 7.0 FTE following the creation of three new positions: a

Senior MCHE Supervisor (i.e., the state lead for MCHE), an adolescent health epidemiologist, and an oral health/nutrition epidemiologist. These epidemiologists were directly supported with federal funding from their respective programs. The MCHE generalist was restructured to be a subject matter expert position for the Children and Youth with Health Care Needs (CYSHCN) and Fetal, Infant, Child, and Maternal Mortality Review (FICMMR) programs.

The section maintained this capacity until DPHHS underwent a restructuring in 2020 in which the Early Childhood and Family Support Division was created to house programs such as WIC, Title V MCHBG, and Childcare. In 2020, three epidemiologist positions were repurposed to non-epidemiologist roles (Adolescent Health, WIC/Oral Health, SSDI). A MCHE position for maternal health was created in 2022 to support the Enhancing Reviews & Surveillance to Eliminate Maternal Mortality (ERASE) grant awarded to Montana.

Montana has struggled to staff the MCH section due to high cost of living and a national shortage of epidemiologists. In the interim DPHHS relied on contractors to fill MCHE capacity. Montana made efforts to increase staffing in the MCH section including reclassifying positions to increase salary range and allowing partial telework. Now that staffing is complete DPHHS will focus on transitioning contracted work back to internal staff while supporting current staff with professional development opportunities.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

Montana is a State Systems Development Initiative (SSDI) grant recipient. The Senior Maternal & Child Health Epidemiology (MCHE) Supervisor serves as the SSDI Grant Director and supports the Title V Maternal & Child Health Block Grant (MCHBG) through record linkages for use in MCHBG reporting, as well as other MCHBG activities.

The purpose of the Montana State Systems Development Initiative (SSDI) is to improve maternal and child health (MCH) outcomes in Montana by increasing capacity to collect, analyze, and use reliable data for MCHBG policy and program development. SSDI funds support expansion of data linkages of key MCH datasets for analysis; improved access to and analysis of health equity data; and translation of data into action. Montana's SSDI Program has four key goals to ensure the purpose of the program is achieved:

1. Strengthen capacity to collect, analyze, and use reliable data for the MCHBG to assure data-driven programming.
2. Strengthen access to, and linkage of, key MCH datasets to inform MCHBG programming and policy development and assure and strengthen information exchange and data interoperability.
3. Enhance the development, integration, and tracking of health equity and social determinants of health (SDoH) metrics to inform MCHBG programming.
4. Develop systems and enhance data capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats.

These goals are met primarily through: funding to support technological solutions to improve the sustainability of Montana's MCH integrated data systems; supplemental data collection and reporting for the 2025 MCHBG Needs Assessment; and conducting maternal and infant health surveillance, specifically supporting the Pregnancy Risk Assessment and Monitoring System (PRAMS). SSDI funds support the attendance of the new MCHE supervisor at annual AMCHP and MCHBG Title V Federal-State Partnership Meetings allowing for valuable training.

The difficulty in maintaining staffing in the MT DPHHS Maternal Child Health Epidemiology Section (MCHE) over the past few years, detailed in the MCH Epidemiology Workforce section of this report, has delayed some of the SSDI workplan efforts. The recently fully-staffed MCHE and Business Systems and Operations Bureau (BSO) of MT DPHHS ECFSD now allows for reevaluation of the SSDI workplan to ensure that SSDI grant objectives support MCHBG work as comprehensively as possible, and this work is a priority in FFY24. The overarching goals and objectives for the SSDI grant and the activities performed to advance them in the FFY23 are detailed here:

Goal 1: Strengthen capacity to collect, analyze, and use reliable data for the MCHBG to assure data-driven programming. The BSO will achieve this by developing systems and enhance data capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats.

Objective 1: Support MCHBG MCH Block Grant program data needs associated with the 5-year Needs Assessment process and the annual needs assessment update.

- Montana completed the 2020-2025 MCHBG Need Assessment during the spring of 2020. Ongoing SSDI funded needs assessment activities include the implementation of a state-added PRAMS question to measure access to care and public health services, and ongoing consultation and coordination of Early Childhood & Family Support Division (ECFSD) needs assessment activities, including ongoing MCHBG needs assessment activities.
- The MCHE group is prepared to assist the MCHBG group in their data and visualization needs in the upcoming 5-year needs assessment. Secondary data assistance is anticipated for the timeframe of October through December 2024. Also, preliminary planning is underway for a web-based data dashboard and/or storymap, to make the results of the needs assessment more accessible. The project is scheduled to begin in FFY 2026.

Objective 2: Assist MCHBG programs with development, selection, refinement, and/or tracking of data and performance measures that are associated with the MCHBG performance measure framework.

- The Maternal and Adolescent Health Epidemiologist and MCHBG Director chose to evaluate the status of the *NPM1: Well-Woman Visit* in Montana's Medicaid program. The SSDI director is assisting in analysis.

Objective 3: Supporting data needs associated with annual preparation of the MCHBG application/annual report.

- The MCHE group provided data analyses and narratives for the MCHBG 2025 Application & 2023 Annual Report.

Goal 2: Strengthen access to, and linkage of, key MCH datasets to inform MCHBG programming and policy development and assure and strengthen information exchange and data interoperability.

Objective 1. Develop and implement a plan for overcoming barriers to data access and/or data linkage across the 5-year funding cycle.

- Within the ECFSD, a data sharing agreement template and tracking system has been created. Data Use Agreements (DUAs) are now in place for many of the SSDI minimum/core datasets, specifically those that: link PRAMS to Medicaid Part C; newborn screening; Maternal, Infant, and Early Childhood Home Visiting (MIECHV); Children's Special Health Services (CSHS); and Child Protective Services (CPS) data to develop a more comprehensive Children & Youth with Special Health Care Needs (CYSHCN) surveillance system.
- The ECFSD Data Governance Coordinator has initiated two groups to facilitate improved data access for ECFSD: a Data Sharing Agreement Committee and a Data Governance Committee. These groups include members across ECFSD including MCHE and FCHB and aim to facilitate data sharing across the department and division. The committees are currently developing standardized procedures for data sharing within ECFSD and with partners.

Objective 2: Work with other DPHHS divisions to develop and/or maintain an interagency agreement that defines data sharing responsibilities for the following: child maltreatment data, TANF, and SNAP.

- The ECFSD holds an interagency agreement to facilitate the matching and use of SNAP, Medicaid and WIC data.
- The Child & Family Services Division (CFSD) in MT DPHHS collects child maltreatment data. The Healthy Montana Families program has some access to coordinate home visiting services.

Objective 3: Collaborating with the state office that oversees vital statistics to assure access to MCH data.

- The MCHE group meets regularly with Montana Vital Statistics staff. As an essential data quality measure, the MCH Epidemiologist flags likely errors on birth and maternal death certificates and refers them back to Vital Statistics. The Vital Statistics office is currently without a statistician specializing in MCHE data and is in the process of hiring.

Objective 4: Enhancing information exchange systems and data interoperability across MCH partners and stakeholders.

- MCHE and Vital Statistics met with the CDC to evaluate joining CDC's NAPHSIS (or STEVE) system to facilitate the identification of incidents of Severe Maternal Mortality. A follow-up meeting is planned for this summer following necessary upgrades to Vital Statistics systems.

Objective 5: Designing systems that support access and linkage with key MCH data systems

- Several ECFSD data systems are currently being updated or procured, with the intention to ease access and linkage. However, none of these are SSDI funded.

Goal 3: Enhance the development, integration, and tracking of health equity and social determinants of health (SDoH) metrics to inform MCHBG programming.

Objective 1: Developing and tracking performance measures that can be used to assess the progress of MCHBG programs, policies, or initiatives in achieving health equity or addressing SDoH.

- The current MT PRAMS survey is designed to oversample American Indian/Alaska Native (AI/AN) mothers in recognition of persistent SDoH affecting this demographic in MT. The data may also be stratified to detect the effect of extreme rurality in frontier counties which are recognized by the March of Dimes to be Maternity Care Deserts.
- The Maternal and Adolescent Health Epidemiologist has conducted the evaluation for the *Power Up! Speak Out!* (PUSO) bullying prevention curricula, which was implemented with Rape Prevention and Education (RPE) funding in middle-schools across the state. The distribution and execution of the curricula was impeded by COVID restrictions, presenting a unique analysis challenge.

Objective 2: Working with community-based organizations to understand local data capacity, infrastructure, and needs for assessing progress in reducing disparities and achieving equity.

- No activity on this objective has occurred this funding cycle.

Objective 3: Conducting focus groups, environmental scans, or other data collection methods for obtaining

community feedback on priority needs for addressing SDoH that are contributing to disparities.

- The MT PRAMS steering committee includes community members as well as public health leaders. The Rocky Mountain Tribal Epidemiology Center (TEC) provides one epidemiologist to the steering committee.

Objective 4: Training MCH staff, partners, and community members to strengthen data capacity for understanding and addressing health equity.

- In October 2023, MCHE and MCHBG staff attended a keynote address by Dr. Desi Small-Rodriguez on Data Governance and Data Sovereignty, and a discussion which centered on raising AI/AN voices in data.

Objective 5: Developing product(s) (e.g., chart books, data books, data dashboards, fact sheets, infographics, journal articles, tool kits, websites, and white papers) that enhance state MCH data capacity and facilitate informed decision-making to drive improved MCH outcomes and achieve equity.

- PRAMS Data to Action: Breastfeeding in MT storymap:
  - The State of Breastfeeding in Montana (arcgis.com)

- PRAMS data briefs on breastfeeding, and COVID vaccination acceptance were publicly released:
  - https://dphhs.mt.gov/assets/ecfsd/PRAMSBreastfeedingDataBriefFinal.pdf
  - https://dphhs.mt.gov/assets/ecfsd/PRAMSCOVID-19VaccinationDataBrief.pdf

Goal 4: Develop systems and enhance data capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats.

Objective 1: Developing and/or implementing surveillance systems

- The MCHE section is actively participating in the MT State Health Improvement Plan (SHIP) and State Health Assessment SHA. A priority category in the coming years for the SHIP is Maternal Health. Maternal Health was one of three priority areas selected by a collaboration of statewide epidemiologists in 2023.
- https://dphhs.mt.gov/assets/publichealth/ahealthiermontana/2023SHADesignPeriodFinalReport.pdf
- https://dphhs.mt.gov/assets/publichealth/ahealthiermontana/2024SHIPEngagementandDesignTeamSun
- PRAMS data from 2022 which contained a MCHBG-funded question is now being weighed by the CDC and the results will be made available to MCHBG staff as soon as possible. Likewise, the when the MT PRAMS 2022 data is available the MCHE staff will update the PRAMS data dashboard.

Objective 2: Providing support for ongoing data collection needs.

- The PRAMS Epidemiologist and the PRAMS Operations Coordinator are partially funded through SSDI.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

In addition to the MCH epidemiology workforce support described its specific narrative, other MCH data capacity efforts are managed through the Early Childhood and Family Support Division's (ECFSD) Business Systems and Operations (BSO) Bureau.

The BSO team is led by Chris Delvaux, who has a Bachelor of Science degree in Business Management and Information Technology; fifteen years of leadership experience gained in the military and private sectors; and seven years' experience in the technology field. He directly or indirectly supervises the following BSO team members who manage the Division's data systems (areas of focus included):

- Andrew McKeever: WIC M-SPIRIT System Lead
- Chelsea: Computer Support Specialist for WIC M-SPIRIT System; Child Care Under the Big Sky (CCUBS), and other Division programs as needed
- TJ Damon: MT Maternal and Early Childhood Home Visiting (MTmechv) Database Administrator
- Nancy Bailey and Kane Dean: Child Care Under the Big Sky (CCUBS) Data Steward and Analyst

The BSO manages and offers technical support to most of the maternal and child health programs' data information systems. The systems specific to the Family & Community Health Bureau (FCHB) are as follows:

- WIC M-SPIRIT System and Spirit Web;
- Maternal, Infant, Early Childhood Home Visiting (MIECHV) case management data system MTmechv;
- Children and Youth with Special Health Care Needs (CYSHCN) Child Health Referral Information System (CHRIS), HiTrack system for hearing assessment and management and newborn screening follow-up;
- Adolescent Health's primary data management system REDCap, an open-sourced Public Health database and collection tool administered by the University of Washington Institution of Translational Health Sciences;
- The Fetal, Infant, Child, and Maternal Mortality Review (FICMMR) Prevention Program records the data for fetal, infant, and child mortality reviews into the National Center for Fatality Review and Prevention, Child Death Review (CDR) System.

BSO staff are currently overseeing several enhancement initiatives for these FCHB-housed data systems. These enhancements, not funded by the State Systems Development Initiative (SSDI), include:

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

- The WIC M-SPIRIT system has been in its current form of operation since 2010 and is part of a multi-state consortium. It is being enhanced into a web-based system called SPIRIT Web. SPIRIT Web will provide real-time, quality data to local, state, and federal partners. SPIRIT Web has been beta tested and is currently in pilot with a select number of WIC clinics. The current anticipated date for release of SPIRIT Web to the 85 WIC clinics within the state of Montana (MT), is May 21, 2024.Training will be provided by both the consortium and MT state-level staff.

  The current EBT contract ends in 2025. Because the project to replace the EBT vendor has a large scope encompassing WIC, SNAP, and TANF, the Human and Community Services Division is leading the procurement with BSO Staff and WIC Staff serving as partners. Requirements have been gathered and entered into the Technology Services Division Project Intake process in preparation for the RFP process. The RFP has been submitted to FNS for a final review and approval.

Fetal, Infant, Child, and Maternal Mortality Review (FICMMR)

- MT's FICMMR program entered into a Data Use Agreement (DUA) with the National Center for Fatality Review and Prevention in September 2012, for the purposes of allowing local FICMMR Teams' review data to be entered into the Child Death Review (CDR) System. FICMMR Teams continue to enter the data for their fetal, infant, and child death reviews into CDR Version 6.0.

  Work has begun with the MT Office of Vital Records (OVR), the MCH Epidemiologist, the FICMMR Coordinator, and the Title V MCHBG Director to proceed with a business process enhancement project. The goal is to mitigate errors by standardizing key data fields and keep death certificate numbers static across the system. These data fields include:

- State ID
- Child's First Name
- Child's Last Name
- Child's Date of Death
- Child's Age
- Child's Age Category

After conversations within OVR and DPHHS Technology Services Division (TSD), an OVR database schema has been provided to ECFSD staff to identify the required tables to both satisfy the need and maintain Least Privilege best practices. Once specific tables are identified, TSD's Vital Statistics Database Administrator will provide BSO staff with read-only access to the identified tables so ECFSD can query directly against a copy of the database for the fields needed to upload into the CDR System, and the National Fatality Review Case Reporting System.

Healthy Montana Families (HMF) Home Visiting Program

- HMF is federally funded by MIECHV, with limited support from state general funds that ensure implementation of the *Montana Initiative for the Abatement of Mortality in Infants Act* (MIAMI). Parents as Teachers, Nurse Family Partnerships (NFP), Family Spirit, and, SafeCare Augmented are the evidence-based home visiting models implemented within 18 agencies (3 tribal agencies) in 16 counties across Montana. The MTmechv Database Administrator created an HMF Administrative Database which collects the administrative and financial data for the four models. The data can be entered by program staff through forms that are included in the database within the Access application.

  Currently, the MIECHV Database Administrator acquires the NFP HRSA data through a monthly export of text files from NFP. Having all HRSA required data within MTmechv will greatly improve the efficiency of completing the annual HRSA report. Currently, the System Manager has created the 3-, 9-, 15-, and 21-month NFP update forms. Those forms will collect injury and emergency room information on children within the program. The System Manager is waiting for HRSA approval of the data collection plan. Upon which the latest update forms will become available to NFP Home Visiting staff and some backfilling of historical data will occur for CY 2022.

  The HRSA report is on an annual basis and required to maintain funding for HMF Home Visiting. In the past this project was a major undertaking requiring many spreadsheets and inefficient processes. Over the last year and a half, a SQL Server Report Services (SSRS) report has been in development for the automation of the Form 2 section of the HRSA report. Reports can be run from within MTmechv. This project was on hold until the System Manager position was filled, and is once again underway.

  In addition to reporting aggregations, each dataset within the report represents a Performance Measure from the HRSA report. Each dataset has both drill-down, drill-up capabilities, and groups the data by jurisdiction and home visitor. This report enables the user to easily find missing data and other data quality issues. For the Form 1 section of the HRSA report, R code has been developed to instantly aggregate and report on the many demographic aspects of the home visiting families. In addition, a SSRS report was recently completed and put into use which shows all Form 1 data. This report can be run by both program staff as well as those at home visiting jurisdictions. While this data report is quite wide, it is designed enable the user to easily find missing data through cell coloring and a missing data indicator field.

  The MIECHV vendor contract with Clinisys was extended to December 31, 2033 through the State's Software Exemption program because of its use being foundational to the Healthy MT Families program.

Children's Special Health Services (CSHS)

The current Child Health Referral Information System (CHRIS) contract ends on June 30, 2024. Many of the current users of the CHRIS are procuring their own data systems and as a result the CHRIS system will be retired. Going forward, audiologists will use HiTrack to record their assessment. HiTrack is a data system developed by Utah State University to record newborn hearing screenings conducted by hospitals. The last group of CHRIS users that remain, 3 Parent Peer Partners, have been moved to a REDCap project that has recently been put into production.

- Because of frequent collaboration between the two programs, CSHS has engaged the Public Health & Safety Division (PHSD) Laboratory to identify Lab system requirements for enhancement consideration to the HiTrack system.

Also, within the Early Childhood Services Bureau (ECSB) in the ECFSD, there are three additional data systems:

- Child and Adult Care Food Program (CACFP): Currently designed to manage the food programs claiming and approval system. CACFP has completed a cross-agency agreement with the Office of Public Instruction (OPI) to utilize the CACFP module in LINQ, aligning to the State IT Strategic Plan and enhancing inter-agency collaboration. The LINQ CACFP module went into Production on November 1, 2023.Currently CACFP has been involved in requirement gathering sessions to configure LINQ to better meet the program's needs.

- Child Care Under The Big Sky (CCUBS): CCUBS is the primary data system used to manage childcare provider licensing, family eligibility for childcare assistance through the Best Beginnings Child Care Scholarship Program, and contracts for professional services and staff support.

  CCUBS is undergoing a large-scale modernization effort, which is focused on optimizing current infrastructure with enhancements designed to: streamline business processes; employ security best practices; and, better serve Montanans by replacing legacy processes and infrastructure with current technology.

  ECFSD has hired a Project Manager to navigate the procurement process to acquire a CCUBS replacement system. The Request for Proposal (RFP) has closed and the scoring process is complete. A new system is scheduled to be ready by September 30, 2025.

- MedCompass: MedCompass is a care-management system currently under development to aid the Part C Early Intervention for Children with Developmental Disabilities program. The system is being developed in coordination with the MT Developmental Disabilities Program (DDP), and the MT Program for Automating and Transforming Healthcare (MPATH) Medicaid modernization project. It consolidates all program data, benefits, and care coordination for individual members into one place.

  MedCompass aims to streamline and enhance Part C's services, claims management, and the member experience while consolidating program processes and payment services into one system that directly connects with the MT Medicaid database. The member experience will be enhanced by providing members and their guardians access to their information and care coordination in one place through the member self-service portal. Current work focuses on creating and validating business reports through the MedCompass interface. These reports have been deployed and work continues to fine tune them.

Other data capacity efforts include:

- Data Governance: The BSO Bureau Chief has been identified internally as the Data Governance Lead for ECFSD. In that effort, the BSO Business Analyst, along with the Research and Evaluation Supervisor and ECFSD leadership, are in the process of creating a Data Governance policy and procedure document. The Data Governance policy and procedure document will include data sharing policies, data release rules, governance guidance, and technical requirements for ECFSD. Anticipated drafting and implementation date is the end of CY 2024.

- Agency enhancements: DPHHS has several enhancements in process that will aid non-SSDI funded systems and data.
  - Snowflake: Currently, the State has various agencies which utilize Snowflake as a data repository and marketplace for easier data sharing and collaboration between internal stakeholders. This platform includes basic analytics, and facilitates easier transfer, connection, and access control for various data systems within an agency. The DPHHS Enterprise Data Warehouse (which contains MedCompass data and CCUBS data) is in the process of migrating to Snowflake infrastructure. DPHHS is currently analyzing further use cases to understand how the agency will be implementing the platform.

  - Enterprise solution consolidation: To align with state strategic planning, DPHHS's Technology Services Division is consolidating enterprise applications to provide a better service catalogue for all divisions. The consolidation and creation of a routinely updated service catalogue of both professional services and software will allow for easier collaboration of technology between divisions and allow for easier adoption of new technologies into ECFSD systems.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

The Department of Public Health & Human Services (DPHHS) has an Emergency Operations Plan (EOP), which is written and maintained by the DPHHS Public Health Emergency Preparedness (PHEP) Program, housed in the Public Health and Safety Division. The EOP is reviewed annually with a major update every two to three years or upon the appointment of a new department Director. The current EOP was fully updated in 2023. DPHHS considers and includes all populations in all of its emergency preparedness plans as required by federal funding guidelines for the CDC PHEP cooperative agreement and embodied through its EOP development.

Emergency response operations for DPHHS includes coordinating reasonable modifications to programs, policies, procedures, architecture, equipment, services, supplies, and communication methods for Montana's access and functional needs population. For the purpose of public health emergency preparedness in Montana, this population is defined as people having access or functional health (i.e., mental or medical) or physical (i.e., motor ability) needs beyond their ability to maintain on their own before, during, and after an incident. These populations include medically vulnerable women, infants, and children.

In Montana, local health jurisdictions and healthcare organizations are responsible for managing events within their geographical boundaries. Sometimes those events develop into emergencies that might overwhelm or exhaust local health resources. DPHHS lends support and coordinates activities to fulfill their resource requests if appropriate and the Department's involvement is incident specific.

As an example of preparedness work happening at the local level, Bozeman Deaconess Hospital in Gallatin County hosted a *Pediatric Disaster Response and Emergency Preparedness* (PDREP) training on July 13, 2023. The course prepared students to effectively, appropriately, and safely plan for and respond to a disaster incident involving children, addressing the specific needs of pediatric patients in the event of a community based-incident. Pediatric specific planning considerations include mass sheltering, pediatric-triage, reunification planning, and pediatric decontamination considerations. This was a management resource course for stakeholders like pediatric physicians, emergency managers, emergency planners, and members of public emergency departments like EMS, fire, police, public health, and hospitals in the field of disaster response and preparedness work.

Additional Montana PDREP trainings in 2024 are scheduled as follows: August 5-6 Billings; and October 21-22, in Helena. These courses will cover the same topics as the one detailed above.

Every Division within DPHHS has set responsibilities for how to respond during an emergency and has the opportunity to participate in DPHHS's emergency preparedness planning, review, and update of the EOP. This activity is implemented through the appropriate workgroup and provides direct input from subject matter experts as requested by PHEP staff.

DPHHS programs contribute to their Bureau/Division's Continuity of Operations Plan (COOP) as required under Executive Order. The following is an excerpt from the MT DPHHS manual, Continuity of Operations:

> "DPHHS maintains continuity plans to ensure the function of the agency and the continuity of its assigned State Essential Functions under all conditions. In an event that interrupts the functional operation of the Department, the Continuity of Operations Plan (COOP) guides recovery priorities to move it back to an operable status. The Montana Department of Administration manages the State Government Continuity Program."

The DPHHS Incident Management Structure (IMS), known as the Montana Healthcare Emergency Response Coordination Center (MHERCC) does not directly include Title V MCHBG leadership. The Incident Command (IC) team is supported within its structure by the Health Advisory Committee (HAC) which consists of emergency response experts and *ad hoc* subject matter experts (SME) to give direction for specific events. A MCH SME would be part of the HAC to help develop incident goals for an emergency, based on the populations impacted. Following all emergency responses, the PHEP and IC teams complete an After-Action Report (AAR) of the incident. These AARs are used to develop and update plans for future

response.

Montana's Healthcare Preparedness Program (HPP) is housed in DPHHS as well. It enables healthcare providers from diverse sectors to join forces with state and local health departments and emergency managers before, during, and after disasters. Together, the healthcare delivery system and public health authorities plan together, coordinate their preparedness efforts and strengthen their ability to meet the needs of all patients during emergencies. HPP addresses gaps in healthcare preparedness through capacity strengthening activities, identifying hospital bed surge capacity, and training in diseases caused by bioterrorism. Regional funding supports involvement in jurisdictional and regional planning, training, and exercising.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Through partnerships, collaboration, and coordination with Family & Community Health Bureau (FCHB) and Early Childhood & Family Support Division (ECFSD) programs, and County Public Health Departments (CPHDs) contributions, the MCHBG program focuses on improving health care delivery for the maternal and child population. MCHBG programs also rely on partnerships with public and private entities, such as: universities; hospitals and health care systems; physicians; the MT Healthcare Foundation; Caring Foundation of MT; University of MT Rural Institute for Inclusive Communities (UMRIIC); MT State University College of Nursing; Healthy Mothers Healthy Babies; Billings Clinic (BC); and the Maternal Mortality Review Committee (MMRC).

MCHC Section

The MCHBG Program Specialist (PS) and Fetal, Infant, Child and Maternal Mortality Review (FICMMR) PS, both work directly with the CPHDs and report to the Title V Director/MCHC Supervisor. The MCHC Supervisor also oversees these federally-funded programs: MT Obstetrics and Maternal Support (MOMS); and the Maternal Mortality Review & Prevention Program (MMRP).

The FICMMR Program ensures that the CPHDs' local FICMMR teams, composed of local professionals, convene death review meetings that focus on determining death preventability. The review results are used for planning, implementing, and evaluating an injury prevention activity, which is a MCHBG contract requirement. The coordinator conducts a quality assurance review of the team's findings, prior to its submission to the National Child Death Review database. The state-level program also works closely with vital records.

The MOMS Program implemented the Empaths program with the BC, which streamlined paths to substance use disorder and mental health treatment for rural pregnant/postpartum women. The MOMS/UMRIIC partnership produced the MOMS Postpartum Care and Contraception Study, Maternal Health Care Experiences Survey – Wellness Visit Survey Module, and Facilitators and Barriers to Seeking Treatment and Care of Postpartum Depression. Details on Phase One of the work are in the NPM 1 report for FFY 2023.

The MOMS Program is funded through HRSA's Maternal Health Innovation (MHI) grant. The purpose of the MHI grant is to reduce maternal mortality and severe maternal morbidity by improving access to care that is: comprehensive; high-quality; appropriate; and on-going throughout the preconception, prenatal, labor and delivery, and postpartum periods.

The MMRP continues to partner with UMRIIC to conduct an in-depth analysis of maternal deaths by calendar year, beginning with those occurring in 2020. This is to determine contributing medical and social factors, which appear to be prenatal and mental health care access. The first MMRP report of the findings and committee recommendations is set to be distributed in summer of 2024. It will guide the MMRC's discussions to determine prevention recommendations and be used to aide to inform future health care priorities.

CSHS Section

The Title V CSHCN Director/CSHS Supervisor, and Title V CSHCN PS, oversee state and federal funded programs which focus on all children and their families having a Medical Home. The CSHS Supervisor also oversees the following programs:

Family-to-Family Health Information Centers (F2FHIC): The Title V MCHBG Family Delegate position is integrated into the F2F Centers. The Family Delegate advises on CSHS policy and supports resource navigation and program alignment.

Genetic Program: CSHS has a contract with the Shodair Children's Hospital. Shodair Children's Hospital provides clinical genetic and metabolic services to individuals or family members who are affected by or are at risk of developing a genetic or metabolic disorder.

The goal of the Newborn Screening Program is to ensure every baby born in MT will receive these three essential newborn screenings: metabolic screening, newborn hearing and screening intervention, and critical congenital heart disease. Partnerships for the hearing screening include the MT School for the Deaf, and the MT Chapter of Hands & Voices. Shodair Children's Hospital provides follow up for the metabolic screening.

MT Access to Pediatric Psychiatry Network is a Pediatric Mental Health Care Access (PMHCA) HRSA-funded federal grant. It increases primary care providers' capacity to treat children and adolescents with behavioral health needs, through provider education and a provider consultation access line. Partners include the Billings Clinic, UMRIIC, the MT Chapter of

American Academy of Pediatrics, WIM Tracking, Academy of Family Practitioners, and Catalyst for Change.

UMRIIC has been a long-standing partner with CSHS Programs to provide evidence-based transition resources to MT's youth and families. UMRIIC works to: maintain and expand the 15-member Consumer Advisory Council (CAC); maintain and disseminate a health care transition (HCT) guide; develop evidence-based/informed HCT training and resource materials; conduct distance learning opportunities; maintain a transition website; and, provide technical assistance to other initiatives related to HCT.

FCHB Programs

The FCHB includes the following programs which partner closely with the MCHBG: Healthy MT Families Home Visiting (HMF); Supplemental Nutrition for Women, Infants & Children (WIC); Oral Health (OH); the Primary Care Office (PCO); and adolescent health focused programs in the Community Health Section.

Home visiting services, offered through HMF's contracts with CPHDs and non-profits, are voluntary and family-centered to pregnant women; new parents; or families or caregivers with infants and young children under five years of age. Home Visitors focus on improving maternal and child health outcomes such as child development and school readiness; child and maternal health; family economic self-sufficiency; positive parenting practices; and reductions in child maltreatment.

WIC provides healthcare and nutrition services to low-income pregnant women, breastfeeding women, and children under the age of five with a family income below 185% of the federal poverty level. WIC's mission is to partner with other services that are key to childhood and family well-being. ECFSD programs and WIC collaborate by supporting Title V MCHBG performance measure activities, breastfeeding, immunization services, and referrals to social service programs.

The OH Program's partnerships continue to raise awareness about the importance of optimal oral health throughout the lifespan. Partnerships specific to oral health include Blue Cross Blue Shield, MT Dental Association, University of Washington School of Dentistry; CPHD-led WIC and home visiting programs, and MT Dental Hygienist Association. In-depth activity details are provided in the FFY 23 Children's Domain report. In FFY24, the OH program, partnering with the PCO, is conducting an in-depth workforce assessment that will contribute to the MCHBG 2025 5-Year Statewide Needs Assessment.

The PCO focuses on ensuring that the 56 counties' Health Professional Shortage Areas (HPSA) in primary care, dental, and mental health designations are at their maximum score. The higher the score, the more appealing for a State Loan Repayment Program or National Health Service Corps awardee to practice in that county.

The adolescent health programs are as follows: Personal Responsibility Education Program; Sexual Risk Avoidance Education; and Sexual Violence Prevention and Victim Services. Their mission is to ensure that MT youth have optimal physical, mental, social, and reproductive health. They promote awareness of current issues adolescents are contending with and strategize with stakeholders to provide relevant services.

ECFSD Programs

ECFSD programs, such as: the Child & Adult Care Food Program; Child Care Development Fund; Preschool Development Grant Birth through Five; and Early Learning/Family Support; focus on lessening the impacts social determinants of health have on the division's shared populations: infants, children, and their families. The ECFSD has over 1,100 contracts and agreements with non-profits, healthcare providers, CPHDs, and small businesses that target early care and education, food security and nutrition education, violence and neglect prevention, family support, and preventative health care.

County Public Health Departments

The 56 CPHDs are key partners for addressing the MCH population's health care needs. State law directs that public health is decentralized, with much of the work done by CPHDs (https://www.cdc.gov/publichealthgateway/sitesgovernance/index.html). Annually, an average of 50 CPHDs participate in the MCHBG, who submit semi-annual and annual reports on their National and/or State Performance Measure activities and evaluation plans. MCHBG funding, when combined with their local or other state funding, plays a critical role in the CPHD's capacity for providing needed maternal and child health services to their county residents.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

The Montana Medicaid Program is authorized under 53-6-101, Montana Code Annotated, and Article XII, Section XII of the Montana Constitution. The Department of Public Health and Human Services (DPHHS) administers the program. Each state Medicaid program is a combination of state plan and waiver authorities, allowing each state to meet the unique needs of their citizens.

Montana's Medicaid program is embedded in several DPHHS divisions and programs and is overseen by the Medicaid and Health Services Executive Director/State Medical Director. The Medicaid Director's Office includes the following staff: Medicaid Chief Financial Manager, Medicaid Complex Case Coordinators, Chief Administrative Officer Healthcare Facilities, and subsequent staff.

The Health Resource Division (HRD), Senior and Long Term Care Division, and the Behavioral Health and Developmental Disabilities Division (BHDD) under the Medicaid and Health Services Executive Director/State Medical Director are responsible for administering the following coverage groups, each with specific eligibility requirements: Infants and Children, including newborn coverage, Health Montana Kids Plus (Children's Medicaid); Healthy Montana Kids (Children's Health Insurance Program); Subsidized Adoptions; Subsidized Guardianship and Foster Care; Pregnant Women; Low Income Adults with Severe Disabling Mental Illness (SDMI); Aged, Blind/Disabled and/or receiving Supplemental Security Income; Breast and Cervical Cancer Treatment; Medically Needy or Categorically Needy; Low Income Montanans including Medicaid and Medicaid Expansion, and Montana Medicaid for Workers with Disabilities.

The signatories for the Title V/Title XIX Medicaid IAA are the respective division administrators (DA), as follows: Title V MCHBG is in the Early Childhood and Family Support Division (ECFSD), and the Title XIX/Medicaid is in the HRD.

In the past year, four maternal and child health-focused programs have been working on specific projects with Medicaid:

Montana Obstetrics and Maternal Support Program (MOMS)

MOMS partnered with Medicaid for a special project to using The Medicaid Redetermination Supplemental funding to implement system changes for the extension of postpartum Medicaid coverage. The project funding was utilized for the continued software system changes to automate the process of extending Medicaid coverage for post-partum recipients from 60 days to 12 months. Funding this system change aided in the process of extending postpartum coverage, increasing efficiency, and eliminating gaps in coverage for postpartum Medicaid recipients. Deloitte Consulting is the current eligibility system vendor for DPHHS. They facilitated the design, development, testing, and implementation of functionality for transitioning pregnant Medicaid members to 4 new types of assistance until 12 months postpartum in the eligibility system.

MOMS staff also partner with HRD to participate in the Meadowlark Initiative. The Meadowlark Initiative provides funding and technical assistance to allow medical practices that provide prenatal and postpartum care to implement a coordinated, team-based approach that improves outcomes for women with substance use disorders and mental illness. MOMS staff participate in quarterly meetings lead by the Meadowlark staff and will attend the upcoming Montana Healthcare Foundation's 2024 Symposium: Celebrating Health Care Innovation featuring the Integrated Behavioral Health, School-Based Health, and Meadowlark Initiatives taking place in June 2024.

Children With Special Health Care Needs

CSHS staff organizes a quarterly inter-departmental meeting across DPHHS middle-management, covering children's systems of care. This quarterly meeting includes various representatives from Medicaid regarding developmental disabilities and mental health; behavioral health prevention programs; Part C; and the Head Start Collaboration Director. The meetings are an opportunity to share information and identify areas of collaboration.

For example, a family that is deemed ineligible for the CSHS Family Assistance Program (FAP) is provided education and information about other potential programs that may be of assistance. The information sharing at the quarterly meetings assists the CSHS staff to directly refer a family to the specific Medicaid program that may be able to provide the services they need.

The Montana Access to Pediatric Psychiatry Program (MAPP-Net) is located within CSHS. This program is focused on increasing primary care providers' capacity to treat children and adolescents with behavioral health needs, through provider education and a provider consultation access line. The Medicaid and MAPP-Net partnership is illustrated by their continued collaboration in the Perinatal Behavioral Health Initiative Program, housed in the Medicaid office. These programs meet monthly to identify areas of collaboration and sustainability pathways.

Primary Care Office (PCO)

The Title V/Title XIX Interagency Agreement continues to facilitate the PCO's mission: to increase and maintain access to primary and prevention healthcare in Montana to improve the health status of underserved and vulnerable populations. Yearly, the PCO requests updated Medicaid data, which is a variable for calculating a county's Health Professional Shortage Area (HPSA) designation score for these three disciplines: mental health, dental health, and primary care. The HPSA score is a variable for awarding healthcare providers lean repayment awards, from the following loan repayment programs: the federal National Health Service Corps (NHSC) Scholar and Loan Repayment, the NHSC Nurse Corps; and the State Loan Repayment Program (SLRP). The higher the HPSA score, the higher the probability that a qualified healthcare provider will receive loan repayment funding. As a result, that provider practices between two and four years in that HPSA.

Special Supplemental Nutrition Women, Infants and Children (WIC)

The purpose of WIC's agreement with Medicaid is to establish eligibility, conduct outreach, and enhance the health, education and well-being of Montana families.

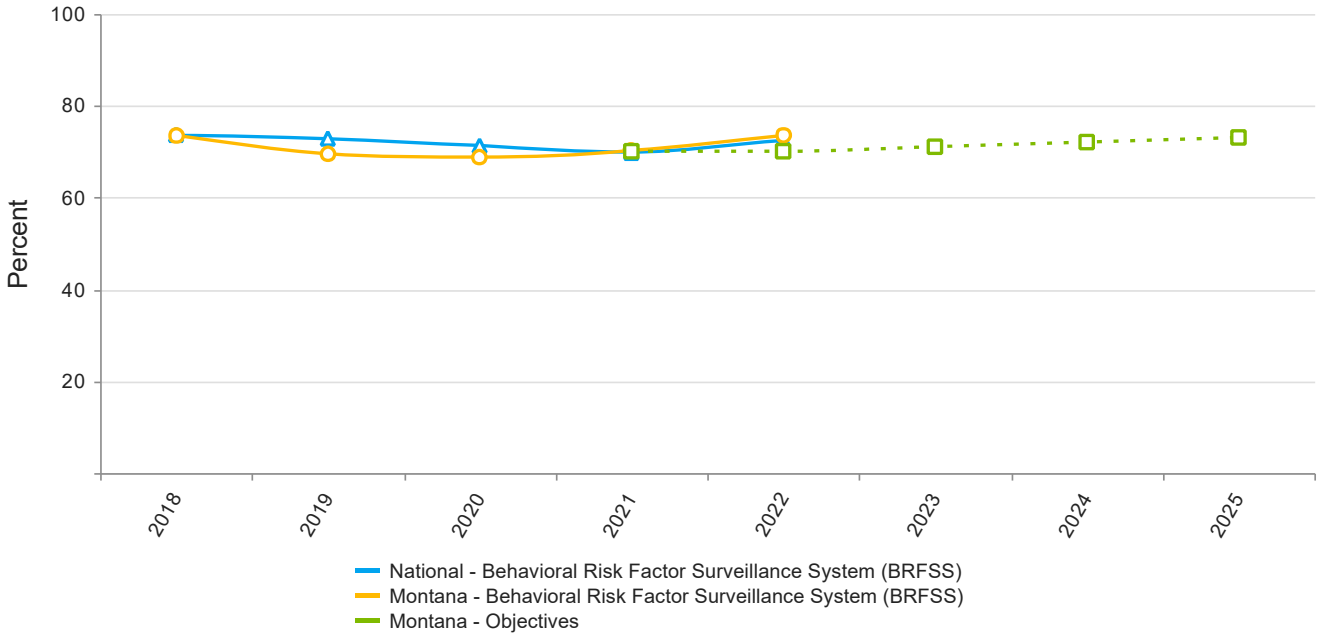
The WIC Program meets with Medicaid at least annually to discuss coverage of medical formulas and nutritionals for mutual participants and other program updates. MT WIC clinics regularly make referrals to Medicaid for any family that appears to qualify and states that they are not enrolled. Likewise, Medicaid staff may refer families to WIC when appropriate. Additionally, WIC and Medicaid have updated and renewed their data-sharing agreement.

III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

National Performance Measures

NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			70.0	70.0	71
Annual Indicator	73.3	69.3	68.6	70.1	73.6
Numerator	123,845	119,515	120,255	123,867	131,768
Denominator	168,903	172,352	175,425	176,723	179,085
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	2025
Annual Objective	72.0	73.0

Evidence-Based or –Informed Strategy Measures

ESM WWV.1 - Percent of activity goals to increase preventive medical visits for women which are met by county public health departments using MCHBG funding for the work.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			80	82	83
Annual Indicator			100	33.3	40
Numerator			4	3	2
Denominator			4	9	5
Data Source			FCHB	FCHB	FCHB
Data Source Year			FFY 2021	FFY 2022	FFY 2023
Provisional or Final ?			Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	84.0	85.0

ESM WWV.2 - Completion of Medicaid data query and report on women's annual preventive healthcare visits.

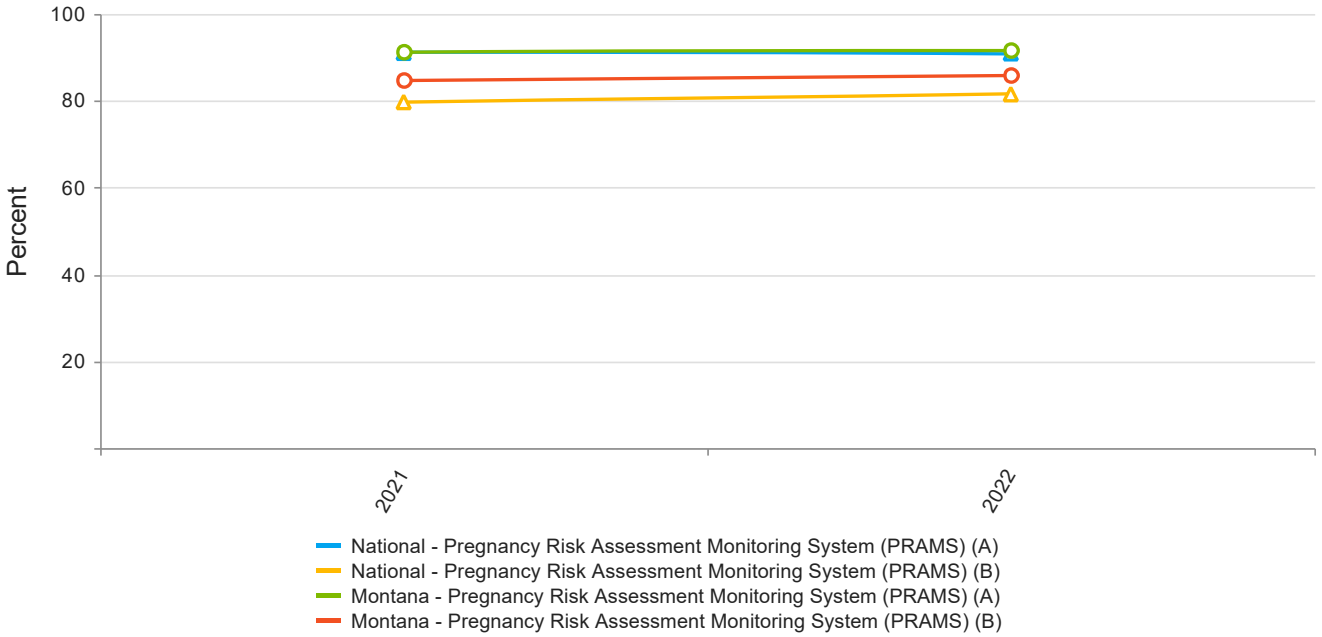
Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives	
	2025
Annual Objective	1.0

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Indicators and Annual Objectives



NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	91.5
Numerator	9,828
Denominator	10,740
Data Source	PRAMS
Data Source Year	2022

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	85.7
Numerator	8,207
Denominator	9,575
Data Source	PRAMS
Data Source Year	2022

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (Montana) - Women/Maternal Health - Entry 1	
Priority Need	
Women's Preventive Healthcare	
NPM	
NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	
Five-Year Objectives	
To increase the percentage of women, ages 18 through 44, who receive a comprehensive annual preventive "well-women" medical visit.	
Strategies	
Support County Public Health Departments who choose NPM 1 as their priority need, or include women's preventive health care activities in their SPM 1 operational plans. State staff will provide technical assistance and resources.	
Create and manage a media campaign to educate and encourage women on the importance of an annual well-woman visit. Messages will be informed by information on this topic from the CDC and the federal Office of the Assistant Secretary for Health / Office of Disease Prevention & Health Promotion (OASH). These resources are evidence-based and vetted. Measurable goals for impressions, hits, and exposure will be set for the various types of media, targeted to women ages 21-44. These will include: social media, billboards, cellphone applications, radio, and magazines.	
ESMs	Status
ESM WWV.1 - Percent of activity goals to increase preventive medical visits for women which are met by county public health departments using MCHBG funding for the work.	Active
ESM WWV.2 - Completion of Medicaid data query and report on women's annual preventive healthcare visits.	Active

NOMs

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM

NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM

NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW

NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB

NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD

State Action Plan Table (Montana) - Women/Maternal Health - Entry 2

Priority Need

Women's Preventive Healthcare

NPM

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Five-Year Objectives

Improve percentages by 5% by FFY 2030.

Strategies

For FFY26: analyze data for baseline percentages, and study evidence-based strategy measures most likely to be successful in a state with Montana's geographic and rural/frontier-level population.

For FFY27: Create and begin to implement action plan, based on results of FFY26 activities.

ESMs | Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

Women/Maternal Health - Annual Report

Well-Women Visit (NPM 1): Percent of women, ages 18 through 44, with a preventive medical visit in the past year.

County Public Health Department (CPHD) Activities

The overarching themes of the CPHD activities for FFY 2023 was partnerships and collaboration. Since a well-woman visit is clinical in nature, the three CPHDs working on NPM 1 met and consulted with many types of organizations and providers, i.e.: Title X Family Planning, Montana Women, Infants, and Children (WIC), hospitals, family-practice clinics, and colleges.

In 2017, Johns Hopkins University Women's and Children's Health Policy Center published a brief on how to *Strengthen the Evidence Base for Maternal and Child Health Programs*. "Scientifically Rigorous" evidence was identified for "Patient Reminder/Invitation." The brief stated: "There is strong evidence to suggest that patient reminders/invitations are effective, both on their own and in combination with other strategies." As an example of this strategy, Beaverhead CPHD implemented a patient reminder and invitation activity. Their focus was specifically on HPV vaccine and cervical cancer screenings for Family Planning and WIC clients.

According to the Johns Hopkins brief, the evidence rating one step down from Scientifically Rigorous is "Moderate Evidence." At this level, it states: "Other interventions targeting the patient/consumer that appear to be effective are community-based group education and patient navigation…(and) on the provider/practice-level reminder/recall systems, provider education, and implementation of a designated clinic/extended hours appear to be effective." Richland CPHD implemented examples of these strategies: 1) working with Family Planning (co-located with the CPHD) to increase the percent of women in their county who received annual well-woman visits over the 2019 baseline, as pertains to improving their client services process; and 2) met with and educated local providers, and created a plan encouraging patients to seek annual visits.

Two additional CPHDs implemented activities for NPM 1 in FFY 2023, Beaverhead and Silver Bow. Here are highlights of their activities:

- Beaverhead:
  1. The CPHD worked with two other programs housed within their department, WIC and Family Planning. They developed a pamphlet on the importance of the well-woman visit that was given out to approximately 50 clients.
  2. They met with Family Practice/Obsteptrics providers at the local hospital, and their staff. Before the meeting the providers were not including information on local services in their packets for clients. They were pleased to have the CPHD start supplying this information, in partnership on this effort. The local services information includes the well-woman appointments available at the CPHD.

- Silver Bow:
  1. The CPHD implemented a community-based education plan to develop and sustain partnerships with other organizations to address unmet reproductive health care needs and address health disparities among women ages 18-44. Here is a list of their activities:
     - Weekly rapid antibody testing (HIV, HCV, Syphilis) at the Montana Chemical Dependency Center (MCDC). This work included connecting any positive HIV or Syphilis cases to the Butte Family Planning Clinic for referrals, confirmatory testing and treatment.
     - Monthly STD/HIV education at MCDC for residents.
     - Health Fest 2023
     - Montana Tech University Game Night – STD/HIV education and information on Family Planning services.
     - Butte Rescue Mission – *Healthcare for the Homeless* connects women ages 18-44 to reproductive healthcare, birth control, and referrals when needed.

  2. The CPHD utilized location-based advertising to deliver targeted messages for reproductive health care access. Engagement was measured, and return on investment tracking was provided to aid the campaign. Measurement included the number of digital ads delivered, the number of impressions per month and the number of clicks through to CPHD website. Mobile ads provided information about access to reproductive health care, with a click-through rate to the CPHD website of 340 clicks to receive additional information. Additionally, non-skippable 6-second videos played on streaming TV, computers, tablets, and mobile devices. 30% of Butte Family Planning clients learned about the clinic from these efforts.

In FFY24, the FCHB is contracting with one CPHD who has chosen to focus on NPM 1: Silver Bow. They are implementing and evaluating two community-level activities during the fiscal year. Also, one CPHD who chose SPM 1 has an activity focused on the Well-Woman Visit. The FCHB is providing these counties with training, resources, and support on:

evidence-based/informed or best-practice activities; goal setting; and evaluation.

State-Level MCHBG Activities

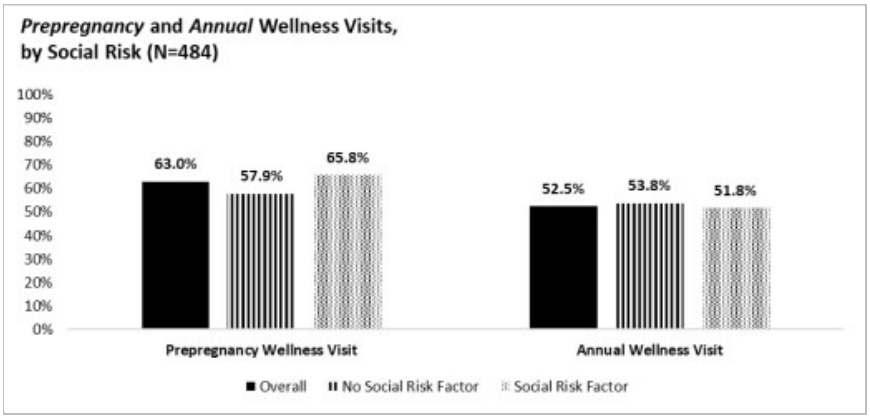
Interim Needs Assessment: Phase One Survey Analysis

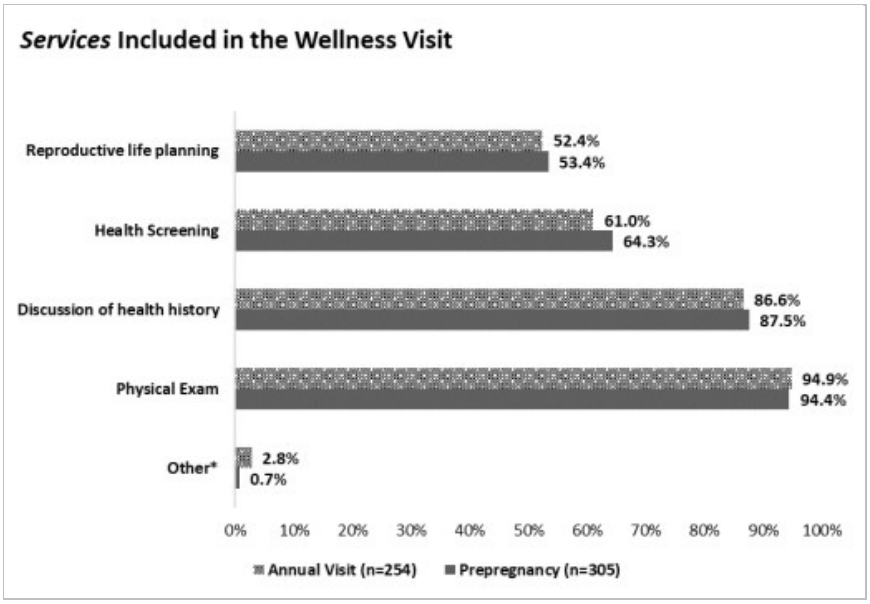
The state-level MCHBG Program is conducting an interim needs assessment with the assistance of the University Montana Rural Institute for Inclusive Communities (UMRIIC). Phase One of this work took place during FFY 2023. One of the deliverables was analysis of the wellness visit module from a survey looking at maternal health care experiences in Montana. The module on well-women visits gathered information on patient access to, and experiences with, the wellness visit. The initial survey work was supported by the Montana Obstetric and Maternal Support (MOMS) Program, a HRSA Maternal Health Innovation Grant.

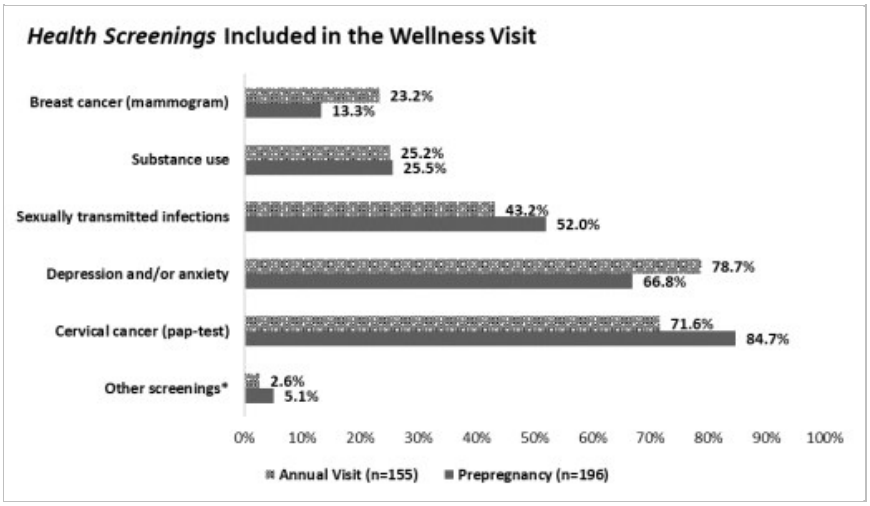
The wellness visit survey module gathered information on *healthcare utilization* (annual wellness visit, and having a wellness visit the year before pregnancy), *services included* (physical exam, health history, health screening(s), reproductive life planning), *health screenings* (cervical cancer, depression and/or anxiety, sexually transmitted infections, substance use, breast cancer, and other screenings), *patient satisfaction*, and an open ended question on *areas for improvement*.

The survey also included the *Health Leads Social Screening Tool* to measure social risk. Health Leads collects information on eight social needs domains: food insecurity, housing instability, utility needs, financial resource strain, transportation challenges, childcare, and social isolation. We categorized respondents with one or more of the social risk factors as "social risk factor" and respondents who did not report any of the social risk factors as "no social risk factor."

Data collection occurred from July 26, 2022 – September 14, 2022. The online survey focused on Montanans who have been pregnant in the last five years. UMRIIC used convenience and purposive sampling methods. Participants were recruited through social media platforms Facebook and Instagram via six custom images. The social media campaign included sponsored posts facilitated by the UMRIIC platforms. A postcard was also sent to all WIC participants, totaling 8,800. The study included 484 participants. Respondents lived in a mix of rural (54.3%) and urban (45.7%) communities. Additional data analysis on this survey module was completed in September 2023, with results as follows:







Examples of categories and answers to “How could the wellness visit have been improved?”

More time with the provider:

- “I feel like it was extremely rushed and I still have some unresolved health issues that weren't taken seriously. They're not emergent issues, but they do negatively impact my quality of life and cause a lot of frustration and anxiety.”

Focus on individual patient needs:

- “The provider focused on my blood pressure when I went in to talk about alternative birth control options. I felt the like apportionment was too quick and the provider didn't listen to my needs.”
- “It was not centralized or about me and my individual situation. Very 'check the box and see ya in a year' vibe. Definitely better and more knowledgeable care when I worked with a women-centric dietician for labs/regulation information.”

Better mental health care assessment and treatment

- “Despite filling out the depression/anxiety screening with clearly elevated issues of both, my provider didn't even read it and just said, 'no mental health issues.' Until I said... 'actually... read that again.'”

MCHBG-Proposed PRAMS Survey State-Added Question

In March 2022, the Montana PRAMS Steering Committee chose, and the CDC and IRB approved a state-added question that was proposed by the MCH Program Specialist. The PRAMS 2022 survey, which closed out on 6/9/2023, included this question:

Here is a list of problems some women can have getting prenatal care. For each item, circle Y (Yes) if it was a problem for you during your most recent pregnancy or circle N (No) if it was not a problem or did not apply to you.

- *I couldn't get an appointment when I wanted one*
- *I didn't have enough money or insurance to pay for my visits*
- *I had no way to get to the clinic or doctor's office*
- *I couldn't take time off from work*
- *The doctor or my health plan would not start care as early as I wanted*
- *I didn't have my Medicaid card*
- *I had no one to take care of my children*
- *I had too many other things going on*
- *I didn't want anyone to know I was pregnant*
- *Other – Please tell us:*

The data collected from this question will provide additional public input data for the upcoming needs assessment. It will also offer insights into regional differences across the state. Weighted data results from the CDC are expected later in FFY24.

Montana Statewide Syphilis Symposium and Public Awareness Campaign

In response to syphilis spreading faster in Montana than it has in decades, a new partnership was formed with the Public Health and Safety Division (PHSD) STD/HIV/Viral Hepatitis Section. Montana's data indicated that during 2022, there were 602 cases of syphilis (all stages), with women of child-bearing age accounting for 281 of these cases, and there were 41 pregnant women. Preliminary 2022 data shows 15 cases of congenital syphilis, with three stillbirths.

The FCHB collaborated with the STD/HIV/Viral Hepatitis Section to sponsor a Montana statewide Syphilis Symposium held June 19-23, 2023. In partnership with the Native American Development Council (NADC) and the Montana Public Health Institute (MTPHI), four cross-sector community meetings were held in Tribal communities across the state, in addition to a full day clinical training hosted by Dr. Melanie Taylor, Medical Epidemiologist at the Centers for Disease Control & Prevention (CDC).

Nearly 300 providers and community partners, including Tribal Health, County Public Health, Indian Health Services (IHS), Urban Indian Health Centers, Tribal Councils, and social service providers were trained on syphilis testing, staging, and treatment. The next steps following the symposium include: providing more clinical training to healthcare providers across the state; increase public awareness; improve access to 340B drug pricing across the state; provide information regarding the Bicillin shortage to healthcare providers; provide recommendations to Fort Peck Tribal Council regarding their tribal code which impacts women seeking prenatal care; and the creation of the Congenital Syphilis Case Review Board to review all cases of Congenital Syphilis and provide prevention recommendations.

To increase public awareness, MCHBG funds were utilized to support the continuation (from July 1- Sept 30, 2023) of an existing Syphilis public awareness campaign. The campaign was focused on increasing awareness of Syphilis, and encouraging prenatal care, testing and treatment for the condition in the most impacted communities in the state. Outreach was through billboards, social media, radio Pubic Service Announcements, and digital ad placements.

Montana Obstetrics and Maternal Support (MOMS) Program NPM1 Activities

The MOMS Program contracted with the UMRIIC for data collection and analysis, evaluation, and research services. Their staff launched several research studies during the reporting period to gather more information on maternal health, focusing on the experiences of pregnant people and providers within the health system.

Maternal Health Care Experiences Study

Purpose of the Study: To gather information on patient experiences of maternal healthcare before, during, and after pregnancy.

Key Findings:
A total of 484 people who experienced pregnancy in Montana in the last five years participated in the survey, and 39 people participated in a phone interview. Sixty-Six percent of participants reported experiencing high levels of respectful care, with about a third (34%) reporting low-to-moderate levels of respect. Overall, about half (53%) of participants reported high levels of autonomy in decision-making, with the rest experiencing low (16%) and moderate levels (31%) of autonomy in their care. Participants with at least one social risk factor reported lower levels of respectful care and autonomy in decision-making.

Emergency Obstetric Services Survey
Purpose of the Study: To assess 1) hospital capacity to provide emergency obstetric services in hospitals without an obstetrics unit and 2) the organization and delivery of care during emergency obstetric events to support the development of specific strategies to integrate those facilities into a regionalized perinatal system of care.

Key Findings:
Survey – thirty-two of thirty-four hospitals (94%) without an obstetric unit participated in the survey assessment. Half (50%) of the hospitals that participated in the survey had experienced an emergency room birth within the last two years, and 34% had experienced a close call or other unanticipated adverse birth outcome. Nearly half (47%) of hospitals felt concerned because of the infrequency of emergency obstetric events and their lack of experience in responding to them, specifically in training (69%) and skills (72%). When hospitals needed to transfer a patient, 37% had experienced challenges arranging for transport for a pregnant patient, citing weather and other delays.

Interviews – twenty semi-structured interviews were conducted with healthcare providers involved in the provision of care during obstetric emergencies. Seven participants worked at non-birthing facilities, three at LOCATe-assessed Maternal Level I facilities, and seven at Maternal Level II and higher facilities. Three interviews were conducted with providers on emergency medical services (EMS) transport teams. Across all levels of care, providers identified communication, distance, weather, and availability of EMS transport teams as challenges. Providers of both lower-level and higher-level facilities also identified the importance of provider-to-provider relationships in facilitating referrals. Finally, providers at non-birthing facilities expressed hesitation to treat pregnant patients among emergency department staff.

The challenges identified by participants in both the survey and interviews indicate the need for greater perinatal regionalization of care in Montana and continued support for rural healthcare providers and EMS through 1) increased clinician and staff training, 2) improved coordination with hospitals that provide obstetric services, and 3) improved coordination with transport teams.

Facilitators and Barriers to Seeking Postpartum Care
Purpose of the Study: Identify risk and protective factors associated with seeking care for postpartum depression symptoms among Montana women who use substances or those with mental health concerns.

Key Findings:
Twenty-five women were referred for interviews, 14 accepted and seven completed the interview process. Interviews were conducted via Zoom and lasted between 15 and 30 minutes. Four main themes arose from the interview process regarding barriers and facilitators to receiving care for postpartum depression: Family history of mental health concerns and/or substance use; stigmatization around mental health or substance use; lack of awareness surrounding postpartum depression; and isolation.
Additional information on the work surrounding the results of the MOMS surveys is provided in the Well-Woman Visit narrative for FFY24.

Women/Maternal Health - Application Year

Well-Women Visit (WWV, previously NPM 1): Percent of women, ages 18 through 44, with a preventive medical visit in the past year.

County Public Health Department (CPHD) Activities

For FFY 2024, the CPHDs with specific well-woman visit activities are Silver Bow (NPM 1), and Deer Lodge (SPM 1):

Silver Bow CPHD

The county seat of Silver Bow County is Butte, which acts as a commercial and services hub for many of the surrounding counties with smaller populations, most specifically: Deer Lodge, Jefferson, Beaverhead, and Madison. The CPHD has made working on activities for NPM 1 its MCHBG priority since FFY 2021, due to the results of Community Health Needs Assessments.

For FFY 2024, the CPHD is focusing on: 1) staff training on the importance of preventive services for all women, including adolescents; and 2) continuing to implement a digital marketing campaign to promote preventive healthcare utilization and preconception health for women of reproductive age in Silver Bow. This is building on continuing activities started in previous years which include provider outreach and screening women for health care needs at a weekly syringe service clinic.

On their pre-contract survey, Silver Bow CPHD stated their reason for choosing NPM 1: *"Public health education is the key to prevention. By expanding our referral network, community partnerships, and providing education we will increase access to care for all, but especially those who are most vulnerable in our community."*

The CPHD's description of their staff training activity included the following information:

> *"The 2023 Silver Bow County Community Health Needs Assessment indicates Butte-Silver Bow rate of births to adolescent mothers (15-19 years of age) of 23.7 is above national and Montana rates, 19.3 and 20.4 respectively. Based on existing Family Planning Clinic data the 18-19 age group consisted of only 10% of the total visits. B-SB Health Department has seen significant staff turnover over the last 12 months. MCH training topics will be used for professional development for new staff members, improve internal coordination, and improve MCH competencies in programming for all programs serving women 18-44. When staff are fully aware of all the resources available they will be more likely to promote preventive services to clients and community partners."*

Here is their evaluation plan and goal for the digital marketing campaign:

> *"Digital marketing metrics will be monitored monthly, including number of impressions, engagement and click throughs. The metrics will be used to evaluate the effectiveness of the campaign and create quality improvement activities. Quarterly we will pull data from the EHR on the number of patients between age 18-44 years seen in Family Planning, stratified by demographics. Goal: Increase the number of women aged 18-44 seen in the Family Planning clinic by 10% from Oct 1, 2023 to September 30, 2024."*

Deer Lodge CPHD

Deer Lodge County's maternal and child population is small enough (2,726) for it to qualify for State Performance Measure 1. This allows them to implement activities on different topics, according to the priority needs of the county, instead of focusing on only one area. For FFY 2024, one of the CPHD's activities is: Mobile STI and pregnancy testing at a minimum of four underserved locations (jail, congregate work/living facilities, rural areas of county, etc.) to identify diseases that may prevent healthy future pregnancies and identify pregnancy early for connection to education/care/resources.

In FFY25, the FCHB will contract with Silver Bow CPHD who has chosen to focus on NPM 1, and the SPM 1 CPHDs with women's preventive healthcare activities. They will implement and evaluate community-level activities during the fiscal year. The FCHB will provide these counties with training, resources, and support on evidence-informed or best-practice activities, goal setting, and evaluation.

State-Level MCHBG Activities

Medicaid Data Query: Women's Preventive Healthcare Visits

In February 2024, the Early Childhood & Family Support Division's MCH Epidemiologist began a query of Montana's Medicaid data. The objective of this analysis was to find the percent of Montana adult (18+) women who were covered by Medicaid and received a preventative healthcare visit during the calendar year of 2022. Through the Medicaid claims database, all adult women (sex coded as female) who were 18+ for at least one day in the 2022 calendar year were identified. Additionally, county of residence, race, and iCD-10 codes were also obtained.

The results showed that the percentage of Medicaid recipients with well-woman visits across six regions of the state varied from 41% - 53%. This demonstrates that only about half of women with Medicaid are receiving preventative healthcare. Additionally, American Indians and Alaskan Native women are receiving less preventative care than other races, and women in their late teens receive less than adult or elderly women. Additional details are reported in the Needs Assessment Update narrative of this application.

Women's Preventive Healthcare Media Campaign

In May 2024, the MCHBG Program Specialist began work on a media campaign to promote the importance of annual preventive healthcare visits for women. The program is partnering with Windfall, Inc., an ad agency which has expertise in public health-related media campaigns in Montana.

Windfall is currently working on a creative brief, media options, and scheduling. The campaign will start later in FFY 2024. Advertising options include: online social media and display banners, billboards, print ads, and digital applications such as Spotify. Windfall was provided with background information and guidance from the following sources:

- The federal Office of the Assistant Secretary for Health / Office of Disease Prevention & Health Promotion (OASH):
  - Specifics about the well-woman visit: https://health.gov/myhealthfinder/healthy-living/sexual-health/get-your-well-woman-visit-every-year;
  - National Women's Health Week / Day 5 prevention focus: https://www.womenshealth.gov/nwhw/day-5-understanding-care-is-there
  - Cervical cancer awareness: https://health.gov/news/202312/january-national-health-observance-cervical-cancer-awareness.
- MCH Evidence website's information about media campaigns for this topic: https://www.mchevidence.org/tools/strategies/1-8.php.
- The CDC on cervical cancer awareness: https://www.cdc.gov/cancer/dcpc/resources/features/cervicalcancer/index.htm. Cevical cancer screenings and HPV vaccinations can be proxies for well-woman visits, and they typically take place during an annual well-woman visit.
- The detail sheet from the MCHBG guidance regarding the Well-Woman Visit.

Montana Obstetrics and Maternal Support (MOMS) Program NPM1 Activities

DPHHS MOMS staff, in conjunction with partners at the University of Montana Rural Institute for Inclusive Communities (UMRIIC) and Billings Clinic (BC), are conducting community education on the importance of: annual well-woman visits; initiating 1st trimester prenatal care; maintaining prenatal care; seeking insurance coverage; and receiving postpartum screening and care. These activities flow from the MOMS Year-4 workplan.

BC is developing a documentary series highlighting maternal health disparities and cultural practices in tribal communities, as well as a series telling the stories of agricultural and rural mothers. The four short videos were completed, posted to the website, and promoted via social media. This community education campaign had targeted promotion statewide.

UMRIIC continues to update and disseminate published work of several maternal health systems needs assessments and studies. The Montana Levels of Care Assessment Tool (LOCATe) Initiative's purpose was to assess the levels of maternal and neonatal care at Montana birthing facilities to provide an environmental scan of the status of the risk-appropriate care in the state. The published manuscript contributed an important rural perspective to the body of literature on risk-appropriate perinatal care.

UMRIIC also conducted a needs assessment survey for birthing facilities, including questions on: transport; accessibility; screening and referral; training; medical products; and medical equipment and technology. Based on these findings, the MOMS program shared results with healthcare providers and initiated education and training on accessible healthcare settings. This was accomplished through presentations at the MOMS Project ECHO Clinic and the Montana Perinatal

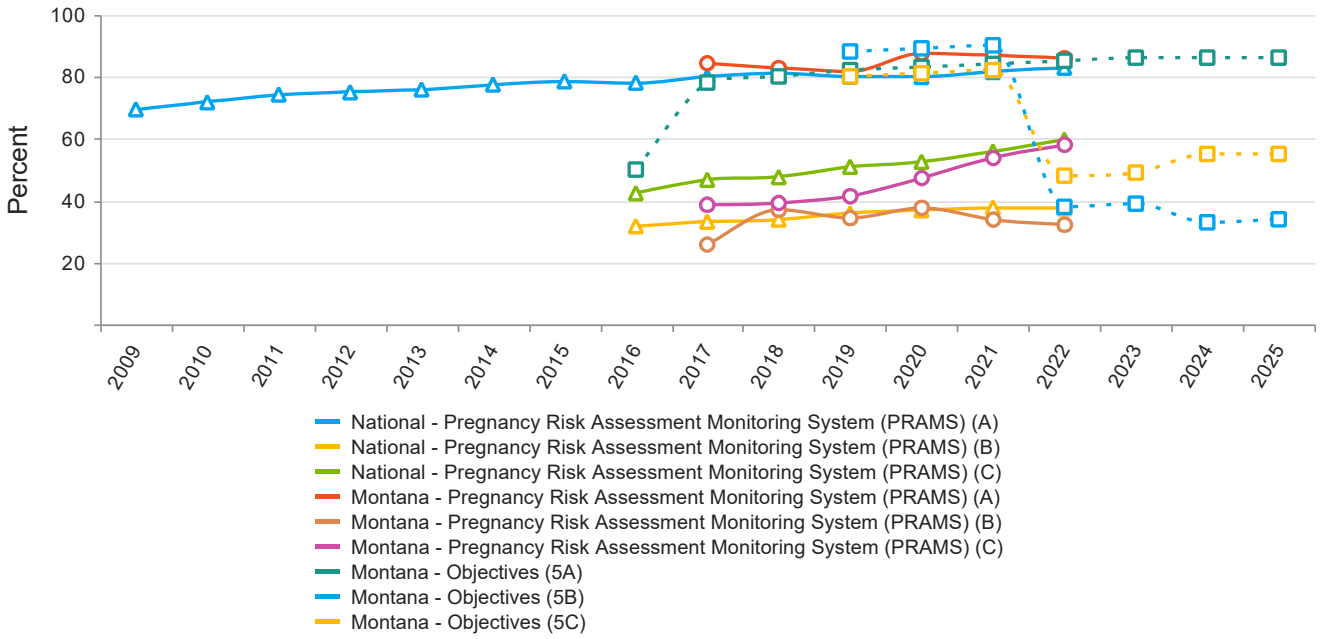
Quality Collaborative Learning Session.

MOMS will continue work with BC to ensure that their Year-5 activities are completed. BC will continue to offer: ECHO clinics; the Empaths Perinatal Substance Treatment System, which streamlined a pregnant/postpartum women's access to substance use disorder (SUD) and mental health treatment; and, Cuddling Cubs, a virtual postpartum support group facilitated by the Rocky Mountain College's Occupational Therapy Doctorate program. UMRIIC, MOMS staff, and BC have collaborated on data collection tools for the purpose of determining these programs' impact and potential for other states to replicate. The MOMS staff will serve as a resource for the CPHDs that have indicated maternal health as an area of focus by selecting NPM 1 or by reaching out for technical assistance from MCHBG staff.

Perinatal/Infant Health

National Performance Measures

NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS
Indicators and Annual Objectives



NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	82	83	84.0	85.0	86
Annual Indicator	84.3	81.7	87.4	86.8	85.8
Numerator	9,362	8,632	8,706	9,165	9,112
Denominator	11,104	10,565	9,958	10,564	10,615
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2021	2022

Annual Objectives		
	2024	2025
Annual Objective	86.0	86.0

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	88	89	90	38.0	39
Annual Indicator	25.9	34.2	37.8	33.8	32.0
Numerator	2,795	3,557	3,578	3,423	3,177
Denominator	10,810	10,387	9,472	10,126	9,934
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	33.0	34.0

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	80	81	82.0	48.0	49
Annual Indicator	38.5	41.6	47.2	53.8	58.0
Numerator	4,169	4,335	4,472	5,432	5,795
Denominator	10,815	10,409	9,480	10,101	9,995
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	55.0	55.0

NPM - D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

Federally available Data (FAD) for this measure is not available/reportable.

Evidence-Based or –Informed Strategy Measures

ESM SS.1 - Percent of activity goals to decrease infant deaths due to unsafe sleep conditions which are met by county public health departments using MCHBG funding for the work.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	80	83	92	92	93
Annual Indicator	100	91.7	100	91.7	88.9
Numerator	15	11	7	11	16
Denominator	15	12	7	12	18
Data Source	FCHB	FCHB	FCHB	FCHB	FCHB
Data Source Year	FFY 2019	FFY 2020	FFY 2021	FFY 2022	FFY 2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	93.0	94.0

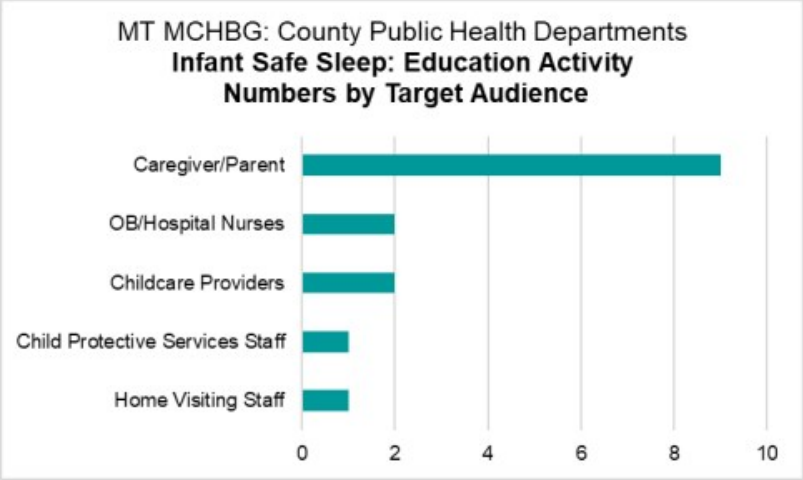
State Action Plan Table

State Action Plan Table (Montana) - Perinatal/Infant Health - Entry 1	
Priority Need	
Infant Safe Sleep	
NPM	
NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	
Five-Year Objectives	
Increase the number of infants who are placed to sleep on their backs to 88% by 2023.	
Increase the number of infants placed to sleep on a separate approved sleep surface to 92% by 2023.	
Strategies	
The FICMMR Coordinator continues to lead CDR quality improvement initiatives, which focus on CDR sections of critical importance for local teams to complete accurately. One of these sections is infant sleep environment.	
Support County Public Health Departments who choose NPM 5 as their priority need, providing technical assistance and resources.	
Promote the DPHHS Infant Safe Sleep Data Dashboard as a technical assistance resource to support stakeholders in tracking and examining trends related to: sleep-related infant mortality; safe sleep behaviors; and safe sleep education.	
ESMs	**Status**
ESM SS.1 - Percent of activity goals to decrease infant deaths due to unsafe sleep conditions which are met by county public health departments using MCHBG funding for the work.	Active
NOMs	
NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM	
NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal	
NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID	

NPM 5 - Safe Sleep: A) Percent of infants placed to sleep on their backs, B) Percent of infants placed to sleep on a separate approved sleep surface, C) Percent of infants placed to sleep without soft objects or loose bedding.

County Public Health Department Activities

For federal fiscal year (FFY) 2023, the nine County Public Health Departments (CPHDs) focusing on NPM 5 implemented nineteen separate activities, seventeen of which reached their outcome goals. Fifteen activities were education-related. The following chart shows the specific target audiences, with the overwhelming majority aimed at caregivers and parents.



All of these education activities used evidence-based/informed materials, the majority from the American Academy of Pediatrics Infant Safe Sleep Toolkit, as well as: Cribs for Kids Safe Sleep Ambassadors; Safe to Sleep; and Charlie's Kids.

- AAP Infant Safe Sleep Toolkit: https://www.aap.org/en/patient-care/safe-sleep/
- Cribs for Kids Safe Sleep Ambassador Training: https://cribsforkids.org/safe-sleep-ambassador/
- Safe to Sleep: https://safetosleep.nichd.nih.gov/
- Charlie's Kids: https://charlieskids.org/

Roosevelt CPHD provided the following report on a training at a hospital:

"RCHD RN gave a Safe Sleep presentation at the monthly nursing staff meeting at Trinity Hospital (only birthing hospital in Roosevelt County). She shared the 2022 AAP safe sleep recommendations. Nurses expressed thanks, saying much of the information was new to them. 13 people were in attendance, not all were nurses. Nine (69%) correctly identified the 3 main safe sleep practices on a post-training survey."

Yellowstone CPHD reported on trainings to families and Child & Family Services staff:

"Two newly hired Registered Nurses have been fully trained, and now both have full caseloads, including several new pregnant women. Both RNs were trained on safe sleep practices per the Charlie's Kids program, and they provide that education to each family they see. Additional Safe Sleep activities this quarter included a presentation to Child & Family Services (CFS) staff during a staff meeting. The CFS staff were provided with both written materials and videos to help train their new employees on safe sleep practices."

Ravalli CPHD reported some challenges they are working to overcome with their infant safe sleep activities:

"Staff have identified some possible barriers to greater participation in the infant safe sleep program. One possible deterrent

could be the type of portable crib offered. We looked at what other counties are using and have identified 'cribsforkids.org.' Another identified barrier is challenges reaching our target audience. We identified that our social media is perhaps out of date with the demographic we are looking to reach. We quickly identified that most of our parents use Instagram. We started an Instagram page but within a few weeks were flagged and our account deleted after posting about our free vaccine mobile clinic. Vaccine is a hot topic in our county. One suggestion to rectify this would be to develop a social media platform that is specific to infant/ child/ mother safety promotion and not post any vaccine related promotions on that platform."

The FCHB is in the process of developing a web-based Infant Safe Sleep dashboard. Slated for release in FFY24, it will provide data on infant safe sleep behavior and related deaths. The dashboard will be updated annually, and available to the public.

State-level staff continued to provide technical assistance to the CPHDs, especially in regard to evidence-based/informed resources. During the development of NPM 5 activity details for FFY 2023, special attention was given to a source of materials which did not properly address the issue of co-sleeping. Any CPHD which had initially been considering that option changed over to using materials which follow the AAP guidelines.

In FFY24, the FCHB is contracting with six CPHDs who have chosen to focus on NPM 5. They are implementing and evaluating a total of eleven community-level activities during the fiscal year. The FCHB is providing these counties with training, resources, and support on: evidence-based/informed or best-practice activities; goal setting; and evaluation.

Fetal, Infant, Child & Maternal Mortality Review Program: CPHD Injury-Prevention Activities

Three CPHDs worked on infant safe sleep as their designated Fetal, Infant, Child & Maternal Mortality Review (FICMMR) best-practice, injury prevention activity for FFY23.

Glacier CPHD collaborated with the Cut Bank/Glacier County WIC office to provide infant safe sleep education and awareness to their participants. Through this collaboration, they were able to reach more new mothers, as well as women who already have children**.** Eighteen pregnant mothers, as well as ten newer mothers, received education and information on infant safe sleep education. Specifically, they received sleep sacks and the following materials:

- Safe Sleep For Your Baby: https://www.nichd.nih.gov/sites/default/files/publications/pubs/Documents/STS_DoorHanger_General_2013.pdf
- What Does A Safe Sleep Environment Look Like?: https://www.nichd.nih.gov/sites/default/files/2022-10/NICHD_STS_2022_Handout_English508_0.pdf
- Sudden Infant Death Syndrome (SIDS) flier - Noodle Soup: https://www.noodlesoup.com/product/sudden-infant-death-syndrome-sids-flier/
- Sleep Baby, Safe and Snug, Charlie's Kids Foundation Book: https://charlieskids.org/order-books/

The Madison CPHD identified two key audiences to partner with on the goal to increase consistent, infant safe sleep messaging and best practices in their county: childcare facilities and primary care physicians. Madison's staff took a warm-up approach by visiting nine childcare facilities to simply introduce their new public health nurse while providing small gifts. They communicated their desire to partner together on infant safe sleep education with each facility through dialogue and assessing current practices at the facilities. Madison's staff also worked to build relationships between the CPHD and primary care physicians in the county. They visited both of the primary care physicians in the county as an introductory first step with follow-up plans to meet, discuss infant safe sleep and identify ways to work together.

As a result of the visits and dialogue, one communication gap was identified in Madison County. Birthing facilities were not notifying the Madison CPHD when newborns arrived in the county. The communication breakdown was addressed and they are now receiving notifications. A total of seven childcare facilities providing care for 81 children were visited several times throughout the year. During the rounds of daycare visits, the public health nurse and a nursing student initiated conversations with daycare staff about current sleep practices, any challenges, and AAP Safe Sleep recommendations.

The Roosevelt CPHD presented the updated 2022 American Academy of Pediatric Safe Sleep Recommendations (AAP) to

six physicians, physician assistants and nurse practitioners from the Northeast Montana Health Services (NEMHS) in January 2023. Also, the only midwife in the county was in attendance. In the county, and for most of the Fort Peck Reservation, NEMHS providers are the only source of: prenatal care; labor and delivery services; newborn care and assessment; and well-baby visits through six months of age.

The Fort Peck Indian Reservation consists primarily of the Assiniboine and Sioux Tribes. In early 2023, the Roosevelt CPHD sought advice on how to effectively approach infant safe sleep in a culturally relevant way with potential American Indian partners. They spoke to Stephanie Iron Shooter, the American Indian Health Director at Montana's Department of Public Health and Human Services (DPHHS).

In the summer of 2023, Roosevelt's FICMMR coordinator met in-person with approximately 40 Indian Health Service staff members to talk about safe sleep. She provided de-identified, infant sleep death data from their county and introduced them to the safety benefits of the AAP Safe Sleep recommendations. The coordinator fielded questions and provided a handout: "What Does a Safe Sleep Environment Look Like." Several IHS staff members commented on how they could easily incorporate this information into patient visits.

The coordinator also traveled to a medical center an hour away, where many county residents go for healthcare, to share the AAP recommendations. The hospital CEO, one physician and a physician assistant (PA) participated. The PA stated he was unaware of the changes in the safe sleep guidelines, that he appreciated the presentation and would give a strong recommendation for parents/guardians of infants to use them.

Utilizing MCHBG funding, the state FICMMR Office purchased Charlie's Kids Sleep Safe and Snug Books for every CPHD in Montana. Just under 1,700 total books were divided up and distributed to every MCHBG participating county. Also, 180 additional books in Spanish were purchased and distributed to six counties.

In FFY23, the state FICMMR Program Specialist shared the following infant safe sleep resources with the CPHDs:

- *American Academy of Pediatrics:* Sleep-Related Infant Deaths, Updated 2022 Recommendations for Reducing Infant Death in the Sleep Environment
- *The U.S. Food and Drug Administration Safety Communication:* Do Not Use Infant Head-Shaping Pillows to Prevent or Treat any Medical Condition
- *American Academy of Pediatrics Task Force on SIDS:* Infants Are Not as Reactive When Sick (impacting their ability to roust themselves if airways become blocked)
- *Cribs for Kids Organization.* Poster, 12 Steps for 12 Months
  - Safe Sleep Video Library
  - Songfinch: Just Baby: A Safe Sleep Lullaby
- *Eunice Kennedy Shriver National Institute of Child Health & Human Development (NIH):* Get a Head Start on Spring Cleaning: Clear Baby's Sleep Area
- *Eunice Kennedy Shriver NIH* - An Interactive Visual Tool: What Does A Safe Sleep Environment Look Like. Additional articles from NIH:
  - Ways to Reduce Baby's Risk
  - No Product Can Prevent SIDS

The State FICMMR Program Specialist established a relationship with the Coroner Liaison from the Department of Justice. This occurred while conducting a quality assurance review on a CPHD FICMMR team's completion of the Child Death Review Report and using input from the quarterly FICMMR Trainings. Local county coroners complete their county's death certificates, and need infant safe sleep education training. Networking between the FICMMR Program Specialist and Coroner Liaison proved beneficial to both programs. MCHBG funding supported the purchase of infant safe sleep training dolls for each county, which were used by the Coroner Liaison at a Fall/Winter 2023 training.

MCHBG funding also supported the creation of a safe sleep data dashboard by the summer Graduate Student Epidemiology Program (GSEP) intern. The GSEP used data from the Child Death Review System and anticipates that the dashboard will be functioning on October 1, 2024.

Perinatal/Infant Health - Application Year

Infant Safe Sleep (SS, previously NPM 5): A) Percent of infants placed to sleep on their backs, B) Percent of infants placed to sleep on a separate approved sleep surface, C) Percent of infants placed to sleep without soft objects or loose bedding.

County Public Health Department Activities

The six County Public Health Departments choosing to work on NPM 5 activities during FFY 2024 are: Big Horn, Gallatin, Lake, Lewis & Clark, Ravalli, and Yellowstone. Additionally, Phillips CPHD has an SPM 1 infant safe sleep-related activity.

On their Pre-Contract Survey, Gallatin CPHD provided the following insights into why they chose NPM 5:

> *"We chose this Performance Measure as a result of home visitor experience and feedback. Home visitors continue to report seeing a lot of families not following Safe Sleep practices. We provide education on home visits about Safe Sleep but didn't start tracking it until FY20.We feel that having this as a performance measure helps hold the staff accountable to making sure they are providing Safe Sleep education to all families involved in our programs.*
>
> *We had a death in Gallatin County of a baby who was co-sleeping with their mother and died of suffocation as a result of not following Safe Sleep practices a couple of years ago. We later enrolled this family in the home visiting program, after the loss of the child. When they were pregnant with another baby, and home visiting saw the trauma the family was experiencing as a result of that previous loss - it really put Safe Sleep practices as a major priority for the Health Department staff."*

Yellowstone CPHD gave a concise reason for their choice:

> *"Infant mortality continues to be a preventable cause of death in our community. Teaching caregivers about safe sleep practices is key to preventing these deaths."*

Overall, parent/Caregiver education continues to be the leading activity, using a variety of methods and agency partners. Utilizing cross-department partnerships with other programs is the most common method, including: Home Visiting, WIC, and Family Services. Additionally, training staff in other organizations is a popular activity. It helps to broader the scope of families reached with infant safe sleep messaging. In FFY 2024 this includes reaching: Obstetrics providers, Child Protective Services, and daycares.

Details from Lake CPHD on one of its NPM 5 activities is an example of working with daycares:

> *"During immunization day care audits, the nurse will provide safe sleep information (Safe to Sleep materials, information about receiving a Pack 'n' Play, etc.) to all day care staff. The nurse will also leave information packets with the day care providers to give to parents and caregivers whose children attend the day care."*

Distributing portable cribs to families who lack a safe sleep surface for their infants is another main activity. The CPHDs include infant safe sleep education as a part of providing the cribs. Most CPHDs throughout the state do this work in partnership with the *Healthy Mothers Healthy Babies (HMHB) Safe Sleep for Baby Program* (https://hmhb-mt.org/moms-and-families/parenting/safe-sleep-for-baby/). HMHB requires staff from the CPHD to deliver the crib, demonstrate how to set it up, and review safe sleep educational materials with the family.

In FFY25, the FCHB will contract with seven CPHDs who have chosen to focus on NPM 5, and the SPM 1 CPHDs with infant safe sleep activities. They will implement and evaluate community-level activities during the fiscal year. The FCHB will provide these counties with training, resources, and support on evidence-informed or best-practice activities, goal setting, and evaluation.

Fetal, Infant, Child & Maternal Mortality Review Program: CPHD Injury-Prevention Activities

The FICMMR program is working to address instances where the best practice Sudden Unexpected Infant Death Investigation (SUIDI) tool is not being used when county coroners investigate an infant sleep death. The SUIDI is a systematic data collection tool developed by the CDC. It is a guided process in how to conduct an infant sleep environment death investigation.

It is important Montana has a standard, uniform data collection process that is consistently adhered to by county coroners, following the same protocols of investigative work and asking the same questions.The issue in Montana is no one can mandate that coroners use the SUIDI tool. The Montana Coroner's Association, and State Medical Examiner's Office can request its use, but it is not mandated by law. In the past, when an infant sleep death occurred and no SUIDI was used, the FICMMR State Coordinator would work with the County FICMMR Leader to identify and employ strategies to secure buy-in with the coroner. Then the Medical Examiner's Office would call the county and request that the SUIDI tool be used in the future.

The MT State Medical Examiner's Office has now created a new position, a Coroner Liaison, whose charge is to develop working relationships with all MT coroners and provide training. The new Coroner Liaison, Kayla Wallace, has advanced education/certifications in the death scene investigation field and 10 years of experience working in an area of the country with a high volume of deaths. The State FICMMR Coordinator approached Ms. Wallace to request education and re-emphasis on the application of the SUIDI tool at a basic coroner training for new coroners, and also at an advanced coroner conference. Both trainings took place in December 2023.

A key component of the SUIDI practice is utilizing a SUIDI doll for death scene reconstruction. Many counties did not have a SUIDI doll. To help strengthen the coroner trainings and increase incentive to use the SUIDI protocol, MCHBG funding was used to purchase 56 SUIDI dolls, one for every county in Montana. The trainings went well and feedback on the SUIDI was very positive. The basic coroner training had 32 new coroners from 17 counties present and the advanced conference had 34 coroners representing 20 counties. After the training a survey question was submitted to the audience, and every participant responded they felt re-enactment is essential and they will implement changes in their investigative practices. Other feedback included:

- "I never considered how easy a doll can make a case."
- "Please teach this course to detectives."
- "Can we get adult-sized dolls to use too? These would be a great to understand the position a body is found in."
- "The importance of safe sleeping is something I believe has been overlooked in infant death investigations."

One county requested the coroner liaison come out and teach the course to all of their deputies. A total of 37 SUIDI dolls were distributed at both trainings. The other counties will receive SUIDI education and dolls at future trainings.

Ongoing safe sleep education and resources are shared with County FICMMR Leaders on a regular basis. A few examples include for FFY 2024:

- *Children Safety Network Newsletter:* Do Not Use Infant Head Shaping Pillows to Prevent or Treat Any Medical Condition: FDA Safety Communication, Food and Drug Administration
- *National Center for Fatality Review & Prevention Webinar:* Safe Sleep Safe Success Stories featuring South Dakota and Illinois
- *Eunice Kennedy Shriver National Institute of Child Health & Human Development (NIH):* What surfaces are never safe for babies to sleep? Room Sharing is Caring
- *Children Safety Network Newsletter:* Safe Sleep: Strategies to Reach Historically Marginalized Communities
- *Cribs for Kids*: Make A Plan - How to Join in for Safe Sleep Month
- *National Institute for Children's Health Quality (NICHQ) – Safe to Sleep eBlast:*

- Charlie's Kids Set an Alarm every Time you Breastfeed
- Community-Based Approaches to Safe Sleep & Breastfeeding Promotion

Three County Public Health Departments are working on infant safe sleep for their FFY 2024 FICMMR Injury-Prevention activity: Glacier, Roosevelt, and Sheridan. Here are their descriptions of activities currently under way:

Glacier: *"The Glacier County Health Department is partnering with Glacier County WIC office, Logan Health Cut Bank, Glacier Community Health Center, and local childcare facilities to provide the evidence-based Safe to Sleep materials for awareness and education to staff members and their patients. Our target audience is pregnant women, new parents, healthcare facility staff, grandparents and childcare providers. Participants will complete both Pre & Post-education surveys to access their confidence, knowledge, and tools for providing a safe sleep environment for their infants."*

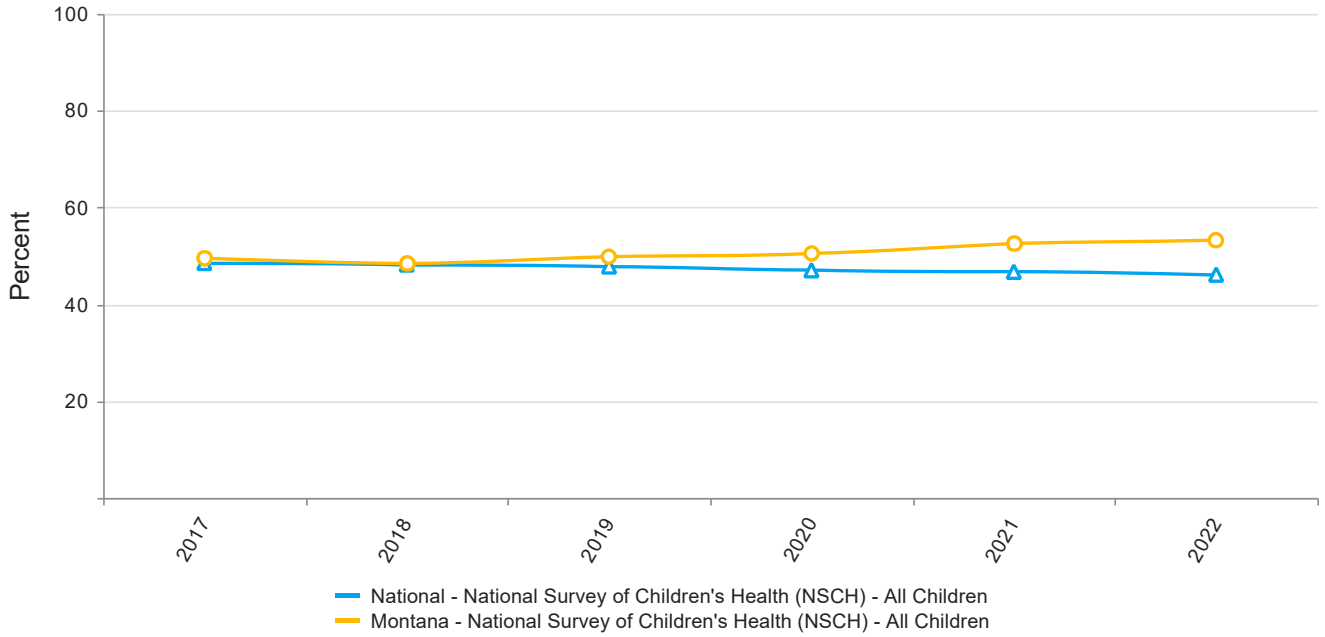
Roosevelt: *"We are partnering with Redbird Women's Center and Fort Peck Tribal Court to provide safe sleep training, which reflects current 2022 AAP Safe Sleep Guidelines and is culturally sensitive to the best of our abilities, to parents of young children who attend parenting classes. Goals include having participants be able to identify the ABC's of Safe Sleep and two ways in which they can improve the current sleep environment/practices used for their child."*

Sheridan: *"Safe sleep swaddles and education materials are provided to all pregnant and new moms in the WIC Clinic to promote best practices for Safe Sleep. There are approximately 15-20 new mom's or newborns seen in our WIC department within a year. Each mom/dad watches a safe sleep educational video when they come to the WIC appointment and then receives the swaddle. The swaddles are in a nice bag which also contains safe sleep educational materials. Each parent is also asked to demonstrate using the swaddle."*

Child Health

National Performance Measures

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH
Indicators and Annual Objectives



NPM MH - Child Health - All Children

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Children	
	2023
Annual Objective	
Annual Indicator	53.1
Numerator	122,359
Denominator	230,397
Data Source	NSCH-All Children
Data Source Year	2021_2022

Evidence-Based or –Informed Strategy Measures

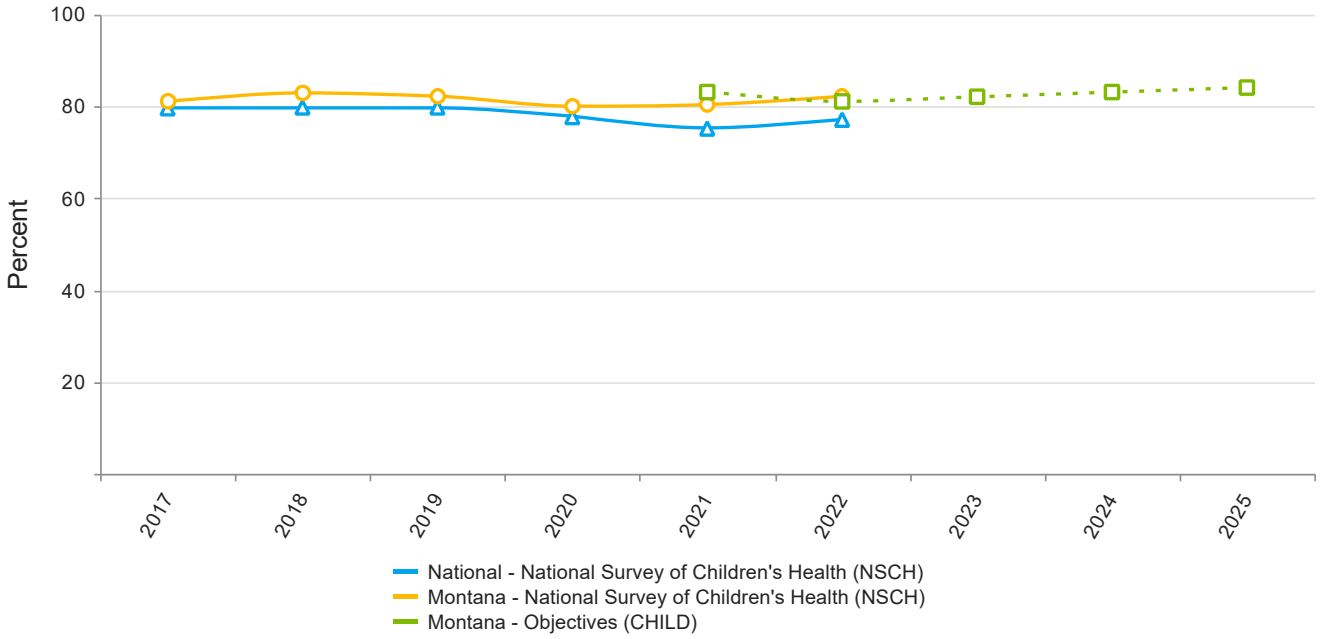
ESM MH.1 - Percent of CYSHCN receiving services from a Parent Partner.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	25	5	5	18	19
Annual Indicator	18.4	56.9	0.3	0.5	0.6
Numerator	36	132	159	274	328
Denominator	196	232	55,048	60,401	57,687
Data Source	FCHB	FCHB	FCHB	FCHB	FCHB
Data Source Year	FFY 2019	FFY 2020	FFY 2021	FFY 2022	FFY 2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	0.7	0.7

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child
Indicators and Annual Objectives



NPM PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			83.0	81.0	82
Annual Indicator	82.6	82.1	80.4	80.4	82.0
Numerator	179,033	177,165	172,678	171,786	179,994
Denominator	216,777	215,773	214,747	213,627	219,427
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	83.0	84.0

Evidence-Based or –Informed Strategy Measures

ESM PDV-Child.1 - Percent of activity goals to increase preventive dental visits for children which are met by county public health departments using MCHBG funding for the work.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			80	82	83
Annual Indicator			87.5	100	100
Numerator			7	11	4
Denominator			8	11	4
Data Source			FCHB	FCHB	FCHB
Data Source Year			FFY 2021	FFY 2022	FFY 2023
Provisional or Final ?			Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	84.0	85.0

ESM PDV-Child.2 - Complete the 3rd Grade Basic Screening Surveillance (BSS) to assess student's oral health status, and produce a report to inform needed oral health services.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	1.0	0.0

State Action Plan Table

State Action Plan Table (Montana) - Child Health - Entry 1	
Priority Need	
Children's Oral Health	
NPM	
NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child	
Five-Year Objectives	
Increase the percent of children, ages 1 though 17, who receive annual preventive care dental visits.	
Strategies	
Support County Public Health Departments who choose NPM 13.2 as their priority need or include oral health activities in their SPM 1 operational plans. State staff provide technical assistance and resources.	
MCHBG funding is supporting a Basic Screening Survey for third grade students across the state. Will partner with Association of State and Territorial Dental Directors for technical assistance, which includes guidance for conducting, analyzing, and reporting BSS data	
ESMs	**Status**
ESM PDV-Child.1 - Percent of activity goals to increase preventive dental visits for children which are met by county public health departments using MCHBG funding for the work.	Active
ESM PDV-Child.2 - Complete the 3rd Grade Basic Screening Surveillance (BSS) to assess student's oral health status, and produce a report to inform needed oral health services.	Active
NOMs	
NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC	
NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC	
NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS	

State Action Plan Table (Montana) - Child Health - Entry 2

Priority Need

Medical Home

NPM

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

Five-Year Objectives

Increase percentage of children without special healthcare needs who have a medical home by 5%, by FFY 2030

Strategies

For FFY26, analyze data for baseline and study evidence-based strategy measures likely to be successful in a state with Montana's geographic and rural/frontier population challenges.

FFYs 2027-2030, create and implement action plan based on results of FFY26 activities.

ESMs	Status
ESM MH.1 - Percent of CYSHCN receiving services from a Parent Partner.	Active

NOMs

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

Oral Health – Child (NPM 13.b): 1) Percent of women who had dental visit during pregnancy; and **2) Percent of infants and children, ages 1 – 17 years, who had a preventive dental visit in the last year.**

County Public Health Department Activities

Two County Public Health Departments implemented activities for NPM 13.2 in FFY 2023, Cascade (MCH Population = 33,739) and Custer (MCH Population = 4,391). They reported successful outcomes for all activity goals.

The following is a snapshot of activities in Custer County from a FFY 2023 quarterly report:

- Provided oral health infographic/fact sheets to seven families of newly birthed/discharged babies in Custer County this quarter.
- 134 WIC families were given the information regarding oral health, and the importance of screenings/preventative care: 14 prenatal; 17 post-partum; 27 <1yr olds; and 76 1-5yr olds.
- The Dentist and Registered Nurse responsible for administering the oral health curriculum, went to the Head Start and did screenings, applied fluoride, and handed out information sheets. There were 42 children who were screened and had fluoride applied; and each child and eight Head Start staff received the education materials.
- After staff assessed a daycare's children and workers' immunizations records, oral health education packets were provided to the 15 daycare families.
- This first quarter of the FFY24, clients of the home visiting program *Supporting Positive Roots by Offering Unique, Teachable Strategies* (SPROUTS) received oral health educational materials.

Cascade CPHD's report included these insights into their work:

Performance Measure Activity #1: Provide oral health education in schools

Evaluation Plan and Goal for Activity #1: The Oral Health Educator will provide education in 25 Cascade County schools, including rural schools and Hutterite Colonies during FFY 2023.

- So far this school year, they have delivered five oral health lessons to 730 students, grades two and three, in Cascade County. Classroom lessons have taken place in 47 classrooms at 19 elementary schools. All students taking part in the Oral Health Program receive toothbrushes and toothpaste to take home.

Performance Measure Activity #2: Provide oral health screenings in schools

Evaluation Plan and Goal for Activity #2: Oral Health Educator will coordinate with local dentists to provide oral health screenings in a minimum of 25 Cascade County schools during FFY2023.

- They have been busy facilitating visual dental health screenings in grades one, three, and four. Dental screenings have been completed in 10 schools, and most schools will finish up next quarter. Any child who has been identified by the school screening in need of dental care, receives a follow-up call from their school nurse, offering assistance to parents in getting their child's needs met, whether it be: helping to find a dentist to treat their child; making an appointment; or helping find financial assistance. The involvement of school nurses in this program has been a beneficial step in helping children receive the dental care they need.

In FFY24, the FCHB is contracting with one CPHD, Beaverhead, who has chosen to focus on NPM 13.2. They are implementing and evaluating two community-level activities during the fiscal year. Seven CPHDs working on SPM 1 have also chosen to implement an oral health activity for FFY24. The FCHB is providing these counties with: training; resources; support on evidence-based/informed or best-practice activities; goal setting; and evaluation.

Oral Health Program Activities for FFY 2023

The Montana Oral Health Program (OHP) received funding from the Health Resources and Services Administration (HRSA) *Grants to States to Support Oral Health Workforce Activities*. The funding will continue to support OHP staffing and activities through September 1, 2026. In FFY 2023, the OHP leveraged existing partnerships with Montana State University College of Nursing (MSUCON), University of Washington School of Dentistry (UWSOD), and Montana Office of Rural Health/Area Health Education Center (MORH/AHEC).

These partners implemented workforce activities that included outreach to high schools students to increase interest in dental careers, training for non-dental students and providers in preventive oral health services in community and medical settings, and dental student rotations in Montana dental health professional shortage areas (DHPSAs). All the activities focused on outreach in Montana's 38 DHPSAs, which are home to underserved and under-resourced communities.

UWSOD and MORH/AHEC collaborated on two programs aimed at addressing the dental workforce challenges by "growing our own." Created by UWSOD, the *Ignite Native Health Scholars (INHS),* for indigenous high school students to learn more about the oral health profession and college preparation, was adapted to be Montana focused. MORH/AHEC began outreach and recruitment with MT American Indian health professionals to serve as mentors and to create a social media marketing plan to market the *INHS* to Montana's American Indian High School students. The first cohort of students will be enrolled in FY 2024.
Additionally, UWSOD and MORH/AHEC adapted the Community Health Professions Academy (CHPA) curriculum for Montana. The CHPA targets 8th through 12th grade students. The students are introduced and paired with a mentor who may be a dental student, faculty, or pre-health undergraduate student, with the goal to introduce the student to a healthcare career. Both of these programs saw delays in implementation in FY23, but will begin implementation in FY24.

Nine students from UWSOD provided care in Montana dental clinic settings: three 4th year students completed their Service-Learning Rotations (SLR) providing 604 dental procedures during 237 patient encounters in rural dental clinics; and six 2nd year students completed their Rural and Underserved Opportunities Program (RUOP) rotation providing 1,440 hours of dental assisting services. SLR rotations allow students to provide a full range of dental services under the supervision of trained dental preceptors and RUOP rotations allow students to shadow and work with dentists and dental assistants to provide preventive services, i.e. fluoride treatments and sealants and local anesthesia.

All UWSOD students rotating in Montana sites received *Dental Education in the Care of Persons with Disabilities* (DECOD) fellowship training for dental curriculum. DECOD includes professional development; interprofessional education; and student training in the care of patients with special health care needs (SHCN). The program was adapted for rural, frontier, tribal, and other underserved populations.

MOHR/AHEC was able to facilitate 87 AHEC Scholars completing eight hours of Smiles for Life curriculum. AHEC Scholars is a certificate program to prepare and promote a diverse, skilled primary care workforce in rural and underserved communities. The Scholars were students from diverse educational programs including: 43 bachelors of nursing students, 10 dietetics, 9 licensed practical nurses, 8 athletic training, 7 doctorate of nurse practitioner, physical therapy, exercise science, and community health workers.

During FFY23 MSUCON provided preventive oral health care during 547 encounters in the Northern Cheyenne and the Blackfeet Head Start Programs. Preventive services were provided by MSU nursing students in collaboration with dental hygiene providers to deliver fluoride varnish applications and provide oral evaluations. Nursing students also assisted RDHs in the delivery of preventive dental sealants in 46 children.

MSUCON also developed an oral health messaging campaign illustrating the mechanism of action of silver diamine fluoride (SDF). Messages on SDF and "First Tooth. First Visit" were run four times a day at 20 American Indian clinic sites, with an estimated 29,380 unique impressions. A survey to evaluate the activity was developed and approved by the health board and data collection began in FFY24.

Other partners, WIM Tracking and Yarrow, facilitated 3 stakeholder meetings to inform oral health workforce assessment activities. Qualitative and quantitative data were collected from stakeholders and has been analyzed to develop an oral health workforce document. The report will be released in FFY24, following the approval process. The 2023 assessment utilizes a broad range of workforce data and, along with the quantitative and qualitative data collected, will inform about current and future oral health workforce distribution and capacity in Montana. The results will benefit the discussions determining the 2026-2030 MCHBG Health Priorities as determined by the MCHBG Needs Assessment.

Child Health - Application Year

Preventive Dental Visit – Child (PDV-Child, previously NPM 13.2): 1) Percent of women who had dental visit during pregnancy; and **2) Percent of infants and children, ages 1 – 17 years, who had a preventive dental visit in the last year.**(We are using for Children's Health domain.)

County Public Health Department (CPHD) Activities

One CPHD, Beaverhead, is implementing activities specific to NPM 13.2 during FFY 2024. However, six CPHDs who chose SPM 1 also have activities related to oral health: Carter, Fergus, Phillips, Sanders, Valley, and Wibaux.

On their Pre-Contract Survey, Beaverhead provided the following information as to why they chose NPM 13.2: *"Dental screening is provided at the rural schools, but there is no data on the percent of students who are actually are screened, and followed up with if referred. We will also inquire if School District 10 provides dental screenings, and if not, help coordinate that service to the school."*

As far as the SPM 1 CPHDs, Carter County's response is representative of the needs they all face: *"These are needs that are warranted in our county due to lack of other options locally and the frontier size of county to access services in other areas. In addition, the rise of living costs and burden of time required to reach other options, also highlight the continued need."*

Additionally, Wibaux CPHD's response speaks specifically to the outcome benefits for children: *"Oral health screening (in the schools) has been beneficial to children in identifying the need to see a dentist, and preventing serious dental concerns. The education and resources given to the children help to give them the control to prevent dental caries."*

Beaverhead CPHD activities, evaluation plans, and goals are as follows:

1. Description and Goal: Collaborate with the six rural schools to coordinate oral health screening for 90% of students utilizing the CHC dentist during the rural school health fairs in the fall of 2023. Evaluation: 1. The number of students per school who were screened vs. number of students who attend school. 2. The number/percent of students who were referred to dental services. 3. The number/percent of students who followed up with referrals.

2. Description and Goal: Meet with two area dentists to collaborate on two activities to promote and encourage dental screening for children five and under by December 2023. Evaluation: 1. Documentation of the date of meeting. 2. Determine at least 2 gaps/needs/concerns the dentists are seeing regarding oral care for children ages five and under. 3. Develop a project or activities to address these concerns.

Carter CPHD (Total MCH Population = 411), is leveraging a partnership with a non-profit organization to implement its activity:

> Description: Partner with provider/organization to provide preventative oral health care which includes referral to oral healthcare providers. Engage with the *Smiles Across Montana* (SAM) organization for preventative oral health care. Participation from county residents will be encouraged through advertisement of SAM's mission, and the resulting ease of accessing local care. Once participants sign up the first time they are then seen for every visit locally thereafter (no re-signup). Goal: track those who are accessing ongoing engagement. Creating a retention goal is difficult due to factors including: ageing out; moving; and eventual lack of need. Therefore, we have a new patient goal to increase by six over the course of the year.

In FFY25, the FCHB will contract with Cascade CPHD who has chosen to focus on NPM 13.2, and the SPM 1 CPHDs with oral health activities. They will implement and evaluate community-level activities during the fiscal year. The FCHB will

provide these counties with training, resources, and support on evidence-informed or best-practice activities, goal setting, and evaluation.

Oral Health Program Activities for FFY 2024

Montana last conducted the Basic Screening Survey (BSS) for third grade students during the 2017-2018 school year. During the 2023-2024 the Oral Health Program (OHP) is surveying the third grade population to update surveillance data. To date, data has been collected in 33 schools in the 40 school sample , which was stratified by geographic location and income variables. Upon completion, data will be submitted to the National Oral Health Surveillance System. OHP staff collaborated with Association of State and Territorial Dental Directors (ASTDD) to assist with sample selection and will leverage their assistance for analysis and report development.

The 3rd grade survey data with be shared with participant sites and a broad group of oral health stakeholders to support oral health literacy, access to dental care in Montana communities, and inform future programming. The BSS data collection is a collaboration between the Maternal & Child Health Block Grant (MCHBG) and the OHP with MCHBG funding for the data collection, and the OHP funding the technical assistance by ASTDD. Additionally, CPHDs and others who request oral health technical assistance will be routed to the OHP.

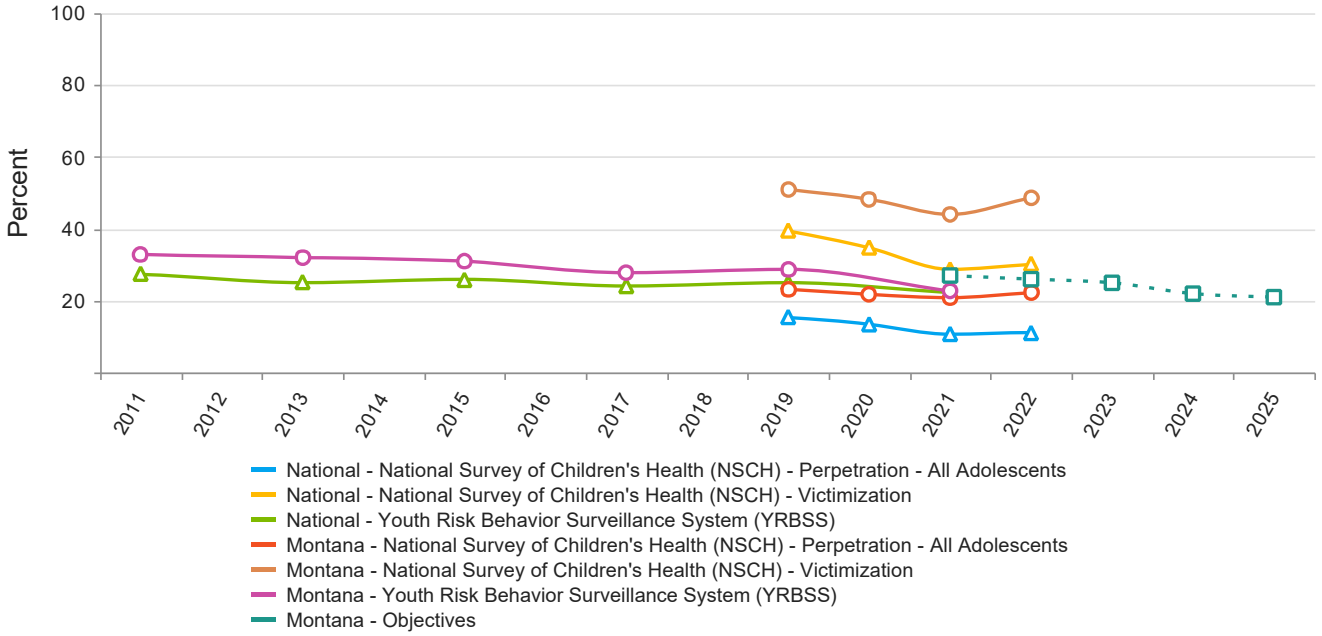
Additional communication planning includes the development of an infographic outlining Kindergarten survey data collected in 2021-2023. This will be shared with the participating schools, and other stakeholders, to inform and elevate the importance of oral health in Montana communities. The *2024 Oral Health Workforce Assessment* will also be released during FFY24 to a broad range of stakeholders, to inform future oral health workforce activities. Dissemination data for BSS and the workforce assessment will be documented in the OHP Communication plan.

In May 2024, the OHP was awarded a $1.7 million grant from the Health Resources & Services Administration, which began on July 1, 2024. This four-year grant is focused on MCH population oral health-medical integration. The work will be led by the Montana Oral Health Equity Alliance (MOHEA) which is a collaborative effort with the OHP as the applicant and lead of the project. Partners include: the Montana Primary Care Association; Montana State University's Mark and Robyn Jones College of Nursing; Montana Office of Rural Health and Area Health Education Center; OneHealth – FQHC; Ag Worker Health and Services – FQHC; Proyecto Salud clinics; and Northern Cheyenne school-based clinics. MOHEA's goal is *improved access to preventive oral health care and oral health equity* among the maternal and child health populations, focusing on persons ages 1-21 living in Montana's rural, frontier, and underserved communities.

Adolescent Health

National Performance Measures

NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, Formerly NPM 9) - BLY
Indicators and Annual Objectives



NPM BLY - Adolescent Health

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			27.0	26.0	25
Annual Indicator	27.8	28.5	28.5	22.9	22.9
Numerator	11,393	11,853	11,853	9,789	9,789
Denominator	40,974	41,603	41,603	42,701	42,701
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2017	2019	2019	2021	2021

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Perpetration - All Adolescents					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			27.0	26.0	25
Annual Indicator	23.2	23.2	22.5	20.3	22.4
Numerator	16,058	16,805	17,091	15,714	17,893
Denominator	69,345	72,374	75,957	77,247	79,994
Data Source	NSCHP	NSCHP	NSCHP-All Adolescents	NSCHP-All Adolescents	NSCHP-All Adolescents
Data Source Year	2018	2018_2019	2019_2020	2020_2021	2021_2022

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Victimization					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			27.0	26.0	25
Annual Indicator	45.2	48.9	48.1	45.0	48.6
Numerator	31,448	35,450	36,567	34,753	38,939
Denominator	69,617	72,511	75,967	77,283	80,203
Data Source	NSCHV	NSCHV	NSCHV-All Adolescents	NSCHV-All Adolescents	NSCHV-All Adolescents
Data Source Year	2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	22.0	21.0

Evidence-Based or –Informed Strategy Measures

ESM BLY.1 - Percent of activity goals to reduce adolescent bullying which are met by county public health departments using MCHBG funding for the work.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			80	82	83
Annual Indicator			80	0	100
Numerator			12	0	2
Denominator			15	4	2
Data Source			FCHB	FCHB	FCHB
Data Source Year			FFY 2021	FFY 2022	FFY 2023
Provisional or Final ?			Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	84.0	85.0

ESM BLY.2 - Completion of Bullying Prevention Social Media Campaign

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	35.0	0.0

State Action Plan Table

State Action Plan Table (Montana) - Adolescent Health - Entry 1	
Priority Need	
Bullying Prevention	
NPM	
NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, Formerly NPM 9) - BLY	
Five-Year Objectives	
Decrease the percent of adolescents, ages 12 through 17, who are bullied or who bully others.	
Strategies	
Support County Public Health Departments who choose NPM 9: Bullying Prevention as their priority need and for those who include bullying prevention activities in their SPM 1 operational plans. State staff will provide technical assistance and resources.	
Conduct an evaluation of the "Power Up Speak Out" curriculum, to determine if could be considered a promising/best practice evidence based curriculum	
Bullying prevention social media campaign, using videos from StopBullying.gov.	
ESMs	**Status**
ESM BLY.1 - Percent of activity goals to reduce adolescent bullying which are met by county public health departments using MCHBG funding for the work.	Active
ESM BLY.2 - Completion of Bullying Prevention Social Media Campaign	Active
NOMs	
NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM	
NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide	

Bullying Prevention (NPM 9): Percent of adolescents, ages 12 through 17, who are bullied or who bully others.

County Public Health Department Activities

The four County Public Health Departments (CPHDs) who worked on NPM 9 activities in FFY 2023 are all in smaller population-size counties: Blaine, Deer Lodge, Granite, and Madison. This tends to provide an advantage for relationship building with the schools and in the communities. In 2017, Johns Hopkins University Women's and Children's Health Policy Center published a brief on how to *Strengthen the Evidence Base for Maternal and Child Health Programs*. In their review, the programs with the best levels of evidence for bullying prevention all involved schools.

Blaine CPHD (MCH population = 3,413) supported bullying prevention education for teachers. They used online curriculums provided through the Montana Office of Public Instruction's Teacher Learning Hub (https://opi.mt.gov/Educators/Teaching-Learning/Teacher-Learning-Hub):

- Building Respect: Bullying Prevention
  An interactive role-play simulation about responding to bullying incidents. It uses practice conversation techniques to: address biased language in the classroom; introduce how to reach out; and reinforce staff responsibilities in reporting bullying behavior.

- Bullying and Cyberbullying Prevention Among Rural and Tribal Youth
  In this course, teens learn how to implement bullying prevention strategies with a focus on rural and tribal communities. The content covers how to recognize bullying, its effects, and how to prevent bullying in school. It also addresses cyberbullying and how to educate students in healthy digital citizenship.

Blaine CPHD also partnered with their Mental Health Local Advisory Council to provide education on bullying prevention. At a joint community event, 250 youth were reached with a bullying-prevention message as a part of that presentation.

Deer Lodge CPHD (MCH population = 2,910) focused on bullying prevention and collaborating with schools to implement education and support student assemblies with national speakers. The CPHD recognized the importance of involving the community in the prevention of bullying. Seven community events were organized, and afterschool supports put in place for at-risk youth. Here are some examples:

- Dr. Heather DiBlasi a National Public Speaker for the Elks made a presentation to Anaconda School's PE classes. The age group targeted were Freshman and Sophomores in high school (14-16 years). Dr. DiBlasi touched on mental health topics, youth in crisis, suicide, bullying and substance abuse.
- The Anaconda Suicide Prevention Taskforce hosted Jeff Mack of the Matthew Shepard Foundation for a community presentation about inclusivity (specifically for the LGBTQ+ population). Around 60+ individuals attended the presentation.
- The CPHD partnered with Anaconda Jr. Sr. High School, and brought a speaker in to discuss online Safety for teens, legal consequences for using phones for cyber bullying and how the legal system works.
- The Deer Lodge County Attorney made a presentation to 9th through 12th grade students. His talk was focused on the legal aspects of using phones for cyberbulling and sending private pictures. He explained to the students if they are caught using a phone for these tactics it is considered electronic communications and charges can be filed on the user. He also discussed the mental stress of being cyber-bullied and that a young person took their life due what someone thought was "No big deal".
- The CPHD met with the school leadership and the mental health council to discuss and support anti-bullying programs in the school. School counselors and mental health council members will implement several strategies into their homeroom classes on a regular basis, coupled with their suicide prevention work. These strategies were also used in summer school, and continue into the 23-24 school year.

Granite CPHD (MCH population = 1,055) has an especially close working relationship with the high school counselor, as that staff person uses an office co-located within the health department. This facilitated consistent communication and guidance as the two organizations collaborated on the creation of a bullying prevention program for the school.

Madison CPHD (MCH population = 2,525) addressed bulling prevention through a poster campaign. Posters were created by youth through a contest. The winning posters were published in the local newspaper, with resources for parents, and posted on social media. Madison CPHD addressed the mental health side of bullying by training students in Question Persuade Refer (QPR).

State-Level MCHBG Activity

Starting in June 2023, state-level staff began working with an advertising agency to create a bullying prevention social media campaign. It used the evidence-based resources available at StopBullying.Gov (https://www.stopbullying.gov/videos-social-media), and created a social media buy across the most relevant platforms. Tracking of click-throughs and impressions are gauging effectiveness and return on investment. The primary target audience is adolescents aged 10-18, with secondary target audiences of parents/caregivers and teachers. The ads began running at the beginning of the schoolyear, during September and October 2023 – and are continuing into FFY24.

In FFY24, the FCHB is contracting with one CPHD who has chosen to focus on NPM 9. They are implementing and evaluating two community-level activities during the fiscal year. Two CPHDs working on SPM 1 have also chosen bullying prevention or suicide prevention activities for FFY24. The FCHB is providing these counties with training; resources; support on evidence-based/informed or best-practice activities; goal setting; and evaluation.

Fetal, Infant, Child & Maternal Mortality Review Teams: Injury-Prevention Activities

During the 2020 Statewide 5-Year Needs Assessment, bullying and suicide emerged as interrelated issues. The 2017 YRBS data showed 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%). The 2021 YRBS data showed 32% of high school students attempted suicide requiring medical treatment.

Twelve CPHDs addressed Suicide Prevention for their FFY 2023 Fetal, Infant, Child, & Maternal Mortality Review (FICMMR) injury-prevention activity. Working with partners in the schools and communities are the top collaborations and venues for these activities. One unique focus is in Yellowstone County, where the CPHD is working with the foster care system. Flathead County received extra funding through a community safety grant to support their gun lock initiative. News of the award was featured in the November 18, 2022 edition of the Daily Inter Lake (https://dailyinterlake.com/news/2022/nov/18/roundup-safety-supports-schools-partnership-nate-c/). The CPHDs utilized one, or a combination of, the following evidence-based/informed programs: Question Persuade Refer (QPR); Mental Health First Aid (MHFA); Signs of Suicide (SOS); and/or firearm storage to educate youth, parents, and community members.

In 2021, young drivers accounted for 18% of the Montana fatalities in crashes which is an increase of 35.5% from the previous year. There were five CPHDs addressing motor vehicle safety through Impact Teen Drivers. Missoula County has created a Drive Save Missoula website to promote road safety (https://www.drivesafemissoula.com/). Missoula County is also working on implementing Impact Teen Drivers' "Be the Change" where young people are facilitating the training to their peers. Powell County also utilized a local resident to talk about her experiences and recovery from an accident when she was 19 years old, and not wearing a seat belt (https://mdt.mt.gov/visionzero/people/buckleup/reality-check.aspx). Her story demonstrates the importance of seat belts and prevention of serious life altering injuries.

During FFY23 Granite CPHD supplemented their MCHBG-specific NPM 9 activities by focusing their FICMMR injury prevention activity on bullying prevention as well. Here are the details of those plans:

Description: The focus was geared toward cyber-bullying prevention in the county's three schools. They partnered with law enforcement (the School Resource Officer); the school therapist; and all school staff that interact with students. They used the following resources for planning purposes: statistics from the CDC website; Youth Risk Behavioral Survey (YRBS) results for schools; and Schoolsmart.org. They have a planning committee to steer the activities in the county.
Goals: 1. Presented age-appropriate activities to the three schools, utilizing resources obtained from the sources mentioned in the description. 2. Pursued mini grants to help the schools bring in additional funding for the activities.
Evaluation: 1. Attendance was taken at each activity. 2. Pre- and post-training surveys were collected from all participants.

Adolescent Health Needs Assessment

The Family & Community Health Bureau, Maternal & Child Health Coordination Section (MCHC), and Adolescent Health Program Specialist collaborated with Yarrow LLC in conducting a statewide Adolescent Health Needs Assessment. The assessment was a systematic, data-driven approach to determining the health status, behaviors, and needs of adolescents in Montana. The goals of the assessment were to more clearly understand the gaps, barriers, and resources across Montana communities and tribal land which are impacting: physical and mental health; teen pregnancy; sexually transmitted infection rates; and rates of bullying and sexual violence.

The needs assessment employed a mixed-method design using both quantitative and qualitative methods and was made up of five components: key Informant Interviews; youth focus groups; community surveys; secondary analysis of population health and demographic data; and resource mapping. The assessment is finished and currently being reviewed internally for release.

MCHC and AHS will be utilizing the MCHBG Statewide 5-Year Needs Assessment to inform future programing for Montana adolescents, and to engage stakeholders in collaboration for meeting identified needs with youth-centered strategies. AHS's *Optimal Health for Montana Youth* continues to promote a holistic teen pregnancy curriculum that encompasses bullying and suicide prevention.

Adolescent Health - Application Year

Bullying Prevention (BLY, previously NPM 9): Percent of adolescents, ages 12 through 17, who are bullied or who bully others.

County Public Health Departments Activities

One County Public Health Department (CPHD), Madison, is implementing activites specific to NPM 9 during FFY 2024. However, two CPHDs who chose SPM 1 also have activities related to bullying prevention: Blaine and Rosebud. In addition, nine CPHDs are addressing suicide prevention for their FICMMR injury-prevention activity. Bullying is often a contributing cause of suicide.

On their Pre-Contract Survey, Madison CPHD provided the following information as to why they chose NPM 9: *"We received feedback from numerous parents within our community expressing their concerns about bullying across all of our schools. Additionally, our county has unfortunately witnessed a notable suicide rate, with a recorded number of 8 suicides from 2021 to the present (according to the local County Clerk and Recorder). As we selected this performance measure for FFY 23, we had high expectations for enthusiastic community involvement, which we did not fully achieve. However, we remain committed to building upon our accomplishments during FFY24, to create a more substantial and meaningful impact."*

Madison's activities for NPM 9 are in partnership with local schools, as noted in their descriptions:

> Activity #1 - Host a poster contest for middle school students in the county. To encourage participation, we plan to offer prizes, including a reward for the teacher who achieves the highest participation percentage among their students. Our objective is to engage students from all schools in this initiative. Furthermore, we intend to showcase the top 5 submissions by printing them on yard signs to be prominently displayed throughout our communities. Additionally, we will publish the winning submission in the county newspaper. Voting will occur both anonymously online and through various social media platforms.
>
> Activity #2 - Provide *Question, Persuade, Refer* (QPR) training to high school students throughout the county. Our objective is to offer training sessions at each of our four high schools, aiming to train a group of five students in each school. To gauge the effectiveness of the training, we will administer pre- and post-training surveys to assess the impact and progress made.

Blaine CPHD's suicide prevention activity for SPM 1 is as follows:

> Sponsor a coloring contest for suicide awareness: a Blaine CPHD staff member, or Mental Health Advisory Council partner, will contact each Blaine County school to provide information and supplies for a coloring contest. The educational /
> awareness message that accompanies the coloring/drawing contest is dependent on, and appropriate for, specific grade categories, i.e. K-3, and 4-12. The goal is to reach every school in the county, and receive 175 entries in the coloring contest and 30 drawings.Prizes will be awarded to top finishers in each category and the winner of the drawing entries will be the coloring page distributed for an additional outreach activity.

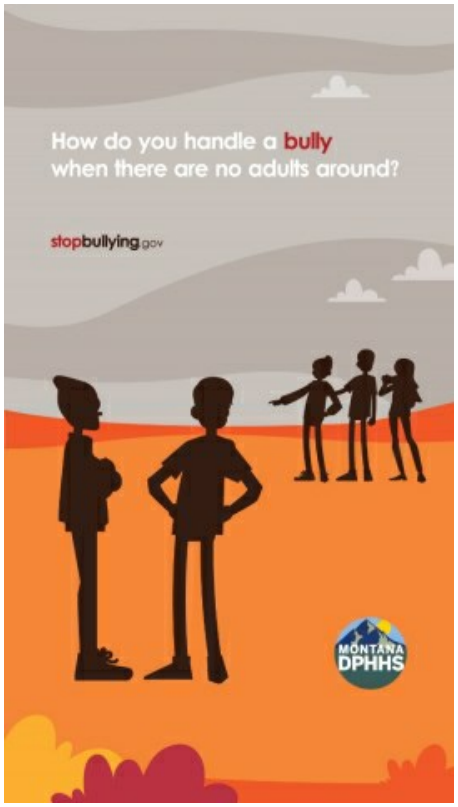
Here are the highlights for Rosebud CPHD's SPM 1 suicide prevention activity:

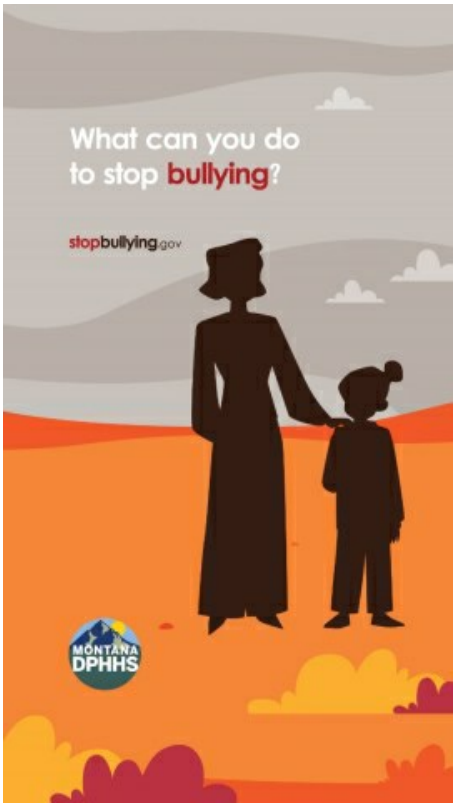
> Present an educational awareness training on suicide prevention in the high school. We will use the evidence-based material from *Signs of Suicide* (SOS). Each student enrolled in the program will take a pre- and post-test. Our goal is that the students will increase their knowledge of suicide prevention by 50%.

In FFY25, the FCHB will contract with the SPM 1 CPHDs who have bullying prevention activities. They will implement and evaluate community-level activities during the fiscal year. The FCHB will provide these counties with training, resources, and support on evidence-informed or best-practice activities, goal setting, and evaluation.

State-Level Activities

As noted in the FFY 2023 report, a bullying prevention social media campaign began in September 2023, and is continuing into FFY 2024. The campaign uses a total of seven different messages and graphics in advertisements on Facebook and Instagram: four targeted toward adolescents; and three toward adults, including one specifically for educators. "Click through rate" (CTR) measures how many times an ad is viewed and clicked through to read more or take other action. Industry standard CTR is 0.5%. To-date, the CTR on the ads for adults is 0.86%, and for adolescents is 0.31%. The following graphics are the ads for the two intended audiences which have had the highest click-through rates:





Fetal, Infant, Child & Maternal Mortality Review (FICMMR) Activities

Nine CPHDs chose suicide prevention for their FICMMR injury-prevention activity for FFY 2024. Six CPHDs are working in partnership with local schools for their activities, two target adults in their communities for training, and one focuses on pediatric providers. Most of these activities have an end goal of increasing participants knowledge and comfort level for recognizing and intervening with someone who is contemplating suicide or self-harm.

For the CPHDs working with schools, four have activities specifically targeted at training students: Lewis & Clark, Phillips, Rosebud, and Sweet Grass. All are using SOS, which is an evidence-based youth suicide prevention program that has demonstrated an improvement in students' knowledge and adaptive attitudes about suicide risk and depression. Designed for grades 6-12, SOS teaches students how to identify signs of depression and suicide in themselves and their peers, while providing materials that support school professionals, parents, and communities in recognizing at-risk students and taking appropriate action.

Carbon CPHD is targeting both school students and staff. For the students they are using a program called *Hope Squad*. A Hope Squad is a group nominated by their peers. They meet regularly with trained advisors to talk and learn about mental health. Members are trained to note signs of distress and reach out, connecting peers to help and hope. Hope Squads interact with and educate the entire student body to reduce stigma and change their community's culture. For the adult/staff focused training they are using QPR. Custer CPHD is also using QPR for training adults in the community.

People trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. QPR utilizes the concept of a gatekeeper, which is someone in a position to recognize a crisis and the warning signs that someone may be contemplating suicide. Gatekeepers can be anyone, but include parents, friends, neighbors, teachers, ministers, doctors, nurses, office supervisors, squad leaders, foremen, police officers, advisors, caseworkers, firefighters, and anyone else who is strategically positioned to recognize and refer someone at risk of suicide.

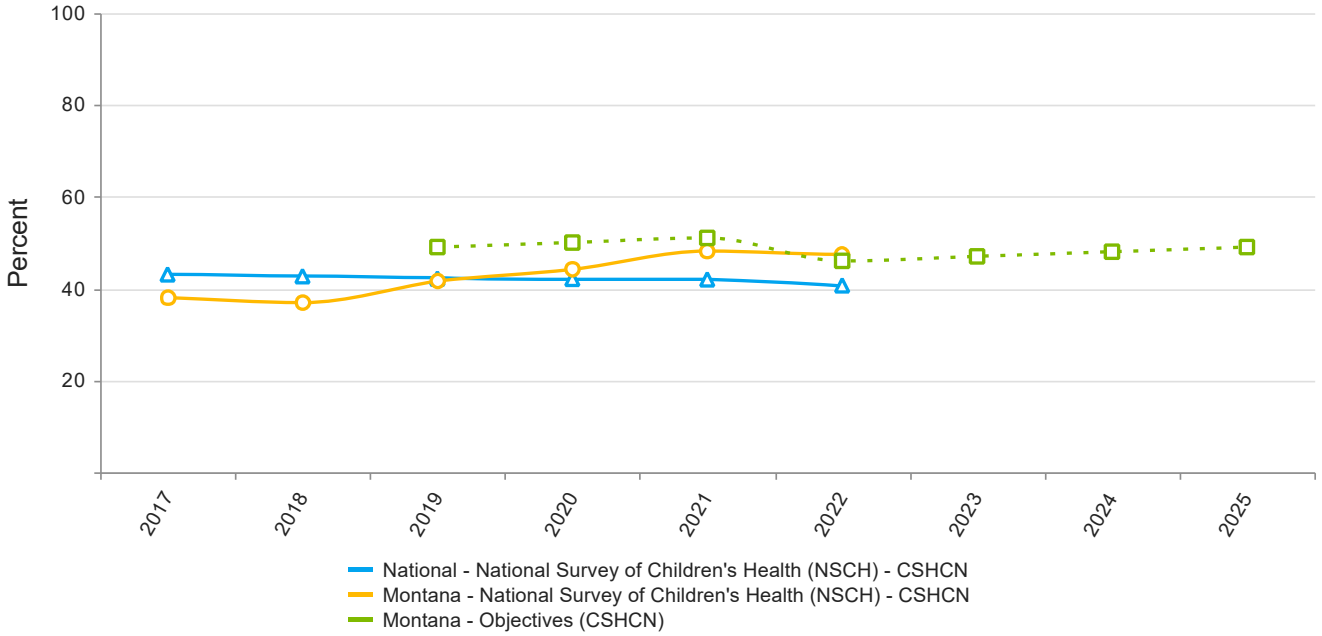
Sanders CPHD is focusing their training on school staff, and is using the *Talk Saves Lives* program. *Talk Saves Lives* is American Foundation for Suicide Prevention's standardized, 45-60 minute education program that provides participants with a clear understanding of this leading cause of death, including the most up-to-date research on suicide prevention, and what they can do in their communities to save lives. Participants learn common risk factors and warning signs associated with suicide, and how to keep themselves and others safe.

Cascade CPHD is taking a different approach with their suicide prevention activity in FFY 2024. Their FICMMR team is concentrating on ways to increase the number of childhood pediatric mental health referrals to providers. The goal of this undertaking is to: increase frequency of screenings; educate parents; share a referral resource list; and provide referrals to providers for children that need immediate services. The team is collaborating with Benefis Healthcare System pediatric providers to evaluate current practice, and increase the frequency of mental health/depression screenings for the pediatric population.

Children with Special Health Care Needs

National Performance Measures

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH
Indicators and Annual Objectives



NPM MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	49	50	51.0	46.0	47
Annual Indicator	36.8	43.5	45.5	46.8	47.3
Numerator	16,404	19,378	19,982	21,866	25,831
Denominator	44,607	44,583	43,885	46,767	54,657
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	48.0	49.0

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Percent of CYSHCN receiving services from a Parent Partner.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	25	5	5	18	19
Annual Indicator	18.4	56.9	0.3	0.5	0.6
Numerator	36	132	159	274	328
Denominator	196	232	55,048	60,401	57,687
Data Source	FCHB	FCHB	FCHB	FCHB	FCHB
Data Source Year	FFY 2019	FFY 2020	FFY 2021	FFY 2022	FFY 2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	0.7	0.7

State Action Plan Table

State Action Plan Table (Montana) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Medical Home	
NPM	
NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	
Five-Year Objectives	
Increase the percent of CYSHCN which have a medical home to 53% by 2023.	
Strategies	
CSHS is collaborating with the Great Falls Public School District to introduce a pilot project focused on transitions for high school aged CYSHCN by providing peer support to reach specific transition goals. There will be an evaluation plan in place with the end goal of expanding this project statewide.	
Montana's Peer Network, through a contract with CSHS, is working to obtain certification for Family Peer Supporters. This requires a committee to form the proposal and legislative approval.	
CSHS will hold a CYSHCN Stakeholders meeting, with a focus on creating opportunities for networking and strategy sharing.	
ESMs	**Status**
ESM MH.1 - Percent of CYSHCN receiving services from a Parent Partner.	Active
NOMs	
NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC	
NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX	
NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS	
NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC	

NPM 11 – Medical Home: percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

CSHS Staff and Programming

Children's Special Health Services (CSHS) addressed NPM 11 by offering gap-filling programs, such as peer support services and resource coordination programs, to all children and their families in Montana. CSHS offered a variety of population health and direct service programs while collaborating with Children & Youth with Special Health Care Needs (CYSHCN) programs across DPHHS. Three CSHS Program Specialists (PS), a CSHS Nurse Consultant and the Title V CYSCHN Director/Section Supervisor, managed these CYSHCN focused programs: Cleft/Craniofacial Clinics; Statewide Genetics Program; Metabolic Clinics; Newborn Hearing Screening Program; and the Montana Access to Pediatric Psychiatry Network (MAPP-Net).

Through Title V Maternal & Child Health Block Grant (MCHBG) funding, CSHS supported initiatives to increase parent leaders and peer-to-peer support through the Family Peer Support program and Circle of Parents. Population-based initiatives were supported through the Transitions Project and Leadership High School Youth Peer Support.

Many staff transitions occurred in FFY23. Position turn over included: the CYSHCN Director/ Section Supervisor; Title V CYSHCN Program Specialist; CSHS Program Assistant; Nurse Consultant; and Newborn Hearing Screening Program Specialist. The CYSHCN Director/ Section Supervisor position was filled by the Newborn Hearing Screening Program Specialist, who brought 16 years of public health experience, eight of which were overseeing the Newborn Hearing Screening Program. The Title V CYSHCN Program Specialist was previously the CSHS Program Assistant. The Newborn Hearing Screening Program Specialist position was filled in the middle of July. Joint interviews for a Nurse Consultant took place with the Title V MCHBG Director, who was also filling a nurse consultant position.

Growth within CSHS

CSHS worked towards implementing the HRSA framework to advance NPM 11 by prioritizing: family engagement; provider engagement; coordinated care; and systems building. These priority areas are all framed and guided by: a family-centered approach; diversity, equity, and inclusion; and evidence-based practices. These priority areas are the basis of the strategic plan and have continued to guide this section during FFY23 and FFY24. The programs that CSHS funds intersect with multiple priority areas. In this report, programs are organized by priority area based on FFY24 future plans and areas of growth.

Coordinated Care

In order to improve access to care coordination across our regional health systems, strategies must be employed to: support systematic improvements of care coordination; advance the Medical Home and National Standards of Care: and ensure that families remain engaged during care coordination. As a part of coordinated care, CSHS continued to provide peer support programs through MCHBG funded programs.

FFY23 Peer Support

The CSHS Family Peer Support Program experienced changes prior to the beginning of FFY 23. To address these changes, an RFP was issued in the summer of 2022. The purpose was to provide funding for family-centered peer support services that improve access to the medical home, and support CYSHCN families in navigating the system of care. This RFP allowed for applicants to address different levels of peer support to include: population, group, and individual peer support; versatility to approach peer support; and helped to identify new partners and collaborations within the state.

Current service providers were invited to respond to the RFP: the HALI/Montana Parent Partner Program, Circle of Parents, and the Medical Home Portal. Montana's Peer Network (MPN), and the Early Childhood Coalition of Beaverhead County (ECCBC) Canvas Early Learning Center were the successful applicants and were awarded contracts that began on October 1, 2022. Quarterly, the CSHS staff met with MPN and ECCBC staff to ensure they were meeting contract deliverables, and to provide technical assistance as needed. Annually, their performance will be reviewed prior to contracts being renewed, under the terms of the RFP.

During FFY23, the Family Peer Support Program, and Circle of Parents were employed to provide individual and group peer support. Below are examples of programs and activities that incorporate care coordination, advance coordinated care, and work to decrease siloes within the healthcare system.

Family Peer Support Program through Montana's Peer Network (MPN)

On October 1, 2022, Montana's Peer Network (MPN) began providing individual peer services to families of CYSHCN across Montana for FFY23. The mission of MPN's Family Division is to provide family peer support across the state for families of children with special health care needs such as those with developmental, intellectual, physical health, mental health, and substance use challenges. Prior to having a family division, MPN provided peer services solely to individuals in recovery. MPN continued the family peer support services began by the HALI Project, whose contract ended September 20, 2022. To ease this transition, the CEO of the HALI Project, Brad Thompson provided technical assistance to MPN.

In the beginning of FFY23, MPN employed four Family Peer Supporters, at three clinic locations: Butte, Billings and Helena. Throughout FFY23, MPN faced turnover of the Family Peer Supporter in Butte leaving only three Family Peer Supporters in Billings and Helena. In FFY23, MPN served 235 distinct clients in 1,675 different encounters; offering valuable support, encouragement, and hope to families. Types of encounters included a phone call to provide support, an in-person conversation about resources, or a simple referral to other programs.

The number of distinct clients served by MPN in FFY23 was more than the number of distinct clients served by the HALI Project in FFY22. One explanation is the Family Peer Supporters that carried over from the HALI project, as they sustained old connections and were able to make new ones. Also, MPN is a well-established organization in Montana providing peer services. Another reason is reduction of restrictions from the COVID-19 pandemic in this fiscal year caused there to be less limitations, allowing Supporters to enhance their connections even further. MPN is eligible for renewal for seven years, pending positive outcomes and value of support.

Circle of Parents (CoP)

Circle of Parents (CoP) is a support group program modeled after the national Circle of Parents *Train the Trainer* model. The CoP aims to decrease isolation, prevent child abuse and neglect, and strengthen families through free monthly caregiver support groups. One unique component of CoP is that it is parent led, and each group was provided a stipend to assist in offering a supportive environment with a free meal and free childcare for families. CoP groups varied based on location and identified community need, some of which included: families with CYSHCN or Mental Health Concerns; Foster Families, and Postpartum Mental Health concerns.

The Early Childhood Coalition of Beaverhead County (ECCBC) is the contractor for this program. In FFY23, eight different groups met in one of these locations: Butte, Missoula, Great Falls, Dillon, Havre, Mineral County, and Big Horn. For context, in October of 2022, eight adults and 12 children attended a meeting in Dillon, while seven adults and four children attended a meeting in Butte. This reflects how each meeting location tends to have different attendance rates, based on the needs of the communities. ECCBC is focused on increasing the number of groups to 12 in FFY24.

Youth Peer Support

CSHS engaged in a new Youth Peer Support project by partnering with the Great Falls Area Chamber of Commerce (GFACC) Leadership High School (LHS) program. This program has been present in Great Falls schools and the surrounding areas for over 15 years. Interested high school students were selected from a competitive application process to ensure that they would be successful as a peer mentor.

The CSHS Youth Peer Support project matched a LHS student with a student with special needs enrolled in the Great Falls Public School (GFPS) system or living in the community. The peer match is required to meet at a minimum once per month and complete a survey upon the conclusion of their monthly activity.

The preparatory work for the CSHS Youth Peer Support project began at the start of 2023 with conversations between the GFACC and CSHS MCHBG Program Specialist. Additional conversations have occurred with the GFPS Special Education Department to ensure that the peer match is with a student with special needs. Additionally, CSHS staff have developed an evaluation plan that consists of multiple surveys involving the contractor, the peer advisors, and the peers themselves. The Youth Peer Support program aims to help the special education student reach transition goals as it relates to NPM 11, and increase exposure of youth peer support to LHS students. The data collected from the evaluation plan will help CSHS understand the impact and outcomes of the program and inform potential expansion of the program to other communities in Montana to make it as successful and as family-friendly as possible.

Provider Engagement

Provider engagement is a continued area where CSHS sees value in creating bi-directional relationships with providers

statewide. Through alignment with contracts and relationship-building across the state, this was a continued priority for CSHS for creating a positive impact to the medical homes of CYSHCN.

The MAPP-Net program has a foundation of provider engagement. Provider participation is instilled in every facet of programming, including Project ECHO sessions, the access line, and the annual Pediatric Mental Healthcare Symposium. MAPP-Net continued to recruit provider participation in Project ECHOs, which are bi-monthly didactic sessions that focus on behavioral health topics, which are distributed to providers in the network.

MAPP-Net also staffs an access line for primary care and behavioral health providers to use for consultation on pediatric mental healthcare cases. Program staff maintain efforts year-long to increase access line utilization, through community outreach statewide and engagement with relevant community-based nonprofits and healthcare facilities.

In addition, MAPP-Net has a yearly Pediatric Mental Healthcare Symposium that is accredited for behavioral health, nursing, and medical education CE credits. MAPP-Net also engaged with state chapters of national professional organizations, including the American Academy of Family Physicians (AAFP) and American Academy of Pediatrics (AAP), and worked with the national chapters to be awarded funding for collaborative curriculum development and sustainability planning.

Montana planned a half-day conference and training for pediatric providers of children with complex medical conditions in collaboration with the Montana Chapter of the American Academy of Pediatrics. The conference was focused on the care of children with special health needs, with the aim of improving provider confidence in caring for this patient population. The theme for this year's special needs pre-conference was transition from NICU/inpatient to the outpatient setting and featured a hands-on skills session on G-Tube and pump management, a family panel, and two guest speakers. This conference was held October 6, 2023.

University of Montana Rural Institute for Inclusive Communities (UMRIIC): Care Coordination Academy & Transitions

CSHS continued to partner with UMRIIC to provide evidence-based transition resources to Montana's youth and families. This program worked to: maintain and expand the 15-member Consumer Advisory Council (CAC); maintain and disseminate a health care transition (HCT) guide; develop evidence-based/informed HCT training and resource materials; conduct distance learning opportunities; maintain a transition website; and provide technical assistance to other initiatives related to HCT. Project staff continued to disseminate this information via the Transition and Employment Projects website (https://transition.ruralinstitute.umt.edu/), which was reviewed and updated quarterly.

Family Engagement

CSHS prioritized family engagement this fiscal year through finding opportunities to elevate family voices in their work with stakeholders and providers. The Newborn Screening Program utilized family engagement of Deaf/ Hard of Hearing (D/HH) children and their families by partnering with MT Hands and Voices to hold family community events and trainings. CSHS also contracted with the Montana School for the Deaf and Blind to provide a Deaf Mentor Program throughout the state.

Montana is inclusive of family voice in decision-making whenever possible. Parents sat on the Consumer Advisory Council for the Transition program, the Newborn Screening Advisory Committee, and the Financial Assistance Program committee. A family panel was convened to present at the half day Pediatric Complex Care Needs conference in October 2023.

Family to Family Health Information Center (F2F): Title V MCHBG Family Delegate

The Title V MCHBG Family Delegate position is integrated into the F2F Center, and on July 1, 2022, it became a contracted position. The contract defined the Family Delegate's job responsibilities and duties; and compensates them for their work. The Family Delegate advises on CSHS policy and supports resource navigation and program alignment. The Family Delegate also supported other CSHS programs by participating in work groups, advising on policies and programs, and supporting outreach to families.

CSHS made an effort to have more accessible programs in FFY23. Accessibility is a large focus of CSHS, as being family-friendly is the primary focus of the section. In this case, accessibility means products, devices, services, or environments are available to as many people as possible. For example: always having closed captioning on in virtual meetings for those that may be D/HH or describing physical appearance in virtual or in-person settings to be inclusive of all attendees, including those that may be blind or low-vision. One example of this commitment to accessibility was the inclusion of the Family Delegate into the Pediatric Mental Health Symposium Planning Committee for FFY23.

The Family Delegate was a key factor in helping with accessibility measures, as they have lived experience with a child with

special healthcare needs. The Family Delegate was able to assist CSHS in making the 2023 MAPP-Net symposium as accessible as possible, and also helped to organize a parent panel where parents were able to share their stories and struggles with access to mental health care for their children in the state of Montana. The Family Delegate organized a virtual meeting prior to the conference for the parents to meet and get comfortable. She also helped put together the questions that parents were asked, to make them family-friendly and mindful of what the parents may have experienced that they were willing to share.

Financial Assistance Program (FAP): Direct assistance to CYSHCN

The CSHS Financial Assistance Program (FAP) continued to provide assistance to qualifying families. The FAP helps to cover out-of-pocket expenses for medical and enabling services, such as: therapeutic services; occupational therapy items; adaptive equipment; and respite care. Qualifying families continued to be eligible to receive up to $2000 per federal fiscal year, per child.

All FAP applications were screened by the FAP committee, which is comprised of: the Title V MCHBG Family Delegate; two staff from the Family-to-Family Health Information Center; and three staff from DPHHS. In instances where funding was not awarded, the committee compiled resources, and reached out to partners like Medicaid and Part C, to redirect the applicants to other available resources. Future FAP plans include continuing to utilize the review committee with a focus on outreach, referral, and resource navigation. CSHS also continued to operate the genetics financial assistance program in FFY23. This program provides financial assistance to CYSHCN who are seeking genetic testing, as the price of genetic tests can be a barrier to access.

CSHS partnered with MonTECH, within UMRIIC, to support their ability to purchase assistive equipment and adaptive technology for their lending library with items specifically needed for families of CYSHCN. Some additional areas of collaboration being discussed included the Montana Mother's Milk Bank of Montana, WIC, and the Office of Public Instruction.

Systems-Building

CSHS worked to improve relationships and build collaborative partnerships to strengthen systems in all programs. Some examples of this work include:

- Partnering with Medicaid and EPSDT staff when questions or clarifications arose through the FAP. CSHS does not have Medicaid or EPSDT staff on the committee currently but continued to explore that option. Through collaboration with Medicaid and Blue Cross Blue Shield, CSHS was able to educate providers and families on Medicaid policies and bring attention to gaps in the plan of benefits.
- Participation by CSHS staff in DPHHS and regional committees to represent CYSHCN standards of care and clinical needs.
- Established a quarterly inter-departmental meeting across DPHHS middle management, each involved with children's systems of care. This quarterly meeting included staff from Medicaid, the Behavioral Health & Developmental Disabilities Division, Part C Prevention and Early Intervention, and the Head Start Collaboration Director. The meetings were an opportunity to share information and identify areas of collaboration. Information from these meetings was shared with our respective stakeholders.

Other CSHS Programs

The CYSHCN Title V Director/CSHS Section Supervisor oversaw these programs: Newborn Hearing Screening, a statewide genetics program, metabolic clinics, and the Montana Access to Pediatric Psychiatry Network (MAPP-Net). These CSHS Programs support the advancement of medical homes for CYSHCN and their families and align with National Standards for Systems of Care for CYSHCN. Further details are available at: http://www.amchp.org/programsandtopics/CYSHCN/.

All MAPP-Net activities aimed to support CYSHCN medical homes by strengthening the primary care provider's knowledge and access to psychiatry resources. In FFY23, MAPP-Net sustained Project ECHO clinics, an access line for providers, and sponsored the fourth annual Symposium of Pediatric Mental Health. The main goal of the Project ECHO clinics is to provide a space for providers to learn more about resources and discuss case studies as related to the ECHO topic. In FFY23, Project ECHO clinics continued to be regularly scheduled with limited COVID regulations in place. Attendance per clinic continued to decrease, and CSHS is reviewing and assessing data on clients.

In FFY 23, MAPP-Net also undertook two needs assessment projects, conducted by the UMRIIC evaluation team. The needs assessments will inform activities for FFY24 and beyond. One needs assessment focused on understanding the service gaps and care needs for Montana youth who identify as LGBTQI, who experience homelessness or who are Native

American. The second needs assessment project was an analysis of the utilization of the access line, with recommendations on how to increase adoption of the tool.

In SFY23, CSHS contracted with Yarrow, LLC, a Public Health Consulting Agency, to conduct the CSHS Cleft/Craniofacial Specialty Clinic Needs Assessment. This project assessed the services that are needed by CYSHCN and their families. The needs assessment analysis indicated that Montana's CYSCHN population and their families would benefit from a new system of care for the cleft/craniofacial clinics. The results informed a solicitation for proposals from healthcare systems.

CSHS and the Metabolic Newborn Screening Program, housed in the DPHHS Public Health Laboratory, continued managing the Newborn Screening Advisory Committee (NSAC). This committee was established by House Bill 423, passed by the 2021 Montana Legislature. The NSAC meetings are attended by healthcare providers, payers, families, advocacy agencies, Tribal Health and legislators. In 2022, the NSAC met on April 19 and December 21. In 2023, they met April 6 and June 29. The NSAC declined to include Krabbe on the required screening and will determine if x-ALD will be included when the Committee meets in the fall of 2023. The committee meetings are an opportunity for the CSHS staff to expand their outreach to include the NSAC members and their partners. Access to medical home is a consideration for conditions to include on the newborn screening panel.

The contract with Shodair Children's Hospital was overseen by the CSHS Section Supervisor while the Nurse Consultant position was vacant in FFY23. Shodair Children's Hospital provides clinical genetic and metabolic services to individuals or family members who are affected by or are at risk of developing a genetic or metabolic disorder.

CSHS continued to uphold the values and standards of NPM 11 through various programs and initiatives. There will continue to be innovation throughout this section to expand the work occurring across the state. The focus will continue to be improving the quality of life for children and youth with special healthcare needs.

Children with Special Health Care Needs - Application Year

Medical Home (NPM 11): percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

Children's Special Health Services Staff and Programming

Children's Special Health Services (CSHS) addresses NPM 11 by offering gap-filling programs, such as peer support services and resource coordination programs, to all children and their families in Montana. CSHS offers a variety of population health and direct service programs while collaborating with Children & Youth with Special Health Care Needs (CYSHCN) programs across DPHHS. Three CSHS Program Specialists (PS), the CSHS Nurse Consultant and the Title V CYSCHN Director/Section Supervisor, manage these CYSHCN focused programs: Statewide Genetics Program; Metabolic Clinics; Newborn Hearing Screening Program; the Montana Access to Pediatric Psychiatry Network (MAPP-Net); and the Title V funded programs.

Through Title V Maternal & Child Health Block Grant (MCHBG) funding, CSHS supports initiatives to increase parent leaders and peer-to-peer support through the Family Peer Support program and Circle of Parents. Population-based initiatives are supported through the Transitions Project and Leadership High School Youth Peer Support.

Staff transitions that occurred in FFY24 consisted of filling vacancies. The vacancies filled included the CSHS Nurse Consultant that was filled October 2, 2023, and the MAPP-Net Program Specialist that was filled January 15, 2024. The CSHS MCHBG Program Specialist position became vacant on April 29, 2024, and the hiring process is underway.

Growth within CSHS

CSHS is working towards implementing the HRSA framework to advance NPM 11 by prioritizing family engagement, provider engagement, coordinated care, and systems building. These priority areas are all framed and guided by a family-centered approach, diversity, equity, and inclusion, and evidence-based practices. These priority areas are the basis of the strategic plan and will continue to guide this section during the remainder of FFY24, and for FFY25. The programs that CSHS funds intersect with multiple priority areas. In this report, programs are organized by priority area based on FFY25 future plans and areas of growth.

Coordinated Care

In order to improve access to care coordination across our regional health systems, strategies must be employed to support systematic improvements of care coordination, advance the Medical Home and National Standards of Care, and ensure that families remain engaged during care coordination. As a part of coordinated care CSHS continues to provide peer support programs through MCHBG funded programs.

FFY24 Peer Support

The CSHS Family Peer Support Program is in the final year of the Request for Proposal (RFP) that was issued in FFY23. Since the RFP was only written for two years of funding, CSHS is issuing another RFP, to be released in FFY24. This RFP will be written for five years of funding and the contracts will begin October 1, 2024. The structure of this RFP will be similar to the previous model and will include response options for group peer support, individual peer support, and state-wide peer support. The purpose is to provide funding for family-centered peer support services that improve access to the medical home, and support CYSHCN families in navigating the system of care. This RFP will allow for applicants to address different levels of peer support to include versatility to approach peer support and will help to identify new partners and collaborations within the state.

Current service providers will be invited to respond to the RFP: Montana's Peer Network (MPN); and Circle of Parents. Organizations throughout the state such as the Montana Empowerment Center and the Family-to-Family Health Information Center have expressed interest in responding so they also being invited to apply.

During FFY24, the Family Peer Support Program, and Circle of Parents continue to provide individual and group peer support. Below are examples of programs and activities that incorporate care coordination, advance coordinated care, and work to decrease siloes within the healthcare system.

Family Peer Support Program through Montana's Peer Network (MPN)

MPN continues to provide Family Peer Support services in FFY24. The mission of MPN's Family Division is to provide family

peer support across the state for families of children with special health care needs such as those with developmental, intellectual, physical health, mental health, and substance use challenges. Prior to having a family division, MPN provided peer services solely to individuals in recovery for substance use.

There are currently three Family Peer Supporters at two clinic locations: Billings, and Great Falls. In the first half of FFY24, MPN served 575 families in 215 hours. They are offering valuable support, encouragement, and hope to families. Types of encounters can include a phone call to provide support, an in-person conversation about resources, or a simple referral to other programs.

MPN has been invited to respond to the RFP to continue this work in FFY25 depending on quality of response.

Circle of Parents (CoP)

Circle of Parents (CoP) is a support group program modeled after the national Circle of Parents *Train the Trainer* model. The CoP aims to decrease isolation, prevent child abuse and neglect, and strengthen families through free monthly caregiver support groups. One unique component of CoP is that it is parent led, and each group is provided a stipend to assist in offering a supportive environment with a free meal and free childcare for families. CoP groups vary based on location and identified community need, which includes families with: CYSHCN or Mental Health Concerns; Foster Families; and Postpartum Mental Health concerns.

The Early Childhood Coalition of Beaverhead County (ECCBC) is the contractor for this program. In the first half of FFY24, seven different groups met in one of these locations: Butte, Missoula, Great Falls, Dillon, Mineral County, and Big Horn County. For context, in October of 2023, 11 adults and 12 children attended a meeting in Dillon, while three adults and four children attended a meeting in Great Falls. This reflects how each meeting location tends to have different attendance rates, based on the needs of the communities. ECCBC is focused on increasing the number of groups to 12 by the end of FFY 24.

Youth Peer Support

CSHS has embarked on a new Youth Peer Support project by partnering with the Great Falls Area Chamber of Commerce (GFACC) Leadership High School (LHS) program. LHS has been present in Great Falls schools and the surrounding areas for over 15 years.

The CSHS Youth Peer Support project matched a LHS student with a student with special needs enrolled in the Great Falls Public School (GFPS) system or living in the community. The peer match was required to meet at a minimum once per month and complete a survey upon the conclusion of their monthly activity. Interested high school students were selected from a competitive application process to ensure that they would be successful as a peer mentor.

This project started in FFY23 with preparatory work and conversations between CSHS, GFACC, and the GFPS Special Education Department. This informed the project goals and objectives for the rollout in December 2023. This project is in the first year of the two-year pilot program so the data collected over the next year will be crucial in determining trends, successes, and errors. CSHS staff have developed an evaluation plan that consists of multiple surveys involving the contractor, the peer advisors, and the peers themselves. The Youth Peer Support program aims to help the special education students reach transition goals as it relates to NPM 11 and increase exposure of youth peer support to LHS students. The data collected from the evaluation plan will help CSHS understand the impact and outcomes of the program and inform potential expansion to other communities in Montana, and to make it as successful and family friendly as possible.

Provider Engagement

Provider engagement is an area where CSHS sees continued value in creating bi-directional relationships with providers statewide. Through alignment with contracts and relationship-building across the state, this is a continued priority for CSHS for creating a positive impact to the medical homes of CYSHCN.

The MAPP-Net program has a foundation of provider engagement. Provider participation is instilled in every facet of programming, including provider education sessions, the access line, and the annual Pediatric Mental Healthcare Symposium.

MAPP-Net also staffs an access line for primary care and behavioral health providers to use for consultation on pediatric mental healthcare cases. Program staff maintain efforts year-long to increase access line utilization, through community outreach statewide and engagement with relevant community-based nonprofits and healthcare facilities.

In addition, MAPP-Net has a yearly Pediatric Mental Healthcare Symposium that is accredited for behavioral health continuing education. MAPP-Net also engages with state chapters of national professional organizations, including the American Academy of Family Physicians (AAFP) and American Academy of Pediatrics (AAP), and has worked with the national chapters to be awarded funding for collaborative curriculum development and sustainability planning.

CSHS was involved in planning a half-day conference and training for pediatric providers of children with complex medical conditions, in collaboration with the Montana Chapter of the American Academy of Pediatrics. This conference was held on October 6, 2023, and received very positive feedback. The conference was focused on the care of children with special health needs, with the aim of improving provider confidence at caring for this patient population. The theme for the first year's special needs pre-conference was transition from NICU/inpatient to the outpatient setting and featured a hands-on skills session on G-tube and pump management, a family panel, and two guest speakers. Planning has started for the second annual conference which will be held October 10, 2024, with a Genetics focus.

University of Montana Rural Institute for Inclusive Communities (UMRIIC): Care Coordination Academy & Transitions

CSHS continues to partner with UMRIIC to provide evidence-based transition resources to Montana's youth and families. This program works to: maintain and expand the 15-member Consumer Advisory Council (CAC); maintain and disseminate health care transition (HCT) guides; develop evidence-based/informed HCT training and resource materials; conduct distance learning opportunities; maintain a transition website; and provide technical assistance to other initiatives related to HCT. Project staff continue to disseminate this information via the Transition and Employment Projects website (https://transition.ruralinstitute.umt.edu/), which is reviewed and updated quarterly.

CSHS is currently working with UMRIIC on a revised scope of work for FFY25. The purpose is to expand on their current work, and include provider focus groups engaged in mapping the system of care. CSHS will use this information to inform future pilot projects that address system gaps.

Family Engagement

CSHS has prioritized family engagement this fiscal year through finding opportunities to elevate family voices in their work with stakeholders and providers. The Newborn Screening Program utilizes family engagement of Deaf/ Hard of Hearing (D/HH) children and their families by partnering with Montana Hands and Voices to hold family community events and trainings. CSHS also contracts with the Montana School for the Deaf and Blind to provide a Deaf Mentor Program throughout the state.

Montana is inclusive of family voice in decision-making whenever possible. Parents sit on the CAC for the Transition program, the Newborn Screening Advisory Committee, and the Financial Assistance Program committee. A family panel was convened to present at the half day Pediatric Complex Care Needs conference in October 2023.

Family to Family Health Information Center (F2FHIC): Title V MCHBG Family Delegate

The Title V Family Delegate position is integrated into the F2FHIC. The ongoing contract for this work defines the Family Delegate's job responsibilities and duties and compensates them for their work. The Family Delegate advises on CSHS policy and supports resource navigation and program alignment. The Family Delegate also supports other CSHS programs by participating in work groups, advising on policies and programs, and supporting outreach to families.

In collaboration with the F2FHIC, CSHS implemented a new model for the Family Delegate work in FFY24 which included hiring two individuals to serve as Family Representatives under the Family Delegate. CSHS anticipates that this will help the work reach families statewide and continue to foster new perspectives. The Family Delegate and Representatives are a key factor in providing family perspective, as they have lived experience with children with special healthcare needs.

CSHS is also making an effort to have more accessible programs. Accessibility is a large focus of CSHS, as being family-friendly is the primary focus of the section. In this case, accessibility means products, devices, services, or environments are available to as many people as possible. For example: always having closed captioning on in virtual meetings for those that may be D/HH or describing physical appearance in virtual or in-person settings to be inclusive of all attendees, including those that may be blind or low-vision. One example of this commitment to accessibility is the inclusion of the Family Delegate into the Pediatric Mental Health Symposium Planning Committee for FFY25.

Financial Assistance Program (FAP): Direct assistance to CYSHCN

The CSHS Financial Assistance Program (FAP) continued to provide assistance to qualifying families. The FAP helps to cover out-of-pocket expenses for medical and enabling services, such as therapeutic services, occupational therapy items, adaptive equipment, and respite care. The income qualification for this program is at or below 300% Federal Poverty Level. Qualifying families are eligible to receive up to $2000 per federal fiscal year, per child.

All FAP applications are screened by the FAP committee, which is comprised of the Title V Family Delegate, two staff from the Family-to-Family Health Information Center (also parents of CYSHCN), three staff from the CSHS section, and one staff from the Family and Community Health Bureau. In instances where funding is not awarded, the committee compiles resources, and reaches out to partners like Medicaid and Part C, to redirect the applicants to other available resources. Future FAP plans include continuing to utilize the review committee with a focus on outreach, referral, and resource navigation.

CSHS also continues to operate the genetics financial assistance program in FFY24. This program provides financial assistance to CYSHCN families who are seeking genetic testing, as the price of genetic tests can be a barrier to access.

CSHS is partnering with MonTECH, within UMRIIC, for the second consecutive year to support their ability to purchase assistive equipment and adaptive technology for their lending library with items specifically needed for families of CYSHCN. Some additional areas of collaboration for CSHS being discussed include the Montana Mother's Milk Bank, WIC, Emergency Medical Services for Children, and the Office of Public Instruction.

Systems-Building

CSHS works to improve relationships and build collaborative partnerships to strengthen systems in all programs. Some examples of this work include:

- Partnering with Medicaid and *Early and Periodic Screening, Diagnostic, and Treatment* (EPSDT) staff when questions or clarifications arise through the FAP. CSHS does not currently have Medicaid or EPSDT staff on the FAP Committee, but is looking to explore that option.
- Participation by CSHS staff in DPHHS and regional committees to represent CYSHCN standards of care and clinical needs.

Other CSHS Programs

The CYSHCN Title V Director/CSHS Section Supervisor oversees the following programs in addition to the Title V work: Newborn Hearing Screening, a statewide genetics program, metabolic clinics, and the Montana Access to Pediatric Psychiatry Network (MAPP-Net). These CSHS Programs support the advancement of medical homes for CYSHCN and their families and align with National Standards for Systems of Care for CYSHCN. Further details are available at: http://www.amchp.org/programsandtopics/CYSHCN/.

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In State Fiscal Year 2023, CSHS contracted with Yarrow, LLC, a Public Health Consulting Agency, to conduct a CSHS Cleft/Craniofacial Specialty Clinic Needs Assessment. This project assessed the services that are needed by CYSHCNs and their families. The needs assessment analysis indicated that Montana's CYSCHN population and their families would benefit from a new system of care for the cleft/craniofacial clinics. The results informed a new model in which CSHS provides supplemental funding for three years to interested entities to help establish their programs with the intention of self-sustainability.

CSHS, and the Metabolic Newborn Screening Program housed in the DPHHS Public Health Laboratory, continue managing the Newborn Screening Advisory Committee (NBSAC). This committee was established by House Bill 423, passed by the 2021 Montana Legislature. The NBSAC meetings are attended by healthcare providers, payers, families, advocacy agencies, Tribal Health and legislators. The NBSAC has declined to include Krabbe and voted to include x-ALD on the required screening. The committee meetings are an opportunity for the CSHS staff to expand their outreach to include the NBSAC members and their partners. Access to medical home is a consideration for conditions to be included on the newborn screening panel.

The CSHS Nurse Consultant oversees the contract with Shodair Children's Hospital, which provides clinical genetic and metabolic services to individuals or family members who are affected by or are at risk of developing a genetic or metabolic disorder.

CSHS continues to strive for coordination of care for CYSHCN and their families. All efforts and projects mentioned above directly relate to assisting CYSHCN in Montana to navigate the system of care.

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - Access to Public Health Services: Number of clients' ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 4,500 or less who choose SPM 1.

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	30	30	30	35	35
Annual Indicator	35.5	41.4	40.4	40.9	43.1
Numerator	14,149	19,550	18,683	17,870	19,962
Denominator	39,874	47,216	46,279	43,733	46,303
Data Source	FCHB	FCHB	FCHB	FCHB	FCHB
Data Source Year	2019	2020	FFY 2021	FFY 2022	FFY 2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	37.0	39.0

SPM 2 - Family Support & Health Education: Number of clients ages 0 - 21, and women ages 22 - 44 who are assessed for social service and health education needs; and are placed into a referral and follow-up system, or provided with health education as needed.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	40	40	45	45	45
Annual Indicator	51.1	70.1	66	66.8	63
Numerator	7,166	7,513	7,047	8,519	5,824
Denominator	14,036	10,714	10,677	12,747	9,244
Data Source	FCHB	FCHB	FCHB	FCHB	FCHB
Data Source Year	FFY19	FFY20	FFY 2021	FFY 2022	FFY 2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	50.0	50.0

State Action Plan Table

State Action Plan Table (Montana) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Family Support and Health Education

SPM

SPM 2 - Family Support & Health Education: Number of clients ages 0 - 21, and women ages 22 - 44 who are assessed for social service and health education needs; and are placed into a referral and follow-up system, or provided with health education as needed.

Five-Year Objectives

County Public Health Departments who choose this performance measure will be providing family support referrals and health education, in the physical setting of their facilities, to 40% of their clients on an annual basis.

State Performance Measure 2 is related to the following National Outcome Measures: 1; 9.1; 9.5; 10; 13; 15; 19; 21; 23; 25.

Strategies

State staff provide training and resources, including tracking templates.

Emphasis on the role of the health education component to cover a variety of MCH priorities.

Supporting the CONNECT referral system.

State Action Plan Table (Montana) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Access to Public Health Services

SPM

SPM 1 - Access to Public Health Services: Number of clients' ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 4,500 or less who choose SPM 1.

Five-Year Objectives

For counties with frontier-level populations who choose this performance measure, support the public health department's ability to continue providing Enabling Services, Public Health Services, and Group Encounter activities to at least 30% of their MCH population through 2023.

State Performance Measure 1 is related to the following National Outcome Measures: 3; 4; 9.1; 9.5; 14; 15; 16.1; 16.2; 16.3; 19; 22.1; 22.2; 22.3; 22.4; 25.

Strategies

Thirty frontier-level population CPHDs are collaborating with the FCHB on this performance measure for FFYs 2024 and 2025. The main focus is to help provide support for all of the MCH services they provide. Although activities do not have to fit into any one performance measure, these partners submit plans and methods of evaluation.

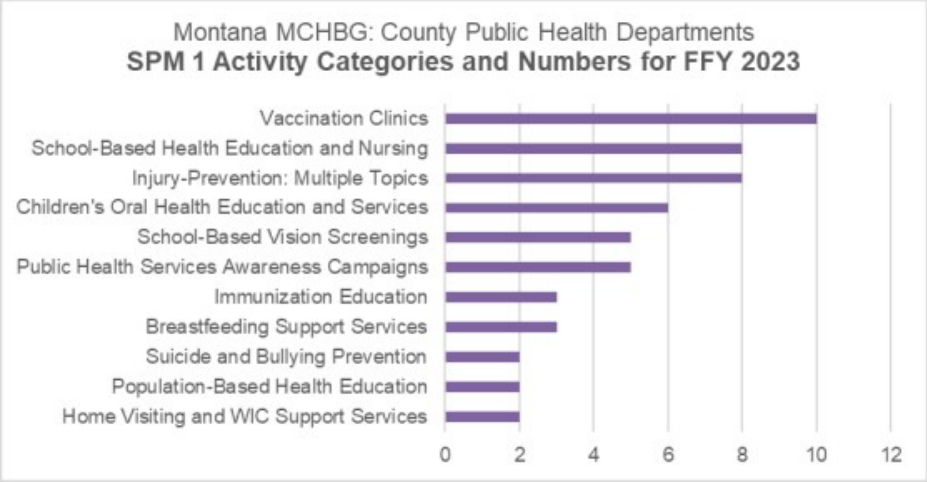
Provide ongoing training to the CPHDs on a wide variety of MCH topics and programs, with an emphasis on strategies unique to the challenges of serving rural and frontier-level populations. This includes agriculture-related injury-prevention for children and families.

Cross-Cutting/Systems Building Domain: Narratives for State Performance Measures 1 and 2

SPM 1 - Access to Care and Public Health Services: Number of clients ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 4,500 or less.

Twenty-five of the County Public Health Departments (CPHDs) participating in the MCHBG for FFY 2023 chose to implement SPM 1 as their performance measure. This was 51% of the total. However, because the funding allocation formula is population-based, they only received 13.7% of the total funding directed to the CPHDs. Sixteen of these CPHDs qualified for the $4,000 baseline funding amount instituted for FFY 2023.

The following graph shows the general categories of the MCHBG activities they selected, along with the number of CPHDs implementing that activity. These choices were determined by the CPHDs through: using results from their Community Health Assessments; internal client usage data; capacity; and emerging trends. Most of CPHDs implemented the required two activities, but two of them implemented an optional third activity. Annual outcome reports for FFY 2023 indicated a 96% success rate in achieving their goals.



Five smaller-population counties in the central part of the state have pooled their public health resources together to form the Central Montana Health District (CMHD): Golden Valley, Judith Basin, Musselshell, Petroleum, and Wheatland. The combined size of these counties in square miles is 8,020, which is very close in size to the state of New Jersey. In contrast, their combined MCH population is only 3,408.

The following narrative is from the 1st quarter report of FFY 2023 for Golden Valley County, in the CMHD, and is very representative of the reports for all five counties:

"CMHD/Golden Valley provided both routine immunization services and dedicated influenza clinics in this quarter. Services included: school-based immunization and influenza clinics to Lavina School; Lavina and Ryegate Community Centers; and Ryegate and Lavina community COVID-19 clinics. Currently, 37% of Golden Valley County residents are fully vaccinated for COVID-19, and 57% have received at least partial coverage. CMHD completed influenza and COVID-19 school-based vaccination clinics in October/November 2022.

CMHD/Golden Valley continues to participate in the Central Montana Coalition for Family Health. Activities either completed this quarter or planned for completion this FFY include: enhanced QPR suicide prevention training, which focused on frontline healthcare and family support staff (completed December 2022); MOMS Project ECHO perinatal classes support; and family outreach support.

CMHD/Golden Valley continues to offer car seat installations on a request basis. We have reached out to providers and other community partners with information and signage and have been able to provide several free car seats and car seat safety checks to expectant parents.

As the effects of the COVID-19 pandemic continue to evolve, CMHD is focusing efforts on education to encourage the vaccination of children for all vaccines, including the COVID-19 vaccine. We also continue to serve as a school health resource and are working with community partners such as elected officials, EMS, law enforcement and schools to identify and mitigate the effects of the pandemic on our schools, daycare centers, and families.

Operational challenges continue to focus on barriers related to vaccine hesitancy. We have noted an increased reluctance, especially in our frontier populations, to vaccinate for many of the recommended vaccines, not only the COVID-19 vaccine. CMHD works to provide up to date COVID-19 information as well as influenza and other routine vaccination clinics to Golden Valley County, which continues to be time and labor-intensive.

The CMHD FICMMR Team continues with their goal to increase the number of certified car seat installers within service area. We have been offering one-on-one car seat checks in our office with two inspections and two free car seats given out. We still plan to organize at least one Golden Valley based car seat installation event before the end of FFY 2023. We are planning to partner with other health- and wellness-related programs: SCL Hospital Mobile Mammogram Bus, MT Tobacco Use Prevention Program, Central Montana Head Start, Youth Challenge Coalition, and Breast and Cervical Health Program to bring a health fair to Golden Valley County."

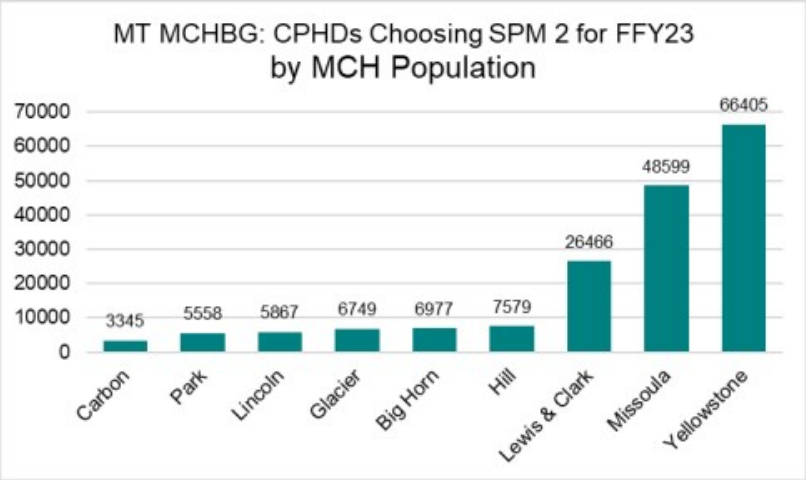
State-level MCHBG and FICMMR staff continued to provide training and resources to SPM 1 CPHDs. This included information more tailored to the needs and environment of the very rural and agriculture-based areas of the state. An example was the online training "Agricultural Health & Safety Course for Medical & Safety Professionals" from the University of Nebraska Medical Center. The training was supported by the following organizations: AgHealth Central States, Ag Health & Safety Alliance, AgriSafe Network, and Great Plains Center for Agricultural Health. Another example was information on five online trainings provided by AgriSafe for "Protecting the Safety of Women in Ag Week." A final example was notification of a new evidence-based toolkit from the Rural Health Information Hub, with practical guidance on planning for, responding to, and recovering from disasters and emergencies.

In FFY24, the FCHB is contracting with 32 CPHDs who have chosen to focus on SPM 1. They are implementing and evaluating at least two community-level activities during the fiscal year. The FCHB is providing these counties with training, resources, and support on: evidence-based/informed or best-practice activities; goal setting; and evaluation.

SPM 2 – Family Support and Health Education: number of clients ages 0 - 21, and women ages 22 - 44 who are assessed for social service and health education needs; and are then placed into a referral and follow-up system, or provided with health education as needed.

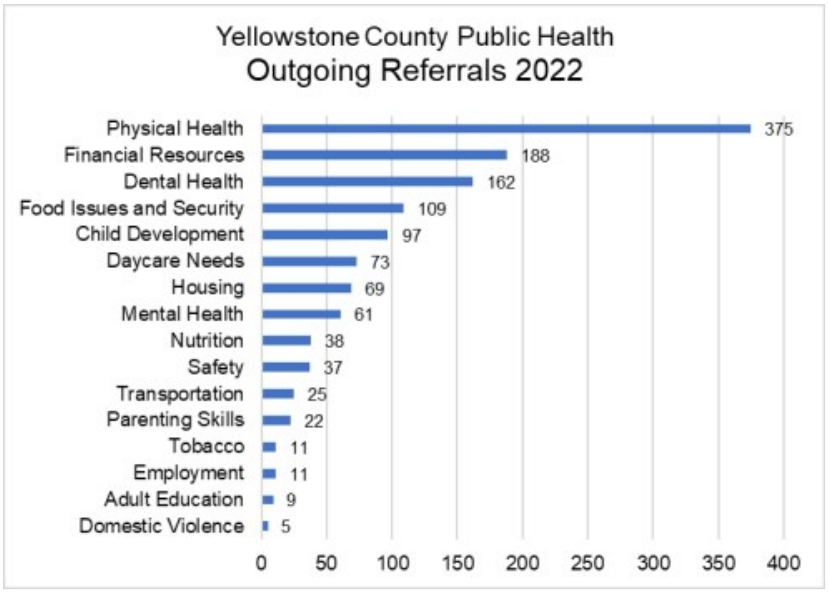
SPM 2 was created for CPHDs to 1) refer vulnerable families to community services, with follow-up; and 2) provide basic health education, especially in caring for infants and children. In FFY 2023, nine County Public Health Departments (CPHDs) focused activities on this measure. They provided enabling services to 5,824 individuals. Examples of referrals include: healthcare providers, economic and food assistance, housing, home visiting, WIC, dental services, and Medicaid. Health education topics included: Pre-Natal/Post-Partum Care, Breastfeeding, Infant and Child Development and Safety, Family Planning, Infant Safe Sleep, Mental Health and Substance Abuse, Parenting, and Oral Health.

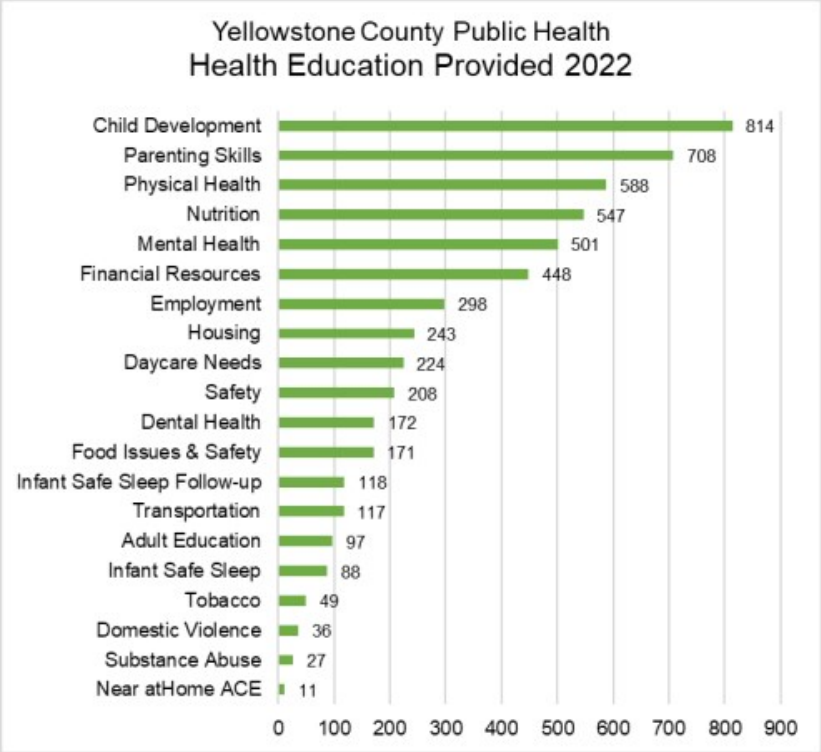
There was a wide range in the size of the MCH-categories population for the CPHDs who chose SPM 2 for FFY23, as shown in the following graph:



The differences in population affected the resources and funding available to each for their activities. Lewis & Clark and Yellowstone CPHDs also used some of their funding for activities related to NPM 5: Infant Safe Sleep. In the annual reports for FFY 2023, the SPM 2 CPHDs showed an overall success rate of 82% in reaching their activity outcome goals.

The larger-populated CPHDs have more sophisticated and extensive electronic health record and data-base systems for tracking the numbers and types of referrals and health education provided to their clients. This technology informs and aides in guiding the CPHDs' planning and allocation of resources going forward. The following two graphs show the categories, numbers, and types of outgoing referrals and health education provided by Yellowstone CPHD, also known as RiverStone Health, in calendar year 2022. Yellowstone County has the largest population in the state, and receives 15% of the total MCHBG funding allocated to the approximately 50 participating counties.





Regarding SPM 2 CPHDs, on the other end of the spectrum for MCH population size is Carbon County. In September of 2021, Carbon CPHD underwent a complete turnover in staff, organizational oversight, and business processes. Additionally, in June 2022 the area was subjected to extreme flooding, which made the national news as it included Yellowstone National Park. Despite these challenges, the new staff did great work and made fast progress. The following excerpt from their first quarterly report for FFY23 provides examples:

"Carbon County Public Health (CCPH) has continued to encounter many different challenges this past quarter. Due to natural disasters beyond our control a lot of our time has continued to be spent on post-flooding health, and socioeconomic and health education needs and issues. We have been dealing with each concern as it comes however and succeeding in following through. We are continuously and tirelessly working on our referral and follow up systems in the midst of continuing to deal with post-flooding issues, and the confusion and learning curve of starting a new department. Our Recall/Reminder function workflow in our department is progressing, however it does remain very simple at this time. There has been increased awareness of the programs and services we can provide, from our efforts in working with: the school health program; the Crisis Coalition; the Mental Health Center; and in working more closely with law enforcement agencies in Carbon County.

Even though we have been and continue to deal with many issues that have arisen from the flooding incident, we have also managed to continue to grow as a department. We have two new Registered Nurses (RNs) who have been busy working in the schools, and with all different populations in our county. They have done a fantastic job at finding patients/clients who have been falling through the cracks, and have been doing quite a bit of work to assist these families. With a growing and newer department, we have had some challenges in figuring out the specific roles of our staff. There is a lack of patient navigator/case management in Carbon County, and we frequently find ourselves working through the confusion and providing this type of work and services simply because there is no one else to do it.

Over the course of the past Quarter there are many areas in our county that continue to struggle with various issues including socioeconomic, housing, food access, clean water access, health education and seeking appropriate care and

preventative care due to the historic 500-year flooding event that happened in June. We continue to share, and push out education on all topics of health as it relates to getting back into their houses safely after a flooding event. We have also continued to be a hub for resources and guidance for families needing resources post-flood that normally would not utilize these services, including: WIC; assistance programs through Red Lodge Area Community Foundation; the food truck program; CART free rides program; Cover Montana-assistance with insurance; and LIFTT who currently comes to Carbon County weekly, and has been collaborating with CCPH very frequently.

Our school RN's are working on updating all vaccination records in schools, and for homeschool families across the County. They have been instrumental in being able to reach out to families that would otherwise fall through the cracks, they have been requested by the schools to assist in everything from: medication administration and continuity of care plans for children with complex health issues; teaching vaping classes; teaching reproductive health classes; and working on getting Narcan and Epinephrine into the schools, and working on processes and procedures for that project. They have been trying to find ways to bring some services (such as access to showers and running water) to some of the families that currently do not have those services.

As far as lessons learned recently at CCPH, they are too numerous to count over this past quarter with all of the things that have been going on. We are learning: how to build a referral and follow up system; how to work with local clinics, hospitals and other entities in order to get our community members the resources and assistance that they need; how our new billing and documentation system works; what workflows and processes will work the best for our department; what our county needs from a public health system and a school health program; how to manage chronic disease programs; and how to better push and advocate for STD/HIV prevention education and awareness."

Due to a major overhaul in the CONNECT Electronic Referral System, Glacier CPHD was the only county with a performance measure activity specifically focused on the system for FFY23. In October of 2022, the CONNECT Electronic Referral System was relaunched by the State, after a yearlong legal review and system update. Updates included removing the Memorandum of Understanding, making it a more streamlined process for sending and receiving referrals. The change means individual users sign a Participation Agreement to individually use the system.

CONNECT State Coordinators requested a slow roll out for the timeframe of October through December 2022. Additional enhancements were launched prior to the official launch in January 2023, that pushed the system to additional agencies and users. When users signed into the system, they were greeted by a new announcement message. This was utilized to alert users of new enhancements, updates, and messages. Additionally, there is now the ability to print referrals. The next updates will be to the referral form itself, to make it easier for users to fill out. As of spring 2023, there were 175 participation agreements signed across the State.

In FFY24, the FCHB is contracting with thirteen CPHDs who have chosen to focus on SPM 2. They are implementing and evaluating at least two community-level activities during the fiscal year. The FCHB is providing these counties with training, resources, and support on: evidence-based/informed or best-practice activities; goal setting; and evaluation. It's supporting them in providing a significant safety-net feature to the maternal and child populations in their counties, and addressing health equity and social determinants of health.

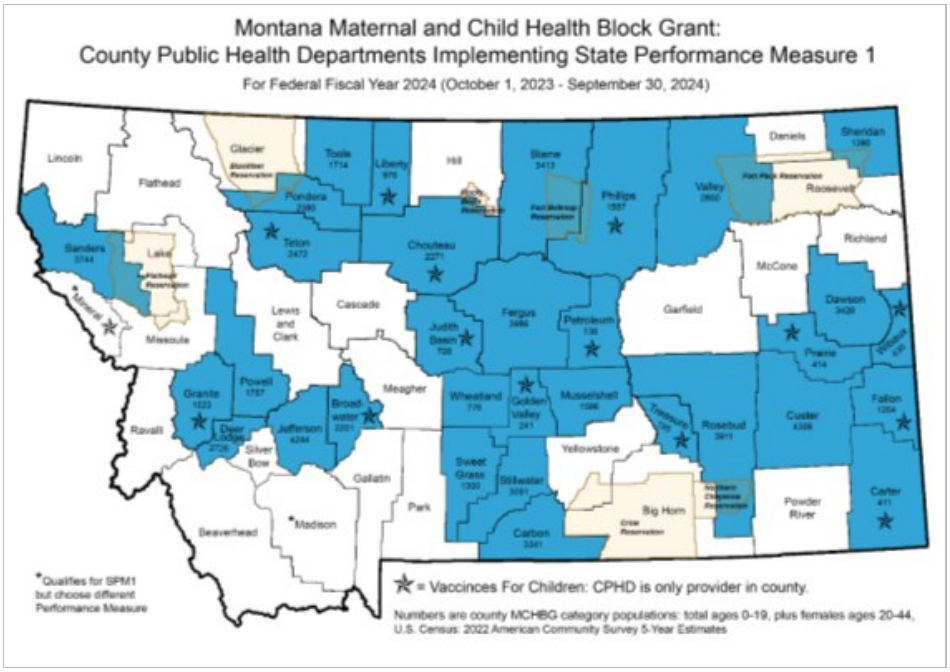
Cross-Cutting/Systems Building - Application Year

Cross-Cutting/Systems Building Domain: Narratives for State Performance Measures 1 and 2

<u>SPM 1 - Access to Care and Public Health Services</u>: Number of clients ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 4,500 or less.

Montana faces large geographic health disparities, as evidenced by HPSA scores showing much of the state is a shortage area for primary care, mental health care, and dental care. Access to public health services is a fundamental action area, and State Performance Measure One (SPM 1) is specifically designed to support access to public health services in the more rural counties of the state with frontier-level populations. Even with a restriction of a maternal and child population of no more than 4,500, thirty-four of the counties participating in the MCHBG in FFY24 qualify.

While Montana as a whole ranks 48th in the nation for population density in the nation, at 7.5 people per square mile, the overall population density for the SPM 1 counties is only 2.4. County Public Health Departments (CPHDs) in the counties choosing SPM 1 are a vital part of the rural healthcare safety-net, and also help to address health equity issues and social determinants of health for their vulnerable families. SPM 1 allows flexibility for the CPHDs to supply critical public health services, and address multiple priority needs for their maternal and child residents. One major service provided by all the SPM 1 counties is immunizations. Fourteen of the SPM 1 CPHDs are the only provider for "Vaccines for Children" in their counties.



Another important role of SPM 1 CPHDs is in regard to partnerships and collaboration with local schools. In FFY24, fifty-two of their MCHBG activities feature working in conjunction with schools. These activities include: school-based health education and nursing, injury-prevention education on various topics, vision and oral health screening, vaccination clinics, and bullying and suicide prevention.

The following report from Chouteau CPHD provides an example of the range of work their MCHBG funding is helping to support:

"The mental health program was active this quarter. We have added 9 new clients and serve 46 persons total. We are continuing to collaborate with our local providers and community groups to educate the public on countywide services available and ways to improve services. We have been posting mental health education on our Facebook page at least monthly. One of our counselors is participating on the Mental Health Advisory Board for Chouteau County, meeting monthly to work on improving mental health to our residents.

We are working with the Chouteau County Foodbank program, which helps food insecure families. We provided 26 food

baskets to families this quarter. Our Backpack Buddy program helps food insecure children, and is present within 3 county schools. We are currently serving 50 students. We also have a food vending machine at one high school that is currently in use. Our summer lunch program, in conjunction with our libraries, runs from June to Aug and serves sack lunches one day a week. Last summer 855 lunches were provided.

We have been providing updates on Covid 19 vaccine changes to our local clinic providers and community via phone and in-person discussions as appropriate. We have handed out updated guidance to staff and providers at the local clinic regarding administering the 2023/24 Covid vaccine. We gave 16 flu vaccines this quarter. Includes 5 adults, 11 children.

We have 1 existing client involved in our Planned parenthood without walls (PPWOW) program that receives contraceptive care. We are currently serving 47 clients on WIC.

We were able to inspect 11 car seats this quarter. We have reached out to our local daycares and WIC clients to offer this service as appropriate. Our car seat technician gave a presentation to 4 district judges regarding our new program that encourages families that are cited for traffic violations. If children are not restrained properly, the caregivers may be referred to us for car seat education, evaluation, and training. If they attend, they have the possibility of a reduced citation for getting this training.

We recently started working with Alluvion Mobile Dental Clinic that comes to the health department twice a month and is providing services to persons of all ages. We have made 20 referrals to the program. We went to 4 local county schools, partnering with Lion's Club, to offer vision screenings. We helped screen 313 kids and sent 22 referrals."

Given the unique challenges of serving the MCH population in rural Montana, SPM1 will continue to play a major role in the public health services delivery system in FFY25.

In FFY25, the FCHB will contract with 29 CPHDs who have chosen to focus on SPM 1. They will implement and evaluate community-level activities during the fiscal year. The FCHB will provide these counties with training, resources, and support on evidence-informed or best-practice activities, goal setting, and evaluation.

SPM 2 – Family Support and Health Education: number of clients ages 0 - 21, and women ages 22 - 44 who are assessed for social service and health education needs; and are then placed into a referral and follow-up system, or provided with health education as needed.

FFY24 marks the ninth year of operation for SPM 2 in Montana. SPM 2 has proven to be a flexible performance measure, helping to meet the needs of County Public Health Departments (CPHDs) seeking to address the social determinants of health and health equity needs in their communities.

In FFY24, the main activities of the thirteen CPHDs working on SPM 2 are: 1) screening clients for social support needs, and 2) topic-specific health education. Some of these activities focus on emerging needs in their communities, including: Medicaid enrollment support; pre-natal education; and STD/STI case management. Three of the CPHDs working on SPM 2 are also implementing activities for NPM 5 (Infant Safe Sleep): Big Horn, Lewis & Clark, and Yellowstone.

Each year, the CPHDs participating in the MCHBG complete a pre-contract survey. One of the questions they answer is: "Why did your county choose the Performance Measure(s) it is going to implement?" The following examples provide insight into the different reasons CPHDs choose SPM 2:

- Flathead CPHD: *"The goals of the 2021 Flathead County Community Health Needs Assessment (CHNA) are to improve residents' health status, increase their life spans, and elevate their overall quality of life and to increase accessibility to preventive services for all community residents. With this goal in mind, we identified a number of gaps in perinatal care and preventive services specific to Flathead County. Selecting SPM2, Flathead County's objective is to bridge and improve these gaps:*
    - *The Montana Pregnancy Risk Assessment and Monitoring System found that only 75% of individuals accessed prenatal care in the first trimester, showing a need for increased education surrounding prenatal care in Flathead County.*
    - *Additionally, from 2021 to 2022, Montana had a 178% increase in the number of syphilis cases, with 90% of cases affecting women of childbearing age. Unfortunately, Flathead County had its first case of congenital syphilis in 2023. These statistics show that there is an increased risk to pregnant women and infants and identify a need for more education on the prevention, identification, and treatment of syphilis in the maternal child health population.*
    - *Last, 5% of Flathead County adults do not have health insurance. While this is a low percentage, pregnant women are especially vulnerable without insurance, as even routine prenatal care is expensive without*

coverage. With recent Medicaid unwinding, we expect that there will be a greater need for Presumptive Medicaid services in Flathead County. Developing our Presumptive Medicaid services will allow us to fill a gap in the community and ensure that pregnant women can secure health insurance and obtain the recommended prenatal care."

- Mineral CPHD: *"Mineral County has had a surge of new population. We also have new services available for families and are rebranding the health department after the pandemic. We will target prenatal families-through woman 44 years-old and offer family support and health education in all areas our services provide (immunizations, WIC, home-visiting, safe sleep, car seat safety, lactation services, family engagement, etc.)"*

- Missoula CPHD: *"MCCHD selected SPM2 because it is very impactful to the work we do in the community. Our ability to focus on family support and health education allows us to link families to resources needed to support their goals. By referring, and following up on referrals, we are able to help families on their road to self-sufficiency and to broaden their support network."*

- Park CPHD: *"Our current internal data collection and follow-up systems are inefficient. Multiple team members are involved in MCH-related activities; streamlining data collection from all team members will increase efficiency and make it easier to assess areas of focus/concern."*

- Roosevelt CPHD: *"Roosevelt County has high rates of family dysfunction, child abuse and neglect, drug and alcohol misuse, teen pregnancy, and STIs (especially syphilis) to name some of the topics. It is very important for children to understand that they can make choices for their lives, and to know the difference between healthy and unhealthy relationships at the beginning of adolescence before many important life decisions are made."*

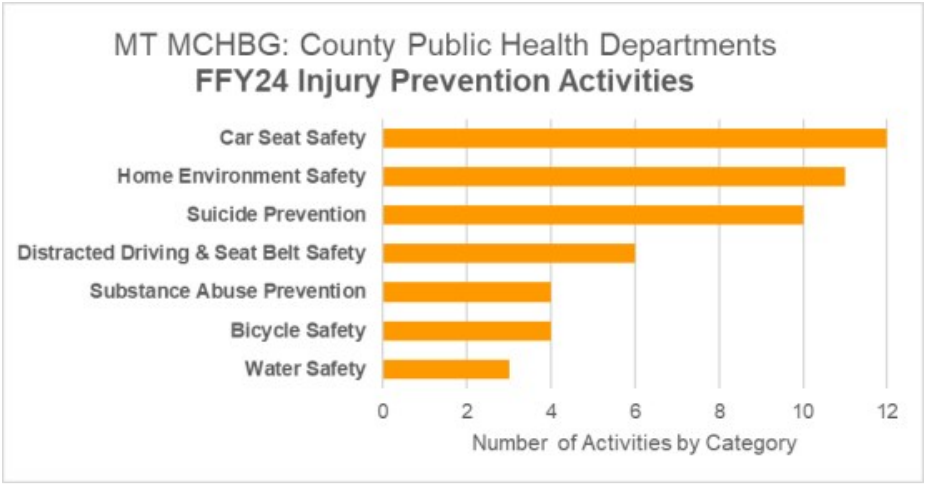
Given it's important contributions to advancing health equity and addressing social determinants of health at the community level, SPM 2 will continue to play a major role in supporting the health and well-being of Montana's families in FFY25.

In FFY25, the FCHB will contract with the 15 CPHDs who have chosen to focus on SPM 1. They will implement and evaluate community-level activities during the fiscal year. The FCHB will provide these counties with training, resources, and support on evidence-informed or best-practice activities, goal setting, and evaluation.

Injury Prevention Education & Activities by All MCHBG-Participating CPHDs

The Fetal, Infant, Child, and Maternal Mortality Review (FICMMR) program in Montana is very closely associated with the MCHBG. FICMMR review teams are county-based, and the program requirements are included in the MCHBG contracts with the CPHDs. Each CPHD participating in the MCHBG is required to implement one FICMMR injury prevention activity. This is in addition to the activities associated with their MCHBG performance measure. The main purpose of FICMMR is to identify which deaths were preventable, and to consider how to reduce those types of death in the future.

The following graph shows the different categories of the fifty injury prevention activities that CPHDs are concentrating on in FFY24, along with the number selecting to work on that issue. Car Seat Safety is the foremost, followed by Suicide Prevention. Home Environment Safety is a consolidated category that includes work on: Childproofing, Gun Safety, Infant Safe Sleep, Lead Poisoning, Emergency Preparedness, Safe Sitter First Aid, and Farm Safety.



III.F. Public Input

Maternal & Child Health Block Grant Program

Public input on the Title V Maternal & Child Health Block Grant Application & Report (MCHBG-AR) relies heavily on feedback and contributions solicited from committees, task force members, advisory councils, and stakeholders. Various associated entities are tasked with providing input, such as: the Public Health System Improvement Task Force (PHSITF); County Public Health Departments (CPHDs); University of MT Rural Institute for Inclusive Communities (UMRIIC); State Health Improvement Plan (SHIP) Workgroups; Montana (MT) Early Childhood Advisory Council, CSHS stakeholders and contractors; the MT (MT) Council on Developmental Disabilities; and the MT Primary Care Association.

Other programs housed within the Family and Community Health Bureau (FCHB) which impact the maternal and child population are also sources of input, including: Fetal, Infant, Child, & Maternal Mortality Review (FICMMR); Supplemental Nutrition Improvement for Women, Infants, & Children (WIC); Healthy MT Families Home Visiting (HMF); MT Obstetrics & Maternal Support (MOMS); Oral Health Program; and Adolescent Health programs.

In 2023, the MCHBG Program contracted with UMRIIC to solicit greater input from the populations it serves:

- In May 2023, listening sessions were held with 20 parents/ caregivers, who helped to improve the survey design and recruitment plan.
- The actual survey data collection occurred from October through December. There were 558 participants.
- The survey included a mix of five open-text and fixed-response questions.

Public Health System Improvement Task Force

The MCHBG Program Specialist (PS) serves as the liaison to the PHSITF, which is overseen by the System Improvement Coordinator in the Public Health & Safety Division. It has 14 members, representing a cross-section of agencies, statewide associations, and CPHDs with differing population levels. Created in 1995 when the MT Legislature adopted the Public Health Improvement Act, it's Charter includes serving as the advisory board for the Title V MCHBG.

At the quarterly meetings, PHSITF members are offered the opportunity to provide input on MCHBG activities and are tasked with ensuring their constituents are made aware of the MCHBG-AR process. PHSITF members are provided with an initial copy of MCHBG-AR for additional input and comments and offered the opportunity to observe the federal review.

Pregnancy Risk Assessment Monitoring System (PRAMS)

In December 2021, MCHBG staff began working with FCHB epidemiologists on the possibility of adding MCHBG-related questions to MT's 2022 PRAMS questionnaire. PRAMS, funded by the Centers for Disease Control and Prevention (CDC), is a survey of women who recently gave birth about their experiences and behaviors before, during, and shortly after pregnancy. It samples between 15 to 20 percent of live births each year, with an anticipated sample size between 1,500 and 2,000.

State-added questions are appended to the end of the fixed main PRAMS survey. The purpose of state-added questions is to use the existing methodology of PRAMS to implement rapid surveillance of topics important to MT programs. The data collected will be used to improve inclusivity in ongoing MCHBG needs assessment activities by collecting more public input data from mothers.

The PRAMS Steering Committee chose, and the CDC and IRB approved, the following state-added question proposed by the MCHBG for the PRAMS 2022 survey:

> *Here is a list of problems some women can have getting prenatal care. For each item, circle Y (Yes) if it was a problem for you during your most recent pregnancy or circle N (No) if it was not a problem or did not apply to you.*
>
> - I couldn't get an appointment when I wanted one
> - I didn't have enough money or insurance to pay for my visits
> - I had no way to get to the clinic or doctor's office
> - I couldn't take time off from work
> - The doctor or my health plan would not start care as early as I wanted
> - I didn't have my Medicaid card
> - I had no one to take care of my children
> - I had too many other things going on

- I didn't want anyone to know I was pregnant
- Other – Please tell us:

Data collection on this question was completed in June 2023, and the PRAMS Program is currently awaiting release of the data from the Centers for Disease Control & Prevention (CDC).

County Public Health Departments

The CPHDs which receive MCHBG funds are contractually required to conduct client satisfaction surveys and report the results to the FCHB. They also use the results for quality improvement in their MCHBG service delivery and for MCHBG program planning. The CPHDs provide feedback on the performance measure they are implementing, and on MCHBG priorities, through: online surveys; in-person site visits; annual training sessions conducted by the MCHBG PS, and Fetal, Infant, Child, and FICMMR PS; and, through the Pre-Contract Survey (PCS).

The PCS gathers information such as populations served, hours of operation, and the needs of their community's maternal and child population. The PCS allows the CPHDs to: 1) identify their selected National or State Performance Measure (N/SPM) and the coming year's activities, goals and evaluation to address the N/SPM; 2) collect CPHD information such as requests for program technical assistance or materials; and 3) gather information about emerging MCH issues which the CPHDs have identified through their own needs assessment.

All 56 counties in MT are supported by the MCHBG PS and FICMMR PS. More in-depth support was provided to the 51 CPHD MCH-focused programs that opted for FFY 23 MCHBG funding, and to the 31 FICMMR teams, some of whom serve more than one CPHD. In FFY 2023, the MCHBG PS facilitated three different types of web-based Title V MCHBG trainings: 1) Refresher training for annual Financial & Data Report; 2) In May 2023: Workforce Development, the June 2023 PCS, and upcoming deliverables for FFY 2024; and, 3) many MCHBG Basics Trainings for new CPHD staff, as needed. The FICMMR Annual Training was held in June 2023, which was one of the four webinar trainings required yearly for county FICMMR Liaisons.

MT Early Childhood Advisory Council

The MT Early Childhood Advisory Council (MECAC) meets twice a year and serves as the formal advisory council to: the Child Care Development Block Grant (CCDBG/CCDF), Healthy MT Families (HMF) (Maternal, Infant and Early Childhood Home Visiting Program), Head Start Collaboration Office (HSCO) and "Act Early" ASD (autism spectrum disorder) State Team.

The strategic goal of the MT Early Childhood Advisory Council is to ensure MT has a comprehensive, coordinated, early childhood system that provides a governance structure and leads to strong collaboration in order to best meet the needs of MT's youngest citizens.

MECAC members represent:
- MT Child Care Resource and Referral Network
- Early Childhood Higher Education Consortium
- MT Association for the Education of Young Children
- Head Start State Collaboration Project
- Head Start Association
- Child Care plus+ Center on Inclusion in Early Childhood (UM)
- Child and Adult Care Food Program
- MT Department of Labor and Industry: Apprenticeship Program and Training
- MT Department of Public Health and Human Services:
  - Early Childhood Services Bureau
  - Quality Assurance Division
- Office of Public Instruction

Information about MECAC can be found at: https://dphhs.mt.gov/ecfsd/MTEarlyChildhoodAdvisoryCouncil.

Affiliated FCHB Needs Assessments

With the strong emphasis on public input throughout DPHHS sponsored programs, MCHBG staff periodically examine the public input provided through other FCHB-affiliated needs assessment activities and public input forums. The FCHB is reviewing the needs assessment activities that have been undertaken recently by all its programs and discussing optimal strategies to gather as much additional public input as possible on N/SPMs and MCHBG population domains.

Children's Special Health Services Section

Consumer Advisory Council

Children's Special Health Services (CSHS) supports the Consumer Advisory Council (CAC) of the University of MT Rural Institute for Inclusive Communities (UMRIIC) in planning strategies to educate families about CYSHCN's transition to adult services. The CAC is made up of five individuals with special health care needs who have utilized transition services; one transition-age youth with special health care needs; seven parents of CYSHCN; and representatives from several agencies, including the Social Security Administration, MT Office of Public Instruction, MT Developmental Disabilities Program and MT Vocational Rehabilitation.

CSHS is planning to convene a stakeholders group at the August 12, 2024 meeting, with the goal to involve parents, agencies, providers, and state program staff in CSHS activities, and solicit engagement from the key stakeholders. CSHS plans to provide an in-depth overview of programs and lead break-out groups to discuss various strategies, with the goal of identifying opportunities for support and overcoming barriers.

In June of 2024 CSHS began the process of updating the program's strategic plan. This involves using an outside facilitation group and will be finalized in September of 2024. The strategic plan will then be updated bi-annually.

Family to Family Health Information Center (F2F)

CSHS utilizes the expertise of contractors when the opportunity presents, as many of them interface regularly with consumers. CSHS collaborates regularly with the MT F2F Health Information Center at UMRIIC. Three family members serve as a part of the Financial Assistance Committee and engage in regular strategic planning and systems building conversations with CSHS. They highlight the ever-present need for family voices to be a part of program creation, support, and delivery.

CSHS and F2F have formalized the relationship between the programs through a Memorandum of Understanding (MOU). Additionally, the Association of Maternal and Child Health Programs (AMCHP) Family Delegate role is housed as a part of the F2F, through a contract between CSHS and F2F. This relationship emphasizes the importance of lived experience, and its influence on CSHS and related services. The AMCHP Family Delegate contract has been in place since July 2022, and has been assisting in special projects since the beginning of the contract period. One of the major special projects is planning the CYSHCN pre-conference to the MT American Academy of Pediatrics (MT AAP) Roundup. This pre-conference focuses on complex care and how to provide quality care to CYSHCN. The theme for the conference that took place October 6, 2023, was transitions. The theme for the conference that will take place October 4, 2024, is genetics. With this conference, the Family Delegate assists with putting together family panels to give providers an opportunity to hear directly from families. Other special projects include assisting to plan the CSHS Stakeholders meetings and attending the CSHS Strategic Planning meetings.

MT Access to Pediatric Psychiatry Network

The MT Access to Pediatric Psychiatry Network (MAPP-Net) maintains an Advisory Council which oversees the activities of the grant. Council members from across the state include: primary care providers; behavioral health providers; Medicaid representatives; the Head Start Director; Child and Adolescent Psychiatrists (CAPs); and representatives from other grant programs working with similar populations.

The MAPP-Net Advisory Council did not meet in FFY23 due to staff changes. The Advisory Council will resume in July of 2024. The goal of the Advisory Council is to seek stakeholder input from across the state on the activities of the MAPP-Net grant.

Similarly, the annual MAPP-Net Pediatric Mental Health Symposium has a planning committee that meets monthly to determine speaker selection, agenda, venue location, continuing education requirements, and other topics as needed or relevant to the Symposium. The 2023 planning committee consisted: of an event planner, a licensed clinical social worker, a registered nurse, the MAPP-Net Program Specialist (PS), and the CYSHCN Title V PS. The Pediatric Mental Health Symposium was held in March 2023 and had 174 attendees.

Starting in March 2023, the Advisory Council and Symposium planning committee for MAPP-Net is participating in a joint stakeholder group funded by the National American Academy of Pediatrics. This stakeholder group aims to increase provider input, and awareness of and participation in *Pediatric Mental Health Care Access* programming. It is comprised of the Executive Director of the MT American Academy of Pediatrics chapter, the Executive Director of the MT American Academy of Family Physicians chapter, a pediatrician, a family physician, the MAPP-Net PS, the MAPP-Net Program Coordinator, and a rotating clinical member whose expertise is based on the meeting agenda priorities.

Language Assessment of Deaf/Hard of Hearing Children

House Bill 619, passed by the 2023 MT legislature, was an act to revise laws relating to the assessment of language development in Deaf/Hard of Hearing (D/HH) children. This bill included the creation of a temporary committee to assist DPHHS and the Office of Public Instruction (OPI) in creating a parent resource on language development and establish language assessment standards. The committee had specific roles, such as: parent using ASL, parent using spoken language, Speech Language Pathologist, and Teacher of the Deaf. The committee had thirteen members, and met six times from March through May of 2024. The end result was a parent resource tool and recommendation of language assessment standards for DPHHS and OPI.

Newborn Screening Advisory Committee

In FFY 2022, a Governor-appointed Newborn Screening Advisory Committee began convening on a bi-annual basis (at a minimum). It was created by legislation in the 2021 legislative session and is supported by a partnership between CSHS and the Public Health & Safety Division's (PHSD) Metabolic Newborn Screening (NBS) Program. Committee membership includes two individuals affected by the condition under consideration, or two family members of individuals affected, regarding conditions screened through the Metabolic NBS Program as well as various health professional role types. The committee met three times in 2022, and twice in 2023.

The focus of the first two meetings was to onboard the members and decide on by-laws, screening criteria and nomination process. In the following meetings, the committee started reviewing nominated conditions such as Krabbe, Adrenoleukodystrophy (ALD), and Pompe. A fourth condition, Gaucher, is on the fall 2024 agenda. ALD was passed unanimously and added to the Newborn Screening Panel with testing to begin August 2024. Pompe was reviewed in April of 2024 and will be voted on by the committee in August 2024. The meetings are public and advertised on the DPHHS calendar.

III.G. Technical Assistance

Montanan's Title V MCHBG Program is continually looking for ways to streamline and strengthen service delivery to those counties and populations served by the MCHBG. Program staff continue to utilize the resources provided by the Health Resource Service Administration (HRSA), The Association of Maternal and Child Health Programs (AMCHP) and The Maternal Health Learning and Innovation Center (MHLIC) to increase knowledge, skills and abilities to best serve Montana's block grant population.

In April 2024, seven MCHBG program staff or contractors attended the annual AMCHP Conference in Oakland, CA. Staff attended plenary sessions, workshops and networking opportunities that not only provided tools and resources for staff development, but also provided vital peer-to-peer learning and development opportunities.

The University of Montana's Rural Institute for Inclusive Communities (UM RIIC) continues to be a MCHBG partner with the upcoming 5-year Title V Needs Assessment. Through the Montana Indigenous Communities Component, MCH Stakeholder Assessment, and State Stakeholder Interviews, this comprehensive assessment will position the MCHBG to move into the next 5-year cycle of the Block Grant funding. The DPHHS Montana team will be requesting targeted single state TA from the MHLIC to provide assistance for Title V MCHBG performance measure prioritization and state action planning following the completion of the needs assessment.

MCHBG program staff continues to recognize the constraints of funding to Montana counties, and this topic remains a top priority as the program moves into the 2025 needs assessment cycle. The possibility of assembling a County Funding Allocation Advisory Task Force will be revisited in the upcoming year, which would also include Tribal Health representatives. Technical assistance for planning, epidemiology support, and facilitation will be vital to increase the probability of a successful outcome.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MT_MCHBG_MedicaidTitleV_MOU_SFY25.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - MT_MedicaidClaimsAnalysis_WomensPreventiveHealthcare2022.pdf

Supporting Document #02 - MT_MCHBG_ExampleDocuments_CPHD_DeliverablesFFY23.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - MT_MCHBG_TitleV_AgencyLocationOrgChart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Montana

	FY 25 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,323,181	
A. Preventive and Primary Care for Children	$ 957,134	(41.1%)
B. Children with Special Health Care Needs	$ 697,267	(30%)
C. Title V Administrative Costs	$ 211,750	(9.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,866,151	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 3,082,402	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 3,164,626	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 2,834,159	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 9,081,187	
A. Your State's FY 1989 Maintenance of Effort Amount $ 485,480		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 11,404,368	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 27,137,314	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 38,541,682	

OTHER FEDERAL FUNDS	FY 25 Application Budgeted
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 17,629,922
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 1,000,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	$ 159,613
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 175,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Loan Repayment	$ 174,190
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 400,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) American Rescue Plan (ARP)	$ 5,044,814
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 22,123
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 259,836
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 159,264
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 850,000
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC Farmers Market	$ 85,344
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC Peer Counseling	$ 222,208

OTHER FEDERAL FUNDS	FY 25 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Enhancing Reviews and Surveillance to Eliminate Maternal Mortality	$ 370,000

	FY 23 Annual Report Budgeted		FY 23 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,323,181 (FY 23 Federal Award: $ 2,366,470)		$ 2,366,470	
A. Preventive and Primary Care for Children	$ 832,857	(35.8%)	$ 965,523	(40.8%)
B. Children with Special Health Care Needs	$ 765,410	(32.9%)	$ 776,628	(32.8%)
C. Title V Administrative Costs	$ 232,318	(10%)	$ 183,628	(7.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,830,585		$ 1,925,779	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 3,343,517		$ 2,634,577	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 3,441,756		$ 3,164,626	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 3,391,241		$ 2,888,530	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 10,176,514		$ 8,687,733	
A. Your State's FY 1989 Maintenance of Effort Amount $ 485,480				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 12,499,695		$ 11,054,203	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 24,009,736		$ 28,089,518	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 36,509,431		$ 39,143,721	

OTHER FEDERAL FUNDS	FY 23 Annual Report Budgeted	FY 23 Annual Report Expended
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 14,486,273	$ 17,802,981
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000	$ 310,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 1,944,429	$ 2,168,159
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	$ 159,003	$ 202,368
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 100,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,020	$ 175,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Loan Repayment	$ 127,500	$ 174,190
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Grants to States to Support Oral Health Workforce	$ 400,000	$ 483,863
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 4,350,895	$ 4,349,780
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 522,622	$ 441,623
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 159,264	$ 159,264

OTHER FEDERAL FUNDS	FY 23 Annual Report Budgeted	FY 23 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 444,883	$ 850,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 22,123	$ 22,635
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 299,379	$ 0
US Department of Agriculture (USDA) > Food and Nutrition Services > Farmers Market, Fun03713-896HK	$ 107,382	$ 71,143
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC Peer Counseling, Fund 03146-896Hk	$ 240,963	$ 229,133
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Enhancing Reviews and Surveillance to Eliminate Maternal Mortality		$ 299,379

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Expended more than original budget. Main reasons were: 1) additional outreach for Oral Health BSS Screenings; and, 2) WWV/NPM1, support for congenital syphilis media campaign.	
2.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Originally budgeted for award cap amount of 10%, actual expenses were less.	
3.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Spent less than budgeted. Main reasons were: 1) Cleft Clinic activities ended in June 2023 with no expenses to CSHS; 2) no revenue was collected or expended for PRAMS.	
4.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Final income was less than budgeted. Main reasons were: 1) WIC rebate was less than anticipated; 2) actual revenue for Cleft Clinics was less than anticipated.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Montana

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Pregnant Women	$ 93,466	$ 90,003
2. Infants < 1 year	$ 200,192	$ 192,358
3. Children 1 through 21 Years	$ 957,134	$ 965,523
4. CSHCN	$ 697,267	$ 776,628
5. All Others	$ 163,372	$ 158,330
Federal Total of Individuals Served	$ 2,111,431	$ 2,182,842

IB. Non-Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Pregnant Women	$ 207,010	$ 202,498
2. Infants < 1 year	$ 3,762,219	$ 3,669,887
3. Children 1 through 21 Years	$ 3,007,821	$ 2,816,655
4. CSHCN	$ 426,602	$ 114,614
5. All Others	$ 1,723,576	$ 1,795,653
Non-Federal Total of Individuals Served	$ 9,127,228	$ 8,599,307
Federal State MCH Block Grant Partnership Total	$ 11,238,659	$ 10,782,149

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Montana

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Direct Services	$ 50,000	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 50,000	$ 0
2. Enabling Services	$ 1,383,804	$ 1,440,594
3. Public Health Services and Systems	$ 889,377	$ 925,876
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 2,323,181	$ 2,366,470

IIB. Non-Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Direct Services	$ 315,000	$ 4,149
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 315,000	$ 4,149
2. Enabling Services	$ 4,574,571	$ 4,533,269
3. Public Health Services and Systems	$ 4,191,616	$ 4,150,314
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 4,149
Direct Services Line 4 Expended Total		$ 4,149
Non-Federal Total	$ 9,081,187	$ 8,687,732

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Montana

Total Births by Occurrence: 11,167 **Data Source Year: 2023**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	11,054 (99.0%)	201	19	19 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Cystic Fibrosis
Glutaric Acidemia Type I	Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency
Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Primary Congenital Hypothyroidism
Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences
Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Critical Congenital Heart Disease	9,237 (82.7%)	8	0	0 (0%)
Hearing Screening	10,399 (93.1%)	22	3	3 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The Montana Newborn Screening Program does not provide or monitor long-term follow-up for all conditions identified through newborn screening. However, programs do provide family and clinical support for some conditions. The Universal Newborn Hearing and Intervention Program provides supportive services to families when a baby is diagnosed deaf or hard of hearing. This support is provided through family-led organizations. Any individual with a metabolic disorder (including infants diagnosed through newborn screening) can receive long-term follow-up services through a contractor funded by CSHS.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Montana

Annual Report Year 2023

Form 5a – Count of Individuals Served by Title V (Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	840	74.6	0.2	12.8	7.6	4.8
2. Infants < 1 Year of Age	2,574	62.2	3.4	16.8	15.4	2.2
3. Children 1 through 21 Years of Age	11,498	49.4	6.5	30.8	9.8	3.5
3a. Children with Special Health Care Needs 0 through 21 years of age^	527	75.4	6.1	9.7	2.9	5.9
4. Others	4,276	25.7	0.3	52.4	8.8	12.8
Total	19,188					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	11,175	Yes	11,175	38.0	4,247	840
2. Infants < 1 Year of Age	11,224	Yes	11,224	94.0	10,551	2,574
3. Children 1 through 21 Years of Age	279,954	Yes	279,954	10.0	27,995	11,498
3a. Children with Special Health Care Needs 0 through 21 years of age^	69,004	Yes	69,004	16.0	11,041	527
4. Others	831,712	Yes	831,712	0.6	4,990	4,276

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2023**
	Field Note: Number provided enabling services by County Public Health Departments using MCHBG funding.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2023**
	Field Note: Number provided enabling services by County Public Health Departments using MCHBG funding.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2023**
	Field Note: Number provided enabling services by County Public Health Departments using MCHBG funding.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2023**
	Field Note: Number provided enabling services by County Public Health Departments using MCHBG funding.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2023**
	Field Note: Number provided enabling services by County Public Health Departments using MCHBG funding.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2023**

Field Note:
Due to rounding constraints of only one decimal point, actual number is off. It is actually 4193.

WIC (n= 3,353) and County Public Health Departments (CPHDs) Total Unduplicated Numbers Served (n= 840).

The CPHD contracts are overseen by the MCHBG Program Specialist.

WIC is in the same bureau as the MCHBG (Family & Community Health Bureau), with both having management oversight from the FCHB Chief. The two programs collaborate and coordinate on data and activities.

2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2023**

Field Note:
Due to rounding constraints of only one decimal point, actual number is off. It is actually 10640, from Newborn Screening.

3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2023**

Field Note:
Due to rounding constraints of only one decimal point, actual number is off. It is actually 27451.

WIC (n= 12190) and County Public Health Departments (CPHDs) Total Unduplicated Numbers Served (n=11498) and Oral Health (n=3384).

CPHD contracts are overseen by the MCHBG Program Specialist.

WIC is in the same bureau as the MCHBG (Family & Community Health Bureau), with both having management oversight from the FCHB Chief. The two programs collaborate and coordinate on data and activities. The same is true for the Oral Health Program.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2023**

Field Note:
Due to rounding constraints of only one decimal point, actual number is off. It is actually 11019.

5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2023**

Field Note:
Due to rounding constraints of only one decimal point, actual number is off. It is actually 4276, from County Public Health Departments (CPHDs) contracts - which are overseen by the MCHBG Program Specialist.

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Montana

Annual Report Year 2023

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	10,969	8,816	59	640	916	117	14	358	49
Title V Served	10,708	8,608	57	624	894	114	13	350	48
Eligible for Title XIX	5,231	3,773	25	358	811	35	6	204	19
2. Total Infants in State	11,228	8,985	61	691	938	122	14	364	53
Title V Served	11,038	8,974	76	607	896	84	7	332	62
Eligible for Title XIX	5,378	3,855	26	396	829	37	6	209	20

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: Source: Montana Birth Certificate Vital Records. Records include all Montana resident mothers birthing a live infant in the state of Montana between 10/1/23 to 9/30/2024	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: Source: Birth Certificate Vital Records and Public Health Laboratory Newborn Screening Bloodspot Results (Montana Minimum/Core Dataset). Records include a distinct count of mothers (mothers of twins, trips deduplicated) included in "deliveries in state" (as defined in field note 1) wherein the mother had an infant with a test result for the Newborn Screening bloodspot panel.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: Source: Birth Certificate Vital Records and Medicaid Eligibility (Montana Minimum/Core Dataset). Records include a distinct count of mothers included in "deliveries in state" (as defined in field note 1) wherein the mother had a Medicaid eligibility span between the estimated last menstrual period (date based on obstetrical estimate of gestational age and date of birth) and the date of birth.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: Source: Montana Birth Certificate Vital Records. Records include all live infants born to a Montana resident in the state of Montana between 10/1/2023 - 9/30/2024.	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2023**
	Column Name:	**Total**

	Field Note: Source: Birth Certificate Vital Records and Public Health Laboratory Newborn Screening Bloodspot Results (Montana Minimum/Core Dataset). Records include a count of infants included in "infants in state" (as defined in field note 4) wherein the infant had a test result for the Newborn Screening bloodspot panel. Note that the laboratory had an excessive number of unknown and no answer for race, these were proportioned to the race of the mother.	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: Source: Birth Certificate Vital Records and Medicaid Eligibility (Montana Minimum/Core Dataset). Records include a count of infants included in "infants in state" (as defined in field note 4) wherein the infant had a Medicaid eligibility span between the infant's date of birth and the infant's first birthday (note not all infants were older than 1 year at time of report).	

Form 7
Title V Program Workforce

State: Montana

Form 7 Entry Page

A. Title V Program Workforce FTEs	
Title V Funded Positions	
1. Total Number of FTEs	4.25
1a. Total Number of FTEs (State Level)	4.25
1b. Total Number of FTEs (Local Level)	0
2. Total Number of MCH Epidemiology FTEs (subset of A. 1)	0
3. Total Number of FTEs eliminated in the past 12 months	0
4. Total Number of Current Vacant FTEs	1
4a. Total Number of Vacant MCH Epidemiology FTEs	0
5. Total Number of FTEs onboarded in the past 12 months	2

B. Training Needs (Optional)	
1	Only internal training for new CSHCN Title V Program Specialist, once hiring is complete.
2	
3	
4	

Form Notes for Form 7:

None

Field Level Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Montana

1. Title V Maternal and Child Health (MCH) Director	
Name	Mandi Zanto
Title	Title V MCHBG Director
Address 1	1625 11th Avenue
Address 2	PO Box 4210
City/State/Zip	Helena / MT / 59620
Telephone	(406) 444-4119
Extension	
Email	mzanto@mt.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Amber Bell
Title	Title V CSHCN Director
Address 1	1625 11th Avenue
Address 2	PO Box 4202
City/State/Zip	Helena / MT / 59620
Telephone	(406) 444-3617
Extension	
Email	abell@mt.gov

3. State Family Leader (Optional)	
Name	Tarra Thomas
Title	Parent Partner and State Coordinator
Address 1	229 Avenue D
Address 2	
City/State/Zip	Billings / MT / 59106
Telephone	(406) 697-4631
Extension	
Email	tarrathomafa@outlook.com

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

5. SSDI Project Director	
Name	Erin Dobrinen
Title	SSDI Project Director
Address 1	1625 11th Avenue
Address 2	PO Box 4210
City/State/Zip	Helena / MT / 59620
Telephone	(406) 444-1921
Extension	
Email	erin.dobrinen@mt.gov

6. State MCH Toll-Free Telephone Line	
State MCH Toll-Free “Hotline” Telephone Number	(888) 706-1535

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Montana

Application Year 2025

No.	Priority Need
1.	Women's Preventive Healthcare
2.	Infant Safe Sleep
3.	Bullying Prevention
4.	Medical Home
5.	Children's Oral Health
6.	Access to Public Health Services
7.	Family Support and Health Education

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Women's Preventive Healthcare	New
2.	Infant Safe Sleep	Continued
3.	Bullying Prevention	New
4.	Medical Home	Continued
5.	Children's Oral Health	New
6.	Access to Public Health Services	Continued
7.	Family Support and Health Education	Continued

Form 10
National Outcome Measures (NOMs)

State: Montana

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM - Percent of pregnant women who receive prenatal care beginning in the first trimester (Early Prenatal Care, Formerly NOM 1) - PNC

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	79.5 %	0.4 %	8,868	11,157
2021	80.4 %	0.4 %	9,018	11,211
2020	79.6 %	0.4 %	8,585	10,781
2019	78.7 %	0.4 %	8,714	11,066
2018	77.5 %	0.4 %	8,884	11,465
2017	77.4 %	0.4 %	9,106	11,765
2016	75.3 %	0.4 %	9,205	12,232
2015	74.6 %	0.4 %	9,340	12,525
2014	75.2 %	0.4 %	9,258	12,317
2013	71.1 %	0.4 %	8,700	12,235
2012	73.5 %	0.4 %	8,774	11,941
2011	73.4 %	0.4 %	8,757	11,928
2010	73.9 %	0.4 %	8,654	11,718
2009	73.4 %	0.4 %	8,074	10,996

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM PNC - Notes:

None

Data Alerts: None

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	77.7	8.8	79	10,169
2020	73.8	8.7	73	9,886
2019	52.8	7.2	54	10,229
2018	38.6	6.0	41	10,613
2017	37.4	5.9	40	10,696
2016	57.5	7.3	63	10,963
2015	64.8	8.8	54	8,338
2014	50.4	6.9	53	10,509
2013	66.1	8.0	69	10,440
2012	71.6	8.4	73	10,192
2011	68.9	8.2	72	10,449
2010	77.7	8.5	84	10,814
2009	70.1	8.0	77	10,977

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SMM - Notes:

None

Data Alerts: None

NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2022	30.5 ϟ	7.4 ϟ	17 ϟ	55,789 ϟ
2017_2021	26.6 ϟ	6.9 ϟ	15 ϟ	56,413 ϟ
2016_2020	22.6 ϟ	6.3 ϟ	13 ϟ	57,464 ϟ
2015_2019	16.9 ϟ	5.3 ϟ	10 ϟ	59,256 ϟ
2014_2018	NR ⚑	NR ⚑	NR ⚑	NR ⚑

Legends:

⚑ Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM MM - Notes:

None

Data Alerts: None

NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	7.6 %	0.3 %	847	11,162
2021	7.6 %	0.3 %	853	11,218
2020	7.7 %	0.3 %	830	10,786
2019	7.3 %	0.3 %	804	11,074
2018	7.4 %	0.2 %	855	11,505
2017	8.0 %	0.3 %	942	11,793
2016	7.9 %	0.2 %	966	12,273
2015	7.1 %	0.2 %	887	12,575
2014	7.4 %	0.2 %	920	12,429
2013	7.4 %	0.2 %	913	12,370
2012	7.4 %	0.2 %	891	12,109
2011	7.2 %	0.2 %	867	12,061
2010	7.5 %	0.2 %	901	12,054
2009	7.1 %	0.2 %	865	12,247

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM LBW - Notes:

None

Data Alerts: None

NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	9.7 %	0.3 %	1,086	11,165
2021	9.7 %	0.3 %	1,090	11,219
2020	9.8 %	0.3 %	1,059	10,788
2019	9.6 %	0.3 %	1,064	11,075
2018	9.1 %	0.3 %	1,047	11,507
2017	9.5 %	0.3 %	1,118	11,794
2016	8.8 %	0.3 %	1,074	12,271
2015	8.4 %	0.3 %	1,059	12,575
2014	9.3 %	0.3 %	1,157	12,423
2013	9.0 %	0.3 %	1,111	12,356
2012	9.4 %	0.3 %	1,136	12,099
2011	8.8 %	0.3 %	1,065	12,052
2010	10.1 %	0.3 %	1,222	12,042
2009	9.0 %	0.3 %	1,101	12,225

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM PTB - Notes:

None

Data Alerts: None

NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	29.0 %	0.4 %	3,240	11,165
2021	28.6 %	0.4 %	3,204	11,219
2020	27.9 %	0.4 %	3,006	10,788
2019	27.1 %	0.4 %	3,005	11,075
2018	24.8 %	0.4 %	2,858	11,507
2017	23.7 %	0.4 %	2,795	11,794
2016	23.8 %	0.4 %	2,915	12,271
2015	22.7 %	0.4 %	2,855	12,575
2014	22.9 %	0.4 %	2,849	12,423
2013	23.0 %	0.4 %	2,837	12,356
2012	23.8 %	0.4 %	2,879	12,099
2011	24.5 %	0.4 %	2,953	12,052
2010	25.0 %	0.4 %	3,008	12,042
2009	26.2 %	0.4 %	3,197	12,225

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM ETB - Notes:

None

Data Alerts: None

NOM - Percent of non-medically indicated early elective deliveries (Early Elective Delivery, Formerly NOM 7) - EED

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022/Q1-2022/Q4	1.0 %			
2021/Q4-2022/Q3	1.0 %			
2021/Q3-2022/Q2	1.0 %			
2021/Q2-2022/Q1	1.0 %			
2021/Q1-2021/Q4	1.0 %			
2020/Q4-2021/Q3	1.0 %			
2020/Q3-2021/Q1	1.0 %			
2019/Q4-2020/Q3	1.0 %			
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	3.0 %			
2017/Q3-2018/Q2	3.0 %			
2017/Q2-2018/Q1	4.0 %			
2017/Q1-2017/Q4	3.0 %			
2016/Q4-2017/Q3	4.0 %			
2016/Q3-2017/Q2	3.0 %			
2016/Q2-2017/Q1	3.0 %			
2016/Q1-2016/Q4	3.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	3.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	4.0 %			
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	7.0 %			
2013/Q2-2014/Q1	8.0 %			

Legends:

NOM EED - Notes:

None

Data Alerts: None

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.2	0.6	47	11,256
2020	4.4	0.6	48	10,812
2019	5.2	0.7	58	11,115
2018	4.9	0.7	56	11,540
2017	4.3	0.6	51	11,823
2016	5.0	0.6	61	12,312
2015	4.8	0.6	61	12,615
2014	6.4	0.7	80	12,470
2013	5.3	0.7	66	12,415
2012	6.4	0.7	78	12,158
2011	5.9	0.7	72	12,103
2010	5.5	0.7	66	12,094
2009	5.5	0.7	68	12,294

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM PNM - Notes:

None

Data Alerts: None

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.9	0.7	55	11,231
2020	5.0	0.7	54	10,791
2019	4.8	0.7	53	11,079
2018	4.8	0.7	55	11,513
2017	5.5	0.7	65	11,799
2016	5.8	0.7	71	12,282
2015	5.8	0.7	73	12,583
2014	5.8	0.7	72	12,432
2013	5.6	0.7	69	12,377
2012	5.9	0.7	72	12,118
2011	6.0	0.7	72	12,069
2010	6.0	0.7	72	12,060
2009	6.2	0.7	76	12,257

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM - Notes:

None

Data Alerts: None

NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	2.4	0.5	27	11,231
2020	3.1	0.5	33	10,791
2019	2.5	0.5	28	11,079
2018	3.0	0.5	35	11,513
2017	3.1	0.5	36	11,799
2016	2.9	0.5	36	12,282
2015	3.5	0.5	44	12,583
2014	3.9	0.6	49	12,432
2013	2.9	0.5	36	12,377
2012	3.5	0.5	42	12,118
2011	4.4	0.6	53	12,069
2010	3.5	0.5	42	12,060
2009	3.3	0.5	41	12,257

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Neonatal - Notes:

None

Data Alerts: None

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	2.5	0.5	28	11,231
2020	1.9	0.4	21	10,791
2019	2.3	0.5	25	11,079
2018	1.7	0.4	20	11,513
2017	2.5	0.5	29	11,799
2016	2.8	0.5	35	12,282
2015	2.3	0.4	29	12,583
2014	1.9	0.4	23	12,432
2013	2.7	0.5	33	12,377
2012	2.5	0.5	30	12,118
2011	1.6	0.4	19	12,069
2010	2.5	0.5	30	12,060
2009	2.9	0.5	35	12,257

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Postneonatal - Notes:

None

Data Alerts: None

NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	124.7 ϟ	33.3 ϟ	14 ϟ	11,231 ϟ
2020	120.5 ϟ	33.4 ϟ	13 ϟ	10,791 ϟ
2019	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2018	156.3 ϟ	36.9 ϟ	18 ϟ	11,513 ϟ
2017	93.2 ϟ	28.1 ϟ	11 ϟ	11,799 ϟ
2016	187.3	39.1	23	12,282
2015	79.5 ϟ	25.1 ϟ	10 ϟ	12,583 ϟ
2014	201.1	40.3	25	12,432
2013	113.1 ϟ	30.3 ϟ	14 ϟ	12,377 ϟ
2012	132.0 ϟ	33.0 ϟ	16 ϟ	12,118 ϟ
2011	124.3 ϟ	32.1 ϟ	15 ϟ	12,069 ϟ
2010	141.0 ϟ	34.2 ϟ	17 ϟ	12,060 ϟ
2009	146.9 ϟ	34.6 ϟ	18 ϟ	12,257 ϟ

Legends:

⚑ Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Preterm Related - Notes:

None

Data Alerts: None

NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	142.5	35.6	16	11,231
2020	129.7	34.7	14	10,791
2019	126.4	33.8	14	11,079
2018	95.5	28.8	11	11,513
2017	127.1	32.9	15	11,799
2016	138.4	33.6	17	12,282
2015	182.8	38.2	23	12,583
2014	112.6	30.1	14	12,432
2013	129.3	32.3	16	12,377
2012	165.0	36.9	20	12,118
2011	132.6	33.2	16	12,069
2010	165.8	37.1	20	12,060
2009	228.4	43.2	28	12,257

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-SUID - Notes:

None

Data Alerts: None

NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	7.8 %	1.0 %	845	10,777
2021	8.9 %	0.9 %	954	10,727
2020	11.6 %	1.3 %	1,192	10,258
2019	9.0 %	1.1 %	957	10,689
2018	8.7 %	1.0 %	961	11,078
2017	10.5 %	1.0 %	1,185	11,319

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM DP - Notes:

None

Data Alerts: None

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	9.4	1.0	98	10,453
2020	7.8	0.9	79	10,118
2019	8.3	0.9	87	10,462
2018	7.8	0.9	85	10,831
2017	9.0	0.9	98	10,855
2016	7.6	0.8	83	10,976
2015	8.3	1.0	68	8,154
2014	7.8	0.9	80	10,321
2013	7.2	0.8	75	10,470
2012	4.4	0.7	47	10,633
2011	4.2	0.6	45	10,603
2010	3.5	0.6	38	10,856
2009	4.5	0.7	48	10,581

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM NAS - Notes:

None

Data Alerts: None

NOM - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL) (Newborn Screening Timely Follow-Up, Formerly NOM 12) - NBS

Federally available Data (FAD) for this measure is not available/reportable.

NOM NBS - Notes:

None

Data Alerts: None

NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR

Federally available Data (FAD) for this measure is not available/reportable.

NOM SR - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	11.2 %	1.2 %	24,653	220,170
2020_2021	11.5 %	1.2 %	24,627	214,678
2019_2020	10.0 %	1.2 %	21,436	214,790
2018_2019	10.0 %	1.2 %	21,702	216,256
2017_2018	10.2 %	1.2 %	22,073	216,953
2016_2017	9.7 %	1.1 %	20,714	213,143

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM TDC - Notes:

None

Data Alerts: None

NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	20.5	4.3	23	112,246
2021	23.7	4.6	27	113,900
2020	22.9	4.5	26	113,380
2019	22.1	4.4	25	113,373
2018	14.9	3.6	17	113,963
2017	10.5	3.0	12	114,293
2016	27.1	4.9	31	114,264
2015	32.6	5.4	37	113,460
2014	13.3	3.4	15	112,885
2013	18.7	4.1	21	112,420
2012	25.2	4.8	28	111,151
2011	28.9	5.1	32	110,879
2010	29.7	5.2	33	111,031
2009	30.0	5.2	33	109,878

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM CM - Notes:

None

Data Alerts: None

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	67.9	7.0	93	137,026
2021	76.6	7.5	105	137,096
2020	50.5	6.2	66	130,639
2019	50.2	6.2	65	129,384
2018	54.1	6.5	70	129,304
2017	42.3	5.8	54	127,681
2016	51.3	6.4	65	126,595
2015	52.2	6.4	66	126,408
2014	43.6	5.9	55	126,045
2013	48.4	6.2	61	125,995
2012	35.7	5.3	45	126,186
2011	46.9	6.1	60	127,899
2010	58.7	6.8	75	127,848
2009	51.7	6.3	67	129,656

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM - Notes:

None

Data Alerts: None

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2022	29.3	3.8	59	201,165
2019_2021	30.6	3.9	60	196,375
2018_2020	23.4	3.5	45	192,579
2017_2019	21.4	3.4	41	191,418
2016_2018	18.8	3.1	36	191,102
2015_2017	24.1	3.6	46	190,925
2014_2016	29.3	3.9	56	191,405
2013_2015	32.3	4.1	62	192,049
2012_2014	28.0	3.8	54	193,188
2011_2013	25.0	3.6	49	196,016
2010_2012	26.2	3.6	52	198,457
2009_2011	31.3	3.9	63	201,589
2008_2010	33.3	4.0	68	204,191
2007_2009	33.7	4.0	70	207,573

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Motor Vehicle - Notes:

None

Data Alerts: None

NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2022	22.2	2.3	90	404,761
2019_2021	20.1	2.3	80	397,119
2018_2020	16.2	2.0	63	389,327
2017_2019	16.6	2.1	64	386,369
2016_2018	17.7	2.2	68	383,580
2015_2017	16.0	2.1	61	380,684
2014_2016	15.6	2.0	59	379,048
2013_2015	14.0	1.9	53	378,448
2012_2014	12.2	1.8	46	378,226
2011_2013	11.3	1.7	43	380,080
2010_2012	10.5	1.7	40	381,933
2009_2011	11.4	1.7	44	385,403

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Suicide - Notes:

None

Data Alerts: None

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17 (CSHCN, Formerly NOM 17.1) - CSHCN

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	23.7 %	1.4 %	54,657	230,563
2020_2021	21.5 %	1.3 %	48,663	225,859
2019_2020	20.8 %	1.6 %	47,022	226,065
2018_2019	22.5 %	1.8 %	51,396	227,966
2017_2018	23.9 %	1.9 %	54,380	227,664
2016_2017	21.6 %	1.7 %	48,741	225,710

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM CSHCN - Notes:

None

Data Alerts: None

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	15.6 %	2.6 %	8,523	54,657
2020_2021	12.8 %	2.1 %	6,231	48,608
2019_2020	12.7 %	2.3 %	5,987	46,968
2018_2019	15.0 %	3.4 %	7,701	51,396
2017_2018	15.3 %	3.6 %	8,338	54,380
2016_2017	15.0 %	3.0 %	7,321	48,741

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM SOC - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder (Autism, Formerly NOM 17.3) - ASD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	3.4 %	0.6 %	6,689	198,357
2020_2021	3.0 %	0.6 %	5,884	193,030
2019_2020	2.1 %	0.5 %	4,036	189,883
2018_2019	1.4 %	0.5 %	2,706	190,713
2017_2018	2.6 %	0.8 %	4,952	191,642
2016_2017	3.3 %	0.9 %	6,296	191,015

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ASD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) (ADD or ADHD, Formerly NOM 17.4) - ADHD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	10.6 %	1.1 %	20,901	197,017
2020_2021	8.9 %	1.0 %	17,070	192,079
2019_2020	9.5 %	1.3 %	17,891	188,900
2018_2019	8.6 %	1.3 %	16,251	188,117
2017_2018	10.4 %	1.6 %	19,615	189,305
2016_2017	10.4 %	1.6 %	19,760	190,202

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ADHD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	53.1 %	3.9 %	19,764	37,214
2020_2021	53.9 %	4.2 %	18,768	34,848
2019_2020	63.7 %	4.8 %	21,754	34,164
2018_2019	63.4 %	4.8 %	20,414	32,183
2017_2018	57.4 %	5.4 %	16,495	28,716
2016_2017	63.7 %	4.9 %	18,690	29,335

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM MHTX - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	92.5 %	0.9 %	213,009	230,393
2020_2021	92.7 %	0.8 %	209,217	225,765
2019_2020	92.8 %	1.0 %	209,552	225,804
2018_2019	92.2 %	1.2 %	208,878	226,545
2017_2018	88.5 %	1.6 %	200,291	226,225
2016_2017	87.9 %	1.6 %	198,094	225,288

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM CHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	10.8 %	0.5 %	392	3,621
2018	11.9 %	0.4 %	772	6,491
2016	12.1 %	0.4 %	801	6,647
2014	12.5 %	0.4 %	913	7,288
2012	11.3 %	0.4 %	893	7,886
2010	13.4 %	0.4 %	963	7,194
2008	13.5 %	0.4 %	1,096	8,142

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	11.8 %	0.7 %	4,859	41,173
2019	11.5 %	0.8 %	4,655	40,435
2017	11.7 %	0.7 %	4,739	40,406
2015	10.3 %	0.6 %	4,215	40,843
2013	9.4 %	0.5 %	3,866	41,112
2011	8.5 %	0.5 %	3,583	42,261
2009	10.3 %	1.1 %	4,474	43,345
2007	10.1 %	0.6 %	4,614	45,914
2005	9.3 %	0.7 %	4,312	46,302

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021_2022	13.9 %	1.6 %	21,683	155,973
2020_2021	12.8 %	1.4 %	19,505	152,183
2019_2020	14.6 %	1.9 %	21,754	148,881
2018_2019	13.8 %	2.0 %	20,427	148,274
2017_2018	11.6 %	1.7 %	16,770	144,785
2016_2017	11.9 %	1.6 %	16,330	137,770

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM OBS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, without health insurance (Uninsured, Formerly NOM 21) - UI

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	6.3 %	1.2 %	14,872	234,336
2021	7.8 %	0.9 %	18,202	234,638
2019	6.6 %	0.8 %	14,902	227,442
2018	4.9 %	0.8 %	10,969	225,588
2017	6.4 %	1.0 %	14,636	229,879
2016	4.2 %	0.7 %	9,543	228,642
2015	7.6 %	1.1 %	17,206	225,498
2014	8.6 %	1.2 %	19,239	224,105
2013	10.3 %	1.5 %	23,082	223,805
2012	10.9 %	1.3 %	24,004	219,888
2011	12.7 %	1.3 %	28,123	220,707
2010	12.7 %	1.2 %	28,315	222,903
2009	13.3 %	1.2 %	29,339	220,142

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM UI - Notes:

None

Data Alerts: None

NOM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months (Childhood Vaccination, Formerly NOM 22.1) - VAX-Child

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	69.2 %	3.8 %	8,000	12,000
2017	64.1 %	3.8 %	8,000	12,000
2016	60.2 %	3.9 %	7,000	12,000
2015	64.6 %	3.9 %	8,000	12,000
2014	67.9 %	3.8 %	8,000	12,000
2013	57.8 %	4.0 %	7,000	12,000
2012	65.6 %	4.3 %	8,000	12,000
2011	65.3 %	3.9 %	8,000	12,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM VAX-Child - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	43.7 %	2.0 %	97,477	223,060
2021_2022	49.7 %	2.5 %	107,813	216,875
2020_2021	50.2 %	2.0 %	108,205	215,547
2019_2020	57.0 %	2.0 %	123,995	217,535
2018_2019	55.7 %	2.4 %	119,209	213,904
2017_2018	50.3 %	2.1 %	108,374	215,516
2016_2017	49.0 %	2.2 %	103,213	210,639
2015_2016	50.0 %	2.5 %	105,587	211,132
2014_2015	45.3 %	2.5 %	95,231	210,363
2013_2014	50.4 %	2.2 %	106,072	210,648
2012_2013	45.8 %	2.2 %	96,850	211,476
2011_2012	42.4 %	2.3 %	87,608	206,624
2010_2011	37.3 %	4.0 %	77,543	207,890
2009_2010	33.9 %	2.4 %	69,998	206,484

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM VAX-Flu - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	81.8 %	2.7 %	57,177	69,922
2021	75.3 %	3.0 %	49,679	66,002
2020	73.7 %	3.2 %	48,275	65,513
2019	63.7 %	3.4 %	41,180	64,676
2018	66.4 %	3.3 %	42,323	63,771
2017	65.5 %	3.2 %	40,700	62,166
2016	55.3 %	3.3 %	34,816	62,957
2015	50.4 %	3.0 %	31,598	62,694

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM VAX-HPV - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	89.6 %	2.2 %	62,654	69,922
2021	88.8 %	2.2 %	58,588	66,002
2020	87.0 %	2.7 %	56,976	65,513
2019	90.1 %	2.1 %	58,274	64,676
2018	86.7 %	2.4 %	55,294	63,771
2017	90.4 %	2.0 %	56,211	62,166
2016	85.7 %	2.4 %	53,951	62,957
2015	89.5 %	1.9 %	56,095	62,694
2014	84.7 %	2.4 %	52,910	62,436
2013	84.3 %	2.6 %	51,921	61,570
2012	90.2 %	1.9 %	56,070	62,190
2011	85.0 %	3.1 %	53,577	63,063
2010	76.1 %	2.6 %	49,007	64,401
2009	63.8 %	3.1 %	41,526	65,085

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM VAX-TDAP - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	81.6 %	2.7 %	57,054	69,922
2021	77.1 %	3.0 %	50,912	66,002
2020	75.8 %	3.1 %	49,690	65,513
2019	73.1 %	3.1 %	47,275	64,676
2018	75.6 %	3.0 %	48,189	63,771
2017	71.2 %	3.0 %	44,265	62,166
2016	67.6 %	3.1 %	42,555	62,957
2015	65.8 %	2.8 %	41,246	62,694
2014	60.3 %	3.3 %	37,615	62,436
2013	51.6 %	3.4 %	31,763	61,570
2012	58.7 %	3.4 %	36,472	62,190
2011	39.8 %	4.3 %	25,114	63,063
2010	40.2 %	3.0 %	25,884	64,401
2009	26.9 %	2.9 %	17,524	65,085

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM VAX-MEN - Notes:

None

Data Alerts: None

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	12.2	0.6	401	32,845
2021	13.6	0.6	442	32,607
2020	13.2	0.7	411	31,200
2019	16.3	0.7	502	30,795
2018	17.2	0.8	531	30,787
2017	21.2	0.8	645	30,363
2016	23.7	0.9	720	30,382
2015	25.6	0.9	770	30,108
2014	26.6	0.9	807	30,342
2013	27.9	1.0	855	30,610
2012	28.7	1.0	892	31,106
2011	29.3	1.0	930	31,763
2010	35.2	1.1	1,128	32,089
2009	38.4	1.1	1,264	32,930

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM TB - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	12.5 %	1.2 %	1,334	10,686
2021	13.2 %	1.1 %	1,399	10,566
2020	14.9 %	1.5 %	1,515	10,158
2019	15.2 %	1.4 %	1,612	10,606
2018	14.2 %	1.3 %	1,555	10,919
2017	15.0 %	1.2 %	1,688	11,239

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM PPD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	3.0 %	0.6 %	6,799	229,227
2020_2021	2.9 %	0.5 %	6,567	225,136
2019_2020	3.4 %	0.7 %	7,635	225,231
2018_2019	2.8 %	0.7 %	6,390	227,450
2017_2018	3.1 %	0.8 %	6,952	227,317
2016_2017	3.0 %	0.8 %	6,800	225,148

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FHC - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Montana

NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			70.0	70.0	71
Annual Indicator	73.3	69.3	68.6	70.1	73.6
Numerator	123,845	119,515	120,255	123,867	131,768
Denominator	168,903	172,352	175,425	176,723	179,085
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	72.0	73.0

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	82	83	84.0	85.0	86
Annual Indicator	84.3	81.7	87.4	86.8	85.8
Numerator	9,362	8,632	8,706	9,165	9,112
Denominator	11,104	10,565	9,958	10,564	10,615
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	86.0	86.0

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	88	89	90	38.0	39
Annual Indicator	25.9	34.2	37.8	33.8	32.0
Numerator	2,795	3,557	3,578	3,423	3,177
Denominator	10,810	10,387	9,472	10,126	9,934
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	33.0	34.0

Field Level Notes for Form 10 NPMs:

None

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	80	81	82.0	48.0	49
Annual Indicator	38.5	41.6	47.2	53.8	58.0
Numerator	4,169	4,335	4,472	5,432	5,795
Denominator	10,815	10,409	9,480	10,101	9,995
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	55.0	55.0

Field Level Notes for Form 10 NPMs:

None

NPM - D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

Federally available Data (FAD) for this measure is not available/reportable.

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, Formerly NPM 9) - BLY - Adolescent Health

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			27.0	26.0	25
Annual Indicator	27.8	28.5	28.5	22.9	22.9
Numerator	11,393	11,853	11,853	9,789	9,789
Denominator	40,974	41,603	41,603	42,701	42,701
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2017	2019	2019	2021	2021

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Perpetration - All Adolescents					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			27.0	26.0	25
Annual Indicator	23.2	23.2	22.5	20.3	22.4
Numerator	16,058	16,805	17,091	15,714	17,893
Denominator	69,345	72,374	75,957	77,247	79,994
Data Source	NSCHP	NSCHP	NSCHP-All Adolescents	NSCHP-All Adolescents	NSCHP-All Adolescents
Data Source Year	2018	2018_2019	2019_2020	2020_2021	2021_2022

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Victimization					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			27.0	26.0	25
Annual Indicator	45.2	48.9	48.1	45.0	48.6
Numerator	31,448	35,450	36,567	34,753	38,939
Denominator	69,617	72,511	75,967	77,283	80,203
Data Source	NSCHV	NSCHV	NSCHV-All Adolescents	NSCHV-All Adolescents	NSCHV-All Adolescents
Data Source Year	2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	22.0	21.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	49	50	51.0	46.0	47
Annual Indicator	36.8	43.5	45.5	46.8	47.3
Numerator	16,404	19,378	19,982	21,866	25,831
Denominator	44,607	44,583	43,885	46,767	54,657
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	48.0	49.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH - Child Health - All Children

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Children	
	2023
Annual Objective	
Annual Indicator	53.1
Numerator	122,359
Denominator	230,397
Data Source	NSCH-All Children
Data Source Year	2021_2022

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			83.0	81.0	82
Annual Indicator	82.6	82.1	80.4	80.4	82.0
Numerator	179,033	177,165	172,678	171,786	179,994
Denominator	216,777	215,773	214,747	213,627	219,427
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	83.0	84.0

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	91.5
Numerator	9,828
Denominator	10,740
Data Source	PRAMS
Data Source Year	2022

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	85.7
Numerator	8,207
Denominator	9,575
Data Source	PRAMS
Data Source Year	2022

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Montana

SPM 1 - Access to Public Health Services: Number of clients' ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 4,500 or less who choose SPM 1.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	30	30	30	35	35
Annual Indicator	35.5	41.4	40.4	40.9	43.1
Numerator	14,149	19,550	18,683	17,870	19,962
Denominator	39,874	47,216	46,279	43,733	46,303
Data Source	FCHB	FCHB	FCHB	FCHB	FCHB
Data Source Year	2019	2020	FFY 2021	FFY 2022	FFY 2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	37.0	39.0

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Family Support & Health Education: Number of clients ages 0 - 21, and women ages 22 - 44 who are assessed for social service and health education needs; and are placed into a referral and follow-up system, or provided with health education as needed.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	40	40	45	45	45
Annual Indicator	51.1	70.1	66	66.8	63
Numerator	7,166	7,513	7,047	8,519	5,824
Denominator	14,036	10,714	10,677	12,747	9,244
Data Source	FCHB	FCHB	FCHB	FCHB	FCHB
Data Source Year	FFY19	FFY20	FFY 2021	FFY 2022	FFY 2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	50.0	50.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Number of counties participating increased from 6 to 9. Also, moved tracking from state fiscal year to federal fiscal year.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Montana

ESM WWV.1 - Percent of activity goals to increase preventive medical visits for women which are met by county public health departments using MCHBG funding for the work.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			80	82	83
Annual Indicator			100	33.3	40
Numerator			4	3	2
Denominator			4	9	5
Data Source			FCHB	FCHB	FCHB
Data Source Year			FFY 2021	FFY 2022	FFY 2023
Provisional or Final ?			Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	84.0	85.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Work on this ESM didn't begin until October 1, 2020, for FFY 2021.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: One County Public Health Department ended up having to redirect a portion of their MCHBG funding to COVID-19 response efforts. This also benefited their Women/Maternal population, but we have not included their activities here.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: For the County Public Health Departments choosing NPM 1, their ability to implement performance measure activities was still heavily impacted by critical COVID-19 response duties. This was the priority service to their maternal population.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: For FFY 2023, only two counties chose WWV / NPM 1. In total they planned five activities. The MCHBG Coordinator in the county which had planned three activities had a serious accident and was unable to follow through.	

ESM WWV.2 - Completion of Medicaid data query and report on women's annual preventive healthcare visits.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives	
	2025
Annual Objective	1.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
It is expected the report will actually be issued in FFY24.

ESM SS.1 - Percent of activity goals to decrease infant deaths due to unsafe sleep conditions which are met by county public health departments using MCHBG funding for the work.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	80	83	92	92	93
Annual Indicator	100	91.7	100	91.7	88.9
Numerator	15	11	7	11	16
Denominator	15	12	7	12	18
Data Source	FCHB	FCHB	FCHB	FCHB	FCHB
Data Source Year	FFY 2019	FFY 2020	FFY 2021	FFY 2022	FFY 2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	93.0	94.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
This number of activities comes from 4 of 6 CPHDs who originally chose NPM 5 for their focus. The other two ended up having to redirect a portion of their MCHBG funding for COVID-19 response efforts.

ESM BLY.1 - Percent of activity goals to reduce adolescent bullying which are met by county public health departments using MCHBG funding for the work.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			80	82	83
Annual Indicator			80	0	100
Numerator			12	0	2
Denominator			15	4	2
Data Source			FCHB	FCHB	FCHB
Data Source Year			FFY 2021	FFY 2022	FFY 2023
Provisional or Final ?			Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	84.0	85.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Work on this ESM didn't begin until October 1, 2020, for FFY 2021.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: For the County Public Health Departments choosing NPM 9, their ability to implement performance measure activities was still heavily impacted by critical COVID-19 response duties. This was the priority service to their adolescent population.	

ESM BLY.2 - Completion of Bullying Prevention Social Media Campaign

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	35.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: FFYs 23 and 24 are timeline for this new ESM.	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The bullying prevention social media campaign began in September 2023, and is continuing into FFY 2024. The campaign uses a total of seven different messages and graphics in advertisements on Facebook and Instagram: four targeted toward adolescents; and three toward adults, including one specifically for educators. “Click through rate” (CTR) measures how many times an ad is viewed and clicked through to read more or take other action. Industry standard CTR is 0.5%. To-date, the CTR on the ads for adults is 0.86%, and for adolescents is 0.31%.	
3.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: Total Impressions as of 3/17/24 = 3,217,540	

ESM MH.1 - Percent of CYSHCN receiving services from a Parent Partner.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	25	5	5	18	19
Annual Indicator	18.4	56.9	0.3	0.5	0.6
Numerator	36	132	159	274	328
Denominator	196	232	55,048	60,401	57,687
Data Source	FCHB	FCHB	FCHB	FCHB	FCHB
Data Source Year	FFY 2019	FFY 2020	FFY 2021	FFY 2022	FFY 2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	0.7	0.7

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: With the increase of 36 more CYHSCN served by Parent Partners in FFY19, the percentage of increase is logically slowing, due to saturation at current locations. FFY20 numbers show that even more children are being reached, but objectives are being adjusted to reflect known population.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 232 families of children with special health needs were served in FFY19. 364 families were served in FFY20. We believe the increase was partially due to COVID19 related impacts on families as many of the encounters were for an initial meeting and referral. As COVID19 continued into FFY21, the number of parent partners declined and new parent partners did not replace them. We anticipate the number served in FFY21 will be less than FFY19 or FFY20 due to the impact COVID19 had on the Parent Partner workforce and clinic priorities.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The definition of the denominator was changed to improve the accuracy of the ESM title measure. Numerator is the total CYSHCN kids served by a Parent Partner, Denominator is total CYSHCN in Montana.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The definition of the denominator was changed to improve the accuracy of the ESM title measure. Numerator is the total CYSHCN kids served by a Parent Partner, Denominator is total CYSHCN in Montana.	
5.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The definition of the denominator was changed to improve the accuracy of the ESM title measure. Numerator is the total CYSHCN kids served by a Parent Partner, Denominator is total CYSHCN in Montana.	

ESM PDV-Child.1 - Percent of activity goals to increase preventive dental visits for children which are met by county public health departments using MCHBG funding for the work.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			80	82	83
Annual Indicator			87.5	100	100
Numerator			7	11	4
Denominator			8	11	4
Data Source			FCHB	FCHB	FCHB
Data Source Year			FFY 2021	FFY 2022	FFY 2023
Provisional or Final ?			Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	84.0	85.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Work on this ESM didn't begin until October 1, 2020, for FFY 2021.

ESM PDV-Child.2 - Complete the 3rd Grade Basic Screening Surveillance (BSS) to assess student's oral health status, and produce a report to inform needed oral health services.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	1.0	0.0

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: Montana

SPM 1 - Access to Public Health Services: Number of clients' ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 4,500 or less who choose SPM 1. Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Support and sustain the public health system in counties with small population bases, and the ability of their health departments to serve the MCH population.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of clients' ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 2,000 (4,500 starting in FY18) or less who choose SPM 1.</td></tr>
<tr><td>Denominator:</td><td>Total population ages 0 – 21, and women ages 22 – 44 in counties with a corresponding population of 2,000 (4,500 starting in FY18) or less who choose SPM 1.</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>ECBP-D07: Increase number of community organizations that provide preventive services.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>MCHBG County Public Health Department Annual Data Reports</td></tr>
<tr><td>Significance:</td><td>Access to care was consistently identified as a continuing health care need on the Needs Assessment Surveys and Key Informant Interviews. Montana faces a large geographic health disparity. Access to Care is a fundamental action area in five sections of the State Heatlh Improvment Plan, and one section is focused on strengthening the public health and health care system. It is also integral to a key results area of the Public Health & Safety Division Strategic Plan.</td></tr>
</table>

SPM 2 - Family Support & Health Education: Number of clients ages 0 - 21, and women ages 22 - 44 who are assessed for social service and health education needs; and are placed into a referral and follow-up system, or provided with health education as needed.
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Address the social determinants of health by supporting County Public Health Department's ability to provide referrals to social services and health education to their clients.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Annual number of MCH clients referred to social services or provided health education by County Public Health Departments choosing SPM 2</td></tr>
<tr><td>Denominator:</td><td>Annual number of County Public Health Department MCH clients in counties choosing SPM 2</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>ECBP-D07: Increase # of community organizations that provide prevention services.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>MCHBG County Public Health Department Annual Data Reports</td></tr>
<tr><td>Significance:</td><td>Family support and parental education have emerged as essentials which are increasingly unmet; and as having a major effect on the health of the whole MCH population, especially ages 0 to 19 years. Numerous strategies in the State Health Improvement Plan, and Public Health & Safety Division Strategic Plan address working to improve outreach in this area.</td></tr>
</table>

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Montana

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Montana

ESM WWV.1 - Percent of activity goals to increase preventive medical visits for women which are met by county public health departments using MCHBG funding for the work.
NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To support county public health departments who have identified increasing preventive medical visits for women as a priority need in their communities.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of activity goals met to increase preventive medical visits for women, by county public health departments using MCHBG funding to support the work.</td></tr>
<tr><td>Denominator:</td><td>Total number of activity goals to increase preventive medical visits for women, by county public health departments using MCHBG funding to support the work.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>FCHB - The number of counties choosing to use MCHBG funding to address this performance measure may change from year to year. Details on activities, goals, and evaluation plans are submitted by the CPHDs on their yearly pre-contract survey. Outcomes are reported on their annual Compliance & Activities report.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The CDC recognizes the value of state departments of health providing technical assistance to local health departments. The role includes help with: problem identification; problem analysis; strategy development; implementation; and evaluation.

Also, Montana's FCHB has a role similar to a backbone organization in a collective impact model. The CPHD's working on NPM 1 have these characteristics of agencies working in a collective impact framework: 1) common agenda; 2) shared measurement systems; 3) mutually reinforcing activities; 4) continuous communication; and 5) a backbone organization.

Research at the National Institutes of Health shows that improvements in health outcomes are associated with an increase in local health department expenditures, FTEs per capita, and location of health department within local networks. (https://pubmed.ncbi.nlm.nih.gov/22502924/)</td></tr>
<tr><td>Significance:</td><td>The FCHB will contract with CPHDs interested in increasing preventive medical visits for women. These counties will implement and evaluate at least two community-level activities during the fiscal year. As part of supporting these activities, the FCHB provides resources on evidence-based/informed strategies and best practices. This will raise community-level understanding on the importance of preventive medical visits for women, and the range of needs which can be addressed. The FCHB also provides training and support on community needs assessment, and on activity goal setting and evaluation.</td></tr>
</table>

ESM WWV.2 - Completion of Medicaid data query and report on women's annual preventive healthcare visits. NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

Measure Status:	Active
Goal:	Run a baseline analysis of CPT codes in Montana's Medicaid data for women's preventive healthcare, and create a report on the results.
Definition:	**Unit Type:** Count **Unit Number:** 1 **Numerator:** 1 **Denominator:**
Data Sources and Data Issues:	Montana Medicaid Data: issues involve choosing which CPT codes to include in the analysis. There are proxy codes for a well-woman visit to consider, such as: cervical cancer screening, contraceptive care, mental health screenings, and immunizations.
Evidence-based/informed strategy:	1) Medicaid claims data offer a significant opportunity to conduct novel research that can drive the development of evidence-based programs and policies for Medicaid beneficiaries before, during, and after pregnancy. 2) "Using Modernized Medicaid Data to Advance Evidence-Based Improvements in Maternal Health," National Institutes of Health, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10262233/ 3) A report from the Medicaid data will provide a basis for subsequent strategies, and provide needed insights. Medicaid represents a lower income population which is of special focus to the MCHBG.
Significance:	This ESM measures progress on analyzing Medicaid data and issuing a report on the results. This is important for a baseline understanding of gaps and challenges, accountability, and timeliness.

ESM SS.1 - Percent of activity goals to decrease infant deaths due to unsafe sleep conditions which are met by county public health departments using MCHBG funding for the work.
NPM – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult during sleep (Safe Sleep, Formerly NPM 5) - SS

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To support county public health departments who have identified decreasing infant deaths due to unsafe sleep conditions as a priority need in their communities.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of activity goals met to decrease infant deaths due to unsafe sleep conditions, by county public health departments using MCHBG funding to support the work.</td></tr>
<tr><td>Denominator:</td><td>Total number of activity goals to decrease infant deaths due to unsafe sleep conditions, by county public health departments using MCHBG funding to support the work.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>FCHB - The number of counties choosing to use MCHBG funding to address this performance measure may change from year to year. Details on activities, goals, and evaluation plans are submitted by the CPHDs on their yearly pre-contract survey. Outcomes are reported on their annual Compliance & Activities report.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The CDC recognizes the value of state departments of health providing technical assistance to local health departments. The role includes help with: problem identification; problem analysis; strategy development; implementation; and evaluation.

Also, Montana's FCHB has a role similar to a backbone organization in a collective impact model. The CPHD's working on NPM 5 have these characteristics of agencies working in a collective impact framework: 1) common agenda; 2) shared measurement systems; 3) mutually reinforcing activities; 4) continuous communication; and 5) a backbone organization.

Research at the National Institutes of Health shows that improvements in health outcomes are associated with an increase in local health department expenditures, FTEs per capita, and location of health department within local networks.
(https://pubmed.ncbi.nlm.nih.gov/22502924/)</td></tr>
<tr><td>Significance:</td><td>The FCHB will contract with CPHDs interested in decreasing the rate of infant deaths due to unsafe sleep conditions. These counties will implement and evaluate at least two community-level activities during the fiscal year. This will raise community-level understanding on the importance of implementing safe sleep recommendations for infants.
The FCHB also provides training and support on community needs assessment, and on activity goal setting and evaluation.</td></tr>
</table>

ESM BLY.1 - Percent of activity goals to reduce adolescent bullying which are met by county public health departments using MCHBG funding for the work.
NPM – Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, Formerly NPM 9) - BLY

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Support county public health departments who have identified decreasing the percentage of adolescents who are bullied or who bully others as a priority need in their communities.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of activity goals met to reduce bullying, by county public health departments using MCHBG funding to support the work.</td></tr>
<tr><td>Denominator:</td><td>Total number of activity goals to reduce bullying, by county public health departments using MCHBG funding to support the work.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>FCHB - The number of counties choosing to use MCHBG funding to address this performance measure may change from year to year. Details on activities, goals, and evaluation plans are submitted by the CPHDs on their yearly pre-contract survey. Outcomes are reported on their annual Compliance & Activities report.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The CDC recognizes the value of state departments of health providing technical assistance to local health departments. The role includes help with: problem identification; problem analysis; strategy development; implementation; and evaluation.

Also, Montana's FCHB has a role similar to a backbone organization in a collective impact model. The CPHD's working on NPM 5 have these characteristics of agencies working in a collective impact framework: 1) common agenda; 2) shared measurement systems; 3) mutually reinforcing activities; 4) continuous communication; and 5) a backbone organization.

Research at the National Institutes of Health shows that improvements in health outcomes are associated with an increase in local health department expenditures, FTEs per capita, and location of health department within local networks. (https://pubmed.ncbi.nlm.nih.gov/22502924/)</td></tr>
<tr><td>Significance:</td><td>The FCHB will contract with CPHDs interested in decreasing the percentage of adolescents who are bullied or who bully others. These counties will implement and evaluate at least two community-level activities during the fiscal year. As part of supporting these activities, the FCHB provides resources on evidence-based/informed strategies and best practices. This will raise community-level understanding on the importance of bullying prevention, and the related negative behaviors which can be reduced. The FCHB also provides training and support on community needs assessment, and on activity goal setting and evaluation.</td></tr>
</table>

ESM BLY.2 - Completion of Bullying Prevention Social Media Campaign
NPM – Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, Formerly NPM 9) - BLY

Measure Status:	Active
Goal:	Facebook & Instagram ads promoting click throughs to BullyingPrevention.Gov webpage, targeting: Adolescents aged 14-18; and 25-65 aged group, parents of school aged children, teachers/staff; 3,505,000 impressions total.
Definition:	**Unit Type:** Count **Unit Number:** 35 **Numerator:** 100,000 **Denominator:**
Data Sources and Data Issues:	Social media sites metrics tracking.
Evidence-based/informed strategy:	The bullying prevention content on StopBullying.Gov is grounded in research, and provides evidence-based strategies: https://www.stopbullying.gov/resources/research-resources. They have fact sheets available for: pediatricians; recognizing bullying as an Adverse Childhood Experience; the essential role of bystanders; consequences of bullying; and digital citizenship skills. The Substance Abuse & Mental Health Services Administration (SAMHSA) points users to Stopbullying.Gov: "find quality information and resources on StopBullying.gov."
Significance:	Bullying should not be tolerated, or silently accepted by anyone. Bullying has a negative effect on all youth (those bullying, those being bullied and those witnessing the bullying). Bullying prevention needs to be addressed from multiple angles. There is not a certain type of youth that bullies or is bullied. Adults and bystanders can have a significant impact on bullying prevention. This campaign will help adolescents, parent/caregivers, and teachers, be more aware of bullying behaviors and how to handle bullying situations. It is intended to encourage them to stop bullying, intervene when they see bullying happening, and seek help if being bullied.

ESM MH.1 - Percent of CYSHCN receiving services from a Parent Partner.
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

Measure Status:	Active
Goal:	Increase number of CYSHCN receiving services from a Parent Partner in FFY 2023.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Title V served CYSHCN receiving services from a Parent Partner in FFY21. **Denominator:** Number of CYSHCN receiving services from Title V FFY21.
Data Sources and Data Issues:	Child Health Referral Information System (CHRIS) and Montana NSCH Data
Evidence-based/informed strategy:	Family Peer support programs have been in existence for decades, building off of traditional workforces such as peers, community health workers and doulas. Evidence suggests that peer to peer relationships between parents and caregivers can provide benefits such as increasing the self-efficacy of families and decreasing social isolation (SAMSHA - https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/family-parent-caregiver-support-behavioral-health-2017.pdf) This ESM contributes to the wrap-around services for CYSHCN that their providers can have available. This expands the medical home support system.
Significance:	The definition for denominator was modified to accurately capture the equation needed to determine percent of Title V served CYSHCN who receiver services from a Parent Partner. The Montana Parent Partner Program will continue to expand in FFY 22 through increased operational efficiency and performance monitoring metrics. Parent Partners assist families with the 'non-medical' parts of the medical home, helping them to access much needed services and supports in their communities

ESM PDV-Child.1 - Percent of activity goals to increase preventive dental visits for children which are met by county public health departments using MCHBG funding for the work.
NPM – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child

Measure Status:	Active
Goal:	Support county public health departments who have identified increasing preventive dental visits for children as a priority need in their communities.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of activity goals met to increase preventive dental visits for children, by county public health departments using MCHBG funding to support the work.</td></tr><tr><td>**Denominator:**</td><td>Total number of activity goals to increase preventive dental visits for children, by county public health departments using MCHBG funding to support the work.</td></tr></table>
Data Sources and Data Issues:	FCHB - The number of counties choosing to use MCHBG funding to address this performance measure may change from year to year. Details on activities, goals, and evaluation plans are submitted by the CPHDs on their yearly pre-contract survey. Outcomes are reported on their annual Compliance & Activities report.
Evidence-based/informed strategy:	The CDC recognizes the value of state departments of health providing technical assistance to local health departments. The role includes help with: problem identification; problem analysis; strategy development; implementation; and evaluation. Also, Montana's FCHB has a role similar to a backbone organization in a collective impact model. The CPHD working on NPM 13b, and oral health activities for SPM 1, have these characteristics of agencies working in a collective impact framework: 1) common agenda; 2) shared measurement systems; 3) mutually reinforcing activities; 4) continuous communication; and 5) a backbone organization. Research at the National Institutes of Health shows that improvements in health outcomes are associated with an increase in local health department expenditures, FTEs per capita, and location of health department within local networks. (https://pubmed.ncbi.nlm.nih.gov/22502924/)
Significance:	The FCHB will contract with CPHDs interested in increasing preventive dental visits for children. These counties will implement and evaluate at least two community-level activities during the fiscal year. As part of supporting these activities, the FCHB provides resources on evidence-based/informed strategies and best practices. This will raise community-level understanding on the importance of preventive dental visits for children. The FCHB also provides training and support on community needs assessment, and on activity goal setting and evaluation.

ESM PDV-Child.2 - Complete the 3rd Grade Basic Screening Surveillance (BSS) to assess student's oral health status, and produce a report to inform needed oral health services.
NPM – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>A report, generated from the results of the 3rd Grade Student Basic Screening Surveillance (BSS) for students attending school during the 2023-24 school year, will be completed in FFY24.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1</td></tr>
<tr><td>Numerator:</td><td>One report, generated from the results of the 3rd Grade Basic Screening Surveillance (BSS) for students attending school during the 2023-24 school year.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The Family & Community Health Bureau's Oral Health Program will contract with a qualified entity to complete the BSS, using a random sample drawn by the Association of State and Territorial Dental Directors (ASTDD). No anticipated data issues.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>In 2020, the Public Health National Center for Innovations released a revised framework of the 10 essentials of Public Health Services. Assessment/surveillance is key to assessing and monitoring population health, and to investigate, diagnose and address health hazards and root causes (https://phnci.org/national-frameworks/10-ephs.)

The 2023-2024 3rd grade BSS surveillance will aide in future planning for addressing and achieving oral health equity in Montana's child population. The BSS, developed by the ASTDD, is an evidence-based tool for oral health surveillance, to assist state and local public health agencies monitor the burden of oral disease.</td></tr>
<tr><td>Significance:</td><td>The 3rd Grade BSS, paid for by the MCHBG, will be conducted during the 2023-2024 school year. The ASTDD Technical Assistance, paid with the Grants to States to Support the Oral Health Workforce, includes geographic and racial data analysis and a final report. This will raise community-level understanding and awareness on the importance of preventive dental visits for children.</td></tr>
</table>

Form 11
Other State Data

State: Montana

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
Part 1 – MCH Data Access and Linkages

State: Montana

Annual Report Year 2023

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Monthly	3		
2) Vital Records Death	Yes	Yes	Monthly	3	No	
3) Medicaid	Yes	Yes	Daily	0	No	
4) WIC	Yes	Yes	Daily	0	No	
5) Newborn Bloodspot Screening	Yes	No	Annually	0	No	
6) Newborn Hearing Screening	Yes	Yes	Daily	0	Yes	
7) Hospital Discharge	Yes	Yes	Quarterly	6	No	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	4	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None

Form 12
Part 2 – Products and Publications (Optional)

State: Montana

Annual Report Year 2023

Products and Publications information has not been provided by the State.