



A partnership of:

- *The Montana Department of Public Health and Human Services, and*
- *The University of Montana Rural Institute, a Center for Excellence in Disability Education, Research, and Service*

Strategic Plan

2012–2015

Introduction

The Big Picture

Disability is one of the nation's most important and underserved public health populations.

People with disabilities often go unrecognized as a health disparity population and physical and programmatic barriers to resources may increase the risk of this population to experience unjust and preventable health-related and functional outcomes.

- In the United States, about one in eight people (**12.6%**) live with some type of disability.¹
- In Montana, people with disability represent **13.2%** of the entire population.²
- People with an ambulatory (5.2%), cognitive (4.4%), or independent living (3.6%) difficulty represent the largest disability populations among adult Montanans.²
- In the United States, about one in every 33 babies (approximately 3%) is born with a birth defect.³
- In Montana, **20.0%** of 0-17 year olds are **Children with Special Health Care Needs (CSHCN)** who are at increased risk of chronic physical, developmental, behavioral, or emotional conditions, and who also require health and related services of a type or amount beyond what is generally required by children.
- Approximately **21,814** Montana households, or **20.9%**, have children with one or more special health care needs, not significantly different from the **23.0%** of U.S. households with CSHCN.⁴
- 936 Montana families are served through the state Part C Infant and Toddler Early Intervention Program that focuses on infants and toddlers (birth to age 3) with disabilities and their families.

Children are exposed to many hazards and risks as they grow and develop into adulthood, and unintentional injuries are the leading cause of death and disability for children and teenagers in the United States. The physical, social, cultural, political and economic environments in which they live can significantly increase or decrease their injury risks.⁵

Some children are at greater risk than others for an injury. Injury-related death and disability are more likely to occur among males, children of lower socioeconomic status, those living in

¹ U.S. Census Bureau, 2014 1-Year Estimate, American Community Survey. <http://factfinder.census.gov>

² U.S. Census Bureau, 2009-2013 5-Year Estimates, American Community Survey. <http://factfinder.census.gov>

³ Journal of Pediatrics, <http://www.cdc.gov/ncbddd/birthdefects/features/key-findings-survival-children-birth-defects.html>

⁴ <http://www.dphhs.mt.gov/Portals/85/publichealth/documents/cshs/CSHCNNeedsinMontanaSummary.pdf>

⁵ <http://www.cdc.gov/safekild/NAP/background.html>

specific geographic regions, and in certain racial/ethnic groups. The vulnerabilities in each category vary according to:

Gender

- In every age group across all races and for every cause of unintentional injury, death rates are higher for males.
- Male death rates are almost twice that of females.
- Males aged 15–19 years have the highest rates of ED visits, hospitalizations, and deaths.

Race/Ethnicity

- Unintentional injury death rates are highest for American Indians and Alaska Natives.
- Unintentional injury death rates are lowest for Asians or Pacific Islanders.
- Unintentional injury-related death rates for whites and African Americans are approximately the same (except for drowning).

Age

- Children less than 1 year of age who die from an injury are predominantly victims of unintended suffocation or accidental strangulation.
- Drowning is the main cause of injury deaths among children aged 1–4 years.
- Most deaths of children aged 5–19 years are due to traffic injuries, as occupants, pedestrians, bicyclists, or motorcyclists.

Socioeconomic Status

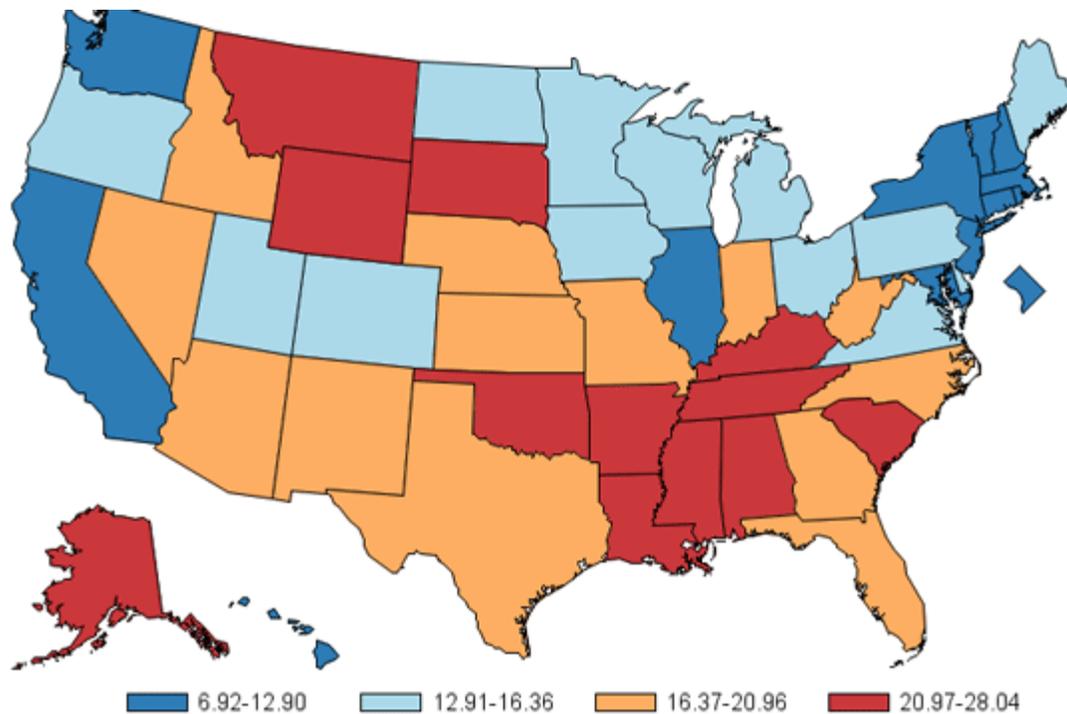
- Children whose families have low socioeconomic status or who live in impoverished conditions and are poor have disproportionately higher rates of injury.
- A broad range of economic and social factors are associated with greater child injury including:
 - Economics: lower household income.
 - Social factors: lower maternal age, increased number of persons in household, increased number of children in household under 16 years, lower maternal education, single-parents.
 - Community: multi-family dwelling, over-crowding, and low income neighborhoods.

Geography

- States with the lowest injury rates are in the northeast.
- The number of fire and burn deaths is highest in some of the southern states.
- The number of traffic injuries is highest in some southern states and in some of the upper plains.
- The lowest traffic injury rates are found in states in the northeast region.

Figure 3 illustrates the geographic distribution of childhood (0–19) unintentional injury death rates per 100,000 people for all races and ethnicities in United States counties for the period 2000–2006. The shaded red portions of the country have the highest rates.

Figure 3: Age-adjusted unintentional injury death rate per 100,000 people for all races, all ethnicities, both sexes, ages 0–19 years, United States, 2000–2006.



SOURCES:

- CDC National Center for Injury Prevention and Control, Office of Statistics and Programming.
- Deaths from the NCHS Vital Statistics System.
- Population estimates from the U.S. Census Bureau.

NOTE: Rates based on 20 or fewer deaths may be unstable. These rates are suppressed for counties. The standard population age-adjustment represents the year 2000 – all races, both sexes. Rates appearing in the map have been geospatially smoothed. For more information, go to <http://www.cdc.gov/injury/wisqars/>.

Location	Age group	Data Type	2009	2010	2011	2012
Montana	Under 5	Number	62,423	62,438	61,114	61,272
	Under 5	Percent	6%	6%	6%	6%

Definitions: The percentage of a county's total population that is under 5 years old.

Data Source: U.S. Census Bureau; annual population estimates.

To access information regarding a particular Montana county's total population that is under 5 years old, click on: <http://www.datacenter.aecf.org/data/tables/5933-population-under-5-by-county?loc=28&loct=2#detailed/5/4264-4319/false/867,133,38/123/14959,12562>

New Measurement Index Shows Decline in Child Poverty⁶

MISSOULA – A different method of measuring child poverty has determined that 39,000 Montana children were lifted out of poverty since 2011.

A report recently released by the Annie E. Casey Foundation shows that the federal government's official poverty measure created in the 1960s uses outdated information on how U.S. families are faring today, failing to illustrate the effects of programs designed to help them.

The new KIDS COUNT Data Snapshot, "Measuring Access to Opportunity in the United States," points to a better index for measuring poverty – the Supplemental Poverty Measure – which captures the effect of safety net programs and tax policies on families.

By using the SPM, researchers have determined that the rate of children in poverty has declined nationally from 33 percent to 18 percent as a result of these programs and policies.

"In Montana, using the SPM illustrates that the rate of children in poverty has declined from 30 percent to 13 percent," says Jennifer Calder, communications director for Montana KIDS COUNT. "In other words, from 2011 to 2013, safety net programs and tax policies have lifted 39,000 children out of poverty in our state."

"The official poverty measure does not provide the accurate information policymakers need to measure the success of anti-poverty programs – nationally and at the state level," said Patrick McCarthy, president and CEO of the Annie E. Casey Foundation. "Relying on this tool alone prevents policymakers from gauging the effectiveness of government programs aimed at reducing child poverty. The SPM is an important tool that should be used to assess state-level progress in fighting poverty."

The official poverty measure, created in the 1960s, is based on a formula that calculated the minimum cost to feed a family a nutritionally adequate diet and multiplied that by three because

⁶ KIDS COUNT Data Snapshot: Measuring Access to Opportunity in the United States, February 25, 2015.

at that time, food costs made up about one-third of the average family budget. Much has changed since the 1960s. Today, food costs represent less than 10 percent of a typical family budget; the official measure of poverty has not been updated to reflect modern budgets.

The Supplemental Poverty Measure, created by the U.S. Census Bureau in 2011, factors in the impact of a number of social programs such as Supplemental Nutrition Assistance Program and the Earned Income Tax Credit, and takes into account rising costs and other changes that affect a family's budget.

The SPM also provides a more accurate assessment of poverty levels on a state and regional basis as it helps illustrate the variations in the cost of living across states like Montana versus California, and the differences in impact of federal programs from one state to the next.

"Measuring Access to Opportunity in the United States" provides national and state-by-state data using the SPM to show the effect of a variety of federal supports to help low-income families.

Similar to the official poverty measure, the SPM shows that poverty rates among American Indian children were approximately two-and-a-half times higher (26 percent), than that of white children (10 percent).

In every state, anti-poverty programs tracked by the SPM have led to a reduction in the child poverty rate. Because federal benefits are not adjusted for differences in regional costs of living, they are likely to have a more significant impact in states where the cost of living is relatively low.

States and localities also vary in their contribution to the safety net programs and tax policies that can help move children out of poverty. These federal and state programs and policies helped cut the child poverty rate by more than 20 percent in Kentucky, Mississippi and the District of Columbia. States where government intervention has had a lesser effect on decreasing child poverty include North Dakota, New Hampshire and Alaska.

"Continued investment in the development of the SPM can ensure our resources are directed in ways that give our children the best opportunity to succeed," said Laura Speer, the foundation's associate director of policy reform and advocacy. "It's critical that we look beyond just the federal poverty rate to evaluate the success of important social programs."

"Measuring Access to Opportunity in the United States" follows the Casey Foundation's 2014 report, "Creating Opportunities for Families: A Two-Generation Approach," which outlined additional recommendations for helping families raise themselves out of poverty that include:

- Expanding access to high-quality education
- Changing tax credit policies to help families keep more of what they earn
- Expanding and streamlining food and housing subsidies
- Developing approaches that link programs for kids—like Head Start—with programs for their parents, such as education and job training.

The report can be accessed online at <http://www.aecf.org/>. For more information on how Montana has been affected by this study, contact

1. Montana KIDS COUNT Director Thale Dillon at: 406-243-5113 or email thale.dillon@business.umt.edu; or

- Jennifer Calder, Communications Director, Montana KIDS COUNT, 406-243-2725, jjennifer.calder@business.umt.edu.

Information and Resources⁷

[Disability.gov](http://www.disability.gov) (the Federal government's central source for disability-related information and services) addresses a range of topics of interest to its users, including: disability benefits, civil rights, community life, education, emergency preparedness, employment, health, housing, technology, and transportation.

The U.S. Department of Education has made dozens of children's television programs available online for students who are blind, visually impaired, deaf or hard of hearing. The shows include closed captioning and video descriptions and can be viewed for free through the Department's Accessible Television Portal project at:

<http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTlwMTUwMzIzLjQzMjcOTcxJm1lc3NhZ2VpZD1NREltUFJELUJVTC0yMDE1MDMyMy40MzI3MTk3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDk0OTEyJmVtYWlsaWQ9YWNvc3RhbGFzQGF1Y2Qub3JnJnVzZXJpZD1hY29zdGFsYXNAYXVjZC5vcmcZmw9JmV4dHJhPU11bHRpdmFyaWF0ZUIkPSYmJg==&&102&&http://www.dcmp.org/accessible-television>.

Available shows include "Magic School Bus" and "Bill Nye the Science Guy." This project is part of the Described and Captioned Media Program

<http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTlwMTUwMzIzLjQzMjcOTcxJm1lc3NhZ2VpZD1NREltUFJELUJVTC0yMDE1MDMyMy40MzI3MTk3MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MDk0OTEyJmVtYWlsaWQ9YWNvc3RhbGFzQGF1Y2Qub3JnJnVzZXJpZD1hY29zdGFsYXNAYXVjZC5vcmcZmw9JmV4dHJhPU11bHRpdmFyaWF0ZUIkPSYmJg==&&103&&http://www.dcmp.org/>.

Eliminating Discrimination against People with Disabilities

"Twenty-five years ago, through the Americans with Disabilities Act (ADA), our nation committed itself to eliminating discrimination against people with disabilities. The U.S. Department of Justice's Civil Rights Division is proud to play a critical role in enforcing the ADA, working towards a future in which all the doors are open to equality of opportunity, full participation, independent living, integration and economic self-sufficiency for persons with disabilities. In honor of the 25th anniversary of the ADA, each month the Department of

⁷ <https://www.disability.gov/disability-gov>

Justice will spotlight efforts that are opening gateways to full participation and opportunity for people with disabilities.

“Passage of the *Americans with Disabilities Act (ADA)* has enabled more people with disabilities to join the workforce than ever before. Today, young people with disabilities expect to join the workforce and to be financially independent. Unfortunately, the vast majority of working age adults with disabilities still face structural and attitudinal barriers that block their access to steady employment and economic security. In order to fulfill the promise of the ADA – equal employment opportunity and full inclusion – we need to create new curb cuts and pathways for people with disabilities.

“Unemployment and underemployment for people with disabilities remain incredibly high, and that is a call to action for all of us. Our charge is to seek out and find creative solutions to these old challenges...The productivity and talent that people with disabilities can contribute is only limited by our own perceptions of what is possible.”

*Curb Cuts to the Middle Class Initiative*⁸ is a federal cross-agency effort working to increase equal employment opportunities and financial independence for individuals with disabilities. The Curb Cuts to the Middle Class Initiative includes participation by agencies across the federal government, including the Department of Education, Department of Labor, Department of Health and Human Services, Department of Justice, Department of Veterans Affairs, Equal Employment Opportunity Commission, National Council on Disability, Office of Personnel Management, and the Social Security Administration.

To change the economic landscape for people with disabilities, private sector employers need to act as Disability Employment Champions. Employers who have made this commitment are reaping innumerable benefits. Employees with disabilities can help businesses understand and meet the needs of an important and expanding customer base of people with disabilities and their families. What’s more, research shows that consumers both with and without disabilities favor businesses that employ people with disabilities, and that people with disabilities can provide businesses with the flexible, innovative thinking required for a competitive edge in the 21st century.

The goal of the Curb Cuts to the Middle Class Initiative – a federal cross agency initiative – is to coordinate and leverage existing resources to increase employment opportunities for people with disabilities. This resource guide is an example of federal agencies working together to ensure employers have the tools and resources they need to recruit, hire, retain, and promote people with disabilities.”⁹

Table 1: American Community Survey (ACS) Disability Statistics¹⁰

Location	Estimate (%)	90% MOE	Base Population	Sample Size
United States	10.1	± 0.06	194,611,800	1,858,236

⁸ <https://www.disability.gov/resource/curb-cuts-middle-class-initiative/>

⁹ <https://www.disability.gov/resource/curb-cuts-middle-class-initiative>

¹⁰ <http://disabilitystatistics.org/reports/acs.cfm?statistic=1>

Montana	10.3	± 0.76	620,700	5,828
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**Table 2: Disability Prevalence and the Need for Assistance by Age:
2010 National Estimates¹¹**

Age	Any Disability	Severe Disability	Needs Assistance
Under age 15	8.4%	4.2%	0.5%
15 to 24	10.2%	5.3%	1.4%
25 to 44	11.0%	7.3%	2.0%
45 to 54	19.7%	13.8%	3.6%
55 to 64	28.7%	20.4%	6.0%
65 to 69	35.0%	24.7%	6.9%
70 to 74	42.6%	29.6%	10.8%
75 to 79	53.6%	37.5%	15.4%
80 and over	70.5%	55.8%	30.2%

Affordable Care Act

Data from Gallup-Healthways¹² shows the share of Americans without health coverage dropped **below 13%** at the end of 2014, a noticeable fall from just a year earlier and a clear sign that one of the Affordable Health Care primary goals is succeeding.

The Gallup-Healthways data is based on more than 43,000 interviews conducted between October 1 and December 30. It shows that in the fourth quarter of 2014, just **12.9 percent** of Americans were uninsured, a substantial drop from a high of 18.0% in 2013. This change was almost entirely due to the Affordable Care Act's new policies such as expanding Medicare, providing subsidies for low income individuals, extending the age of young adults to 26, eliminating premium fees for medical conditions and more.

¹¹ Source: U.S. Census Bureau, Survey of Income and Program Participation, May–August 2010.

¹² <http://www.gallup.com/poll/180425/uninsured-rate-sinks.aspx>

By the end of open enrollment 2015 **11.4 million** were enrolled in state and federal marketplaces. This is up from **10 million** at the start of February. An estimated 4.5 million of the enrollments were auto-renews and renewals.

“The Affordable Care Act has accomplished one of its goals: increasing the percentage of Americans who have health insurance coverage,” the Gallup report states. “The uninsured rate as measured by Gallup has dropped 4.2 points since the requirement to have health insurance or pay a fine went into effect. It will likely drop further as plans purchased during the current open enrollment period take effect.”

The new data shows improvements in all segments of the working-age population with the largest improvement being among young adults age 18-25, minority groups, and low income individuals earning under \$36,000 per year.

According to an article in the Helena Independent Record on Thursday, February 19, “**more than 54,000** Montanans have signed up for individual health insurance policies through the federal online “marketplace” federal health officials said Wednesday—a nearly 50 percent increase over last year. A total of “36,600 signed up in 2014; 54,346 in 2015.

Medicaid-Marketplace Overview¹³

The Federally-facilitated Marketplace (FFM) is offering health coverage in Montana in 2015 through a state partnership model. The state Medicaid agency has delegated authority to the Marketplace to make determinations of eligibility for Medicaid and CHIP. Montana has **not** expanded Medicaid coverage to low-income adults.

Targeted Enrollment Strategies

In response to CMS guidance provided on May 17, 2013, many states have adopted one or more “targeted enrollment strategies” designed to facilitate enrollment and retain coverage for eligible individuals in Medicaid / CHIP. Montana was approved for targeted enrollment strategies in September of 2014.

Olmstead Plan

On June 22, 1999, the Supreme Court ruled in *Olmstead v. L.C.* that, under the Americans with Disabilities Act (ADA), the unjustified institutional isolation of people with disabilities was a form of unlawful discrimination. Since taking office, the Obama Administration has taken many steps to uphold both the letter and the spirit of the ADA.

On June 22, 2011, President Obama remarked that “The landmark *Olmstead* case affirmed the rights of Americans with disabilities to live independently.” The President also suggested that “on this 12th anniversary, let’s recommit ourselves to building on the promise of *Olmstead* by working to end all forms of discrimination, and uphold the rights of Americans with disabilities and all Americans.”

Since the *Olmstead* ruling, much progress has been made. Many individuals have successfully transitioned to community settings, but waiting lists for community services have grown

¹³ State of Montana website:
<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/montana.html>

considerably and many individuals who would like to receive community services are not able to obtain them.¹⁴

Home Care Rule¹⁵

The Civil Rights Division and the Department of Health and Human Services' Office for Civil Rights (OCR) recognize the importance of ensuring adequate workplace protections for home care workers, who provide critical services to millions of Americans. At the same time, it is important that states implement the Department of Labor's rule in ways that also comply with their obligations under Title II of the Americans with Disabilities Act (ADA). In particular, because home care workers, such as personal care assistants and home health aides, often provide essential services that enable people with disabilities to live in their own homes and communities instead of in institutions, states should consider whether reasonable modifications are necessary to avoid placing individuals who receive home care services at serious risk of institutionalization or segregation.

The Department of Justice and OCR enforce the rights of people with disabilities to live integrated lives free from unnecessary segregation in institutions. Specifically, Title II of the ADA requires that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."¹⁶ As directed by Congress, the Attorney General issued regulations implementing Title II which are directed by Congress, the Attorney General issued regulations implementing Title II, which are based on regulations issued under section 504 of the Rehabilitation Act.¹⁷

The Title II regulations require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."¹⁸ The preamble discussion of the "integration regulation" explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible."¹⁹

Moreover, the ADA and the *Olmstead* decision are not limited to individuals currently in institutional or other segregated settings. They also apply to persons at serious risk of institutionalization or segregation. For example, a public entity could violate *Olmstead* if it fails to provide community services, or reduces those services, in a way likely to cause a decline in health, safety, or welfare leading to an individual's eventual placement in an institution.

¹⁴ <http://www.whitehouse.gov/the-press-office/2011/06/22/anniversary-olmstead-obama-administration-recommits->

¹⁵ The Department of Labor announced that it will not bring an enforcement action against any employer related to FLSA obligations under the new Home Care Rule before June 30, 2015. It will then use prosecutorial discretion until December 31, 2015 to determine whether to bring enforcement actions, taking into account the good faith efforts of states and other entities to bring their home care programs into compliance with the Home Care Rule.

¹⁶ 42 U.S.C. § 12132 (1990)

¹⁷ See *id.* § 12134(a); 28 C.F.R. § 35.190(a) (1991); Exec. Order No. 12,250 (1980), 45 Fed. Reg. 72,995 (1980), *reprinted in* 42 U.S.C. § 2000d-1. Section 504 of the Rehabilitation Act of 1973 similarly prohibits disability-based discrimination. 29 U.S.C. § 794(a) ("No otherwise qualified individual with a disability . . . participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . .").

¹⁸ 28 C.F.R. § 35.130(d) (1991).

¹⁹ 28 C.F.R. Pt. 35, App. B at 673 (2011).

The Department of Labor's Home Care Rule narrows the circumstances in which the companionship services and live-in domestic service employee exemptions from FLSA protections apply, both by updating the definition of "companionship services" and by prohibiting third party employers from claiming either exemption. Because of these changes, most home care workers, including those providing services through publicly funded programs, will be entitled to receive at least the Federal minimum wage for all hours worked and overtime compensation—one and a half times the worker's regular hourly rate of pay—for all hours worked over 40 in a workweek.

Implementation of the Home Care Rule will require each public or private agency that administers or participates in a consumer-directed home care program, including those funded by Medicaid, to evaluate whether it is a joint employer under the FLSA. If it is a joint employer, the entity will then be responsible for compliance with the requirements of the FLSA. The Act's minimum wage requirement applies to any time spent traveling between worksites—in the home care context, the consumer's home—when employed by the same sole or joint employer at each worksite. The FLSA's overtime compensation requirement includes, in the home care context, combined hours spent working for more than one consumer as part of the joint employment by the third party entity. More information and guidance regarding the Home Care Rule can be found at: U.S. Dept. of Labor, Wage and Hour Div.²⁰

The Civil Rights Division and OCR encourage states to conduct a thorough analysis of all their home care programs to determine whether any changes must be made to comply with the FLSA once the Home Care Rule becomes effective. In planning implementation steps, states must consider whether reasonable modifications are necessary to avoid placing individuals who receive home care services at serious risk of institutionalization or segregation.²¹ A state's obligation to make reasonable modifications to its policies, procedures, and practices applies even when a home care program is delivered through non-public entities.

Many states are already taking concrete steps to implement the Home Care Rule. Some states are developing budget proposals to pay overtime and travel time for home care workers who work over 40 hours in a week. The Centers for Medicare and Medicaid Services (CMS) has published guidance to assist states in understanding Medicaid reimbursement options that will enable them to account for the cost of overtime and travel time that may be compensable as a result of the Home Care Rule. See Cindy Mann, *CMCS Informational Bulletin: Self-Direction Program Options for Medicaid Payments in the Implementation of the Fair Labor Standards Act Regulation Changes* (July 3, 2014)²²

Money Follows the Person: Expanding Options for Long-Term Care²³

²⁰ <http://www.dol.gov/whd/homecare>

²¹ In the final Home Care Rule regulations, the Department of Labor recognized states' obligations to comply with the requirements of the Americans with Disabilities Act when considering changes to implement the Home Care Rule. 78 Fed. Reg. 60,454, 60,485-87.

²² <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-03-2014.pdf>.

²³ Mathematica Policy Research, <http://www.mathematica-mpr.com/health/moneyfollowsperson.asp>

Many Americans who need long-term care services and supports would prefer to receive them in home- and community-based settings rather than in institutions. Often, decisions relating to the provision of long-term care services are dictated by what is reimbursable under federal and state Medicaid policy rather than by what an individual needs or wants.

The variation in combined Medicare and Medicaid participation across states follows a similar pattern as for SSDI and SSI, but is somewhat greater, mostly reflecting the extent to which each state's Medicaid program covers individuals with disabilities who are neither SSDI nor SSI participants.

The Money Follows the Person (MFP) Demonstration is a large federal initiative to help states reduce their reliance on institutional care for people needing long-term care, and expand options for elderly people and individuals with disabilities to receive care in the community. Funded at \$4 billion over nine years, it is the largest demonstration program of its kind in the history of Medicaid. States use the grant funds to develop systems and services to help long-term residents of nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and psychiatric hospitals who want to move back to home or community-based settings.

They also are increasing efforts to shift Medicaid long-term care spending permanently toward community-based care and services. Mathematica's comprehensive evaluation for the Centers for Medicare & Medicaid Services (CMS) is assessing how state long-term care systems change to support the transition of people from institutions to the community, whether the changes were successful and sustainable, and to what extent MFP helps rebalance state long-term care spending. The evaluation is also analyzing the effects of MFP on Medicaid beneficiaries' health and quality of life, as well as identifying characteristics of individuals and state programs strongly associated with success.

As part of the project, Mathematica is also providing technical assistance to CMS and to state grantees. To date, we have supported CMS's review of the detailed operational plans each demonstration program developed and created a web-based semi-annual reporting system in collaboration with Truven Health Analytics. We are now monitoring grantee progress toward benchmarks.

The Center for Studying Disability Policy was established in 2007 by Mathematica to inform disability policy formation with rigorous, objective research and data collected from the people disability policy aims to serve. The Center supplies the nation's policymakers with the information they need to navigate the transition to 21st-century disability policy. For over two decades, Mathematica has conducted many significant disability studies, including some of the first rigorous evaluations of employment supports for people with severe disabilities and the largest surveys of people with disabilities. More than 30 staff continues this pioneering work today through a wide range of innovative disability research and data collection.

The Montana Disability and Health Program was awarded an MFT grant In September of 2012.

Basic Features of the MFP Program²⁴

Each state in the MFP demonstration must establish a program that has two components: (1) a transition program that identifies Medicaid beneficiaries in institutional care who wish to live in the community and helps them do so, and (2) a rebalancing program that allows more Medicaid long-term care expenditures to flow to community services and supports. MFP programs (like Medicaid programs in general) are subject to general federal requirements, but the design and administration of each MFP program are unique and tailored to state needs.

Transition programs

By statute, the MFP program is for people institutionalized in nursing homes, hospitals, intermediate care facilities for individuals with intellectual disabilities (ICFs/IID), or institutions for mental diseases (IMDs). Until the passage of the Affordable Care Act, MFP required participants to be institutionalized for a minimum of 180 days and they had to be eligible for full Medicaid benefits for at least a month before the transition to be eligible for the program. The Affordable Care Act reduced the length-of-stay requirement to 90 days, but states may not count any rehabilitative care days covered by Medicare.

On the day they transition to the community, MFP participants begin receiving a package of home- and community-based services (HCBS) and federal matching payment for these services are financed by the state's MFP grant funds. MFP- financed services continue for as many as 365 days after the date of transition. After exhausting their 365 days of eligibility for the MFP program, participants become regular Medicaid beneficiaries and receive HCBS through the state plan and/or a waiver program, depending on their eligibility for these services.

State Grantee Progress toward MFP Goals

The federal statute that created MFP requires state grantees to establish two sets of annual goals:

1. The number of institutionalized individuals that programs transition back to the community, by population group; and
2. An increase in total Medicaid expenditures on home and community-based services (HCBS) for all Medicaid enrollees. Both are important indicators of progress toward MFP's overall aim: to enable more people with disabilities to receive long-term services and supports (LTSS) in home or community settings, if that is their preference.

Transition Trends

From the start of the MFP demonstration in January 2008 through December 2012, state grantees have transitioned more than 30,000 people from institutions to the community where they received LTSS. In 2012, the fifth full year of the MFP demonstration, both the cumulative and annual number of MFP transitions increased substantially over previous years (Figure II.1). A total of 9,185 individuals enrolled in MFP and transitioned to the community in 2012, bringing the number of people ever enrolled in MFP since it began in 2008 to 30,141 individuals. This figure represents a 53 percent increase in cumulative enrollment (19,728) since the end of 2011. This growth rate

²⁴ Money Follows the Person 2012 Annual Report, page 1

http://www.mathematica-mpr.com/publications/pdfs/health/MFP_2012_Annual.pdf

sustains the strong upward trend in enrollment seen during each successive year of the program's operation.

MFP programs may provide up to three categories of services: (1) qualified HCBS, (2) demonstration HCBS, and (3) supplemental services.

Qualified HCBS are services that beneficiaries would have received regardless of their status as MFP participants, such as personal assistance services available through a 1915(c) waiver program or the state plan.

Demonstration HCBS are either allowable Medicaid services not currently included in the state's array of HCBS (such as assistive technologies) or qualified HCBS above what would be available to non-MFP Medicaid beneficiaries (such as 24-hour personal care).

MFP requires states to maintain needed services after participants leave the program as long as they maintain Medicaid eligibility, which means that demonstration HCBS tend to be short-term services that are needed to help people adjust to community living.

States may also provide supplemental services to MFP participants that are not typically reimbursable outside of waiver programs but facilitate an easier transition to a community setting (such as a trial visit to the proposed community residence).

States receive an enhancement to the Federal Medical Assistance Percentage (FMAP), which is drawn from their MFP grant funds, when they provide either qualified HCBS or demonstration HCBS. States receive the regular FMAP, which is also drawn from their MFP grant funds, when they provide supplemental services. In general, the MFP demonstration allows states to provide a richer mix of community services for a limited time to help facilitate a successful transition to the community.

The Changing Medical and Long-Term Care Expenditures of People Who Transition from Institutional Care to Home- and Community-Based Services²⁵

Executive Summary

The Money Follows the Person (MFP) demonstration grant program helps long-term residents of institutions move back to the community. While the statute that established the MFP demonstration program did not set forth cost savings as an explicit goal of the MFP demonstration, a program like MFP may only be sustainable after the demonstration period if MFP participants experience improved quality of life and higher quality of care at no additional expense, compared to what would have occurred had they remained in institutional care or transitioned without the benefits of MFP.

An initial analysis of expenditures finds evidence that total Medicaid and Medicare expenditures decline, sometimes substantially so, during the first 12 months after someone transitions from

²⁵ The National Evaluation of the MFP Demonstration Mathematica Policy Research Reports from the Field (Number 15, September 2014) <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/mfp-field-reports-2015.pdf>

institutional care to home and community-based services (HCBS). In most instances, the post-transition total expenditures of MFP participants are similar to those of a matched sample of others who transition without the benefit of MFP.

One exception is the population with mental illness—MFP participants in this group have higher post-transition total expenditures than other similar people with mental illness. For everyone who transitions, expenditures for LTSS shift from institutional care to HCBS as expected. After the transition, MFP participants have greater average HCBS expenditures compared to other transitioning people with similar characteristics, which reflects the additional services MFP programs provide. However, MFP participants typically have lower post-transition Medicaid and Medicare medical care expenditures.

Thus, MFP participants' higher HCBS expenditures are partially offset by the higher medical expenditures experienced by other transitioners, except in the population with mental illness where the greater HCBS expenditures of MFP participants appear to drive their overall higher total expenditures during the 12 months after the transition. This evidence suggests that MFP programs may be effective at helping many participants avoid acute care episodes that could lead to a return to institutional care.

The National Beneficiary Survey²⁶

National and State Program Participation Ratios for Working-Age People with Disabilities

This report contains national and state-level statistics on the number of participants in federal disability programs, drawn and produced from administrative data, relative to the estimated size of the working-age population with any self-reported disability based on the American Community Survey (ACS). For Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) combined, cross-state variation in the participation ratio is remarkably wide, with the two highest estimates (Massachusetts and New York) being more than twice as large as the lowest estimate (Alaska). There is also considerable variation across states in the distribution of participants across the three program categories (SSDI-only, SSI-only, and concurrent SSDI and SSI). The variation in combined Medicare and Medicaid participation across states follows a similar pattern as for SSDI and SSI, but is somewhat greater, mostly reflecting the extent to which each state's Medicaid program covers individuals with disabilities who are neither SSDI nor SSI participants.

The mission of the [Rehabilitation Research and Training Center on Disability Statistics and Demographics \(StatsRRTC\)](#) is to narrow and actively bridge the divide between the producers and end users of disability statistics, thereby supporting better data collection, more accurate information, better decision-making, more effective programs, and better lives for people with disabilities. Mathematica is supporting the University of New Hampshire and other partner agencies with eight research studies over five years. Three studies will focus on methods (such as an examination of changes in self-reported disability over time for youth and young adults),

²⁶ <http://www.disabilitypolicyresearch.org/our-capabilities/case-studies/informing-sustainable-disability-policy-the-national-beneficiary-survey>

while five studies will focus on analysis (such as an estimate of fiscal year 2014 federal and state disability expenditures for children and working-age people with disabilities). In addition, we will provide support on various knowledge translation and dissemination tasks.

The Approach

Mathematica has successfully conducted four rounds of the NBS using computer-assisted telephone interviewing (CATI) and computer assisted personal interviewing (CAPI) to collect data from beneficiaries while achieving high response rates. This has provided SSA with high quality and timely data on a wide range of topics including socio-demographic information, limiting conditions, health and functional status, health insurance, interest in work, barriers to work, use of services, employment, income, and experience with Social Security programs.

The Impacts

The NBS has played an important role in improvements to the TTW program. The leading barriers and disincentives reported include the potential loss of income or health benefits, poor health and functioning, lack of sufficient skills, and lack of a variety of disability services (for example, accessible transportation), but there are other, including:

- Most people are not aware of Social Security programs that can help them live more independently or work.
- People use many different support services to help them live on their own or work (like special equipment and counseling and occupational therapy, job training and job-search assistance).
- 1 out of 10 people said they are not receiving services that they need.
- Even with health problems, many people in Social Security programs want to work: 4 out of 10 people we surveyed in 2010 said they had work goals or saw themselves working within the next five years.

With this valuable information, SSA and other agencies are developing and implementing initiatives intended to improve these outcomes. Changes to the TTW program give beneficiaries with disabilities greater flexibility and expanded choices in obtaining the services they need to attain their employment goals. Mathematica's work highlights the important role that beneficiary survey data can play in the design and evaluation of planned and future initiatives and in providing basic information about the socioeconomic and functional status of beneficiaries that is not available from any other source.

Medicaid

Nearly 60 million Americans are covered by Medicaid. Medicaid was specifically created for low-income families, children, senior citizens, and persons with disabilities. Medicaid recipients are also eligible for numerous aid programs.²⁷

Montana Medicaid²⁸

²⁷ For additional information, go to: <http://medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-eligibility-levels/medicaid-chip-eligibility-levels.html>

²⁸ <http://www.dphhs.mt.gov/medicaid/>

Medicaid-Marketplace Overview

The Federally-facilitated Marketplace (FFM) is offering health coverage in Montana in 2015 through a state partnership model. The state Medicaid agency has delegated authority to the Marketplace to make determinations of eligibility for Medicaid and CHIP. Montana has *not* expanded Medicaid coverage to low-income adults.

Medicaid and CHIP Eligibility

To view the modified adjusted gross income (MAGI)-based eligibility levels, expressed as a percentage of the federal poverty level (FPL) and by monthly dollar amount and family size for Medicaid and CHIP, visit the [National Medicaid and CHIP Eligibility Levels page](#) for more information.

1. These eligibility standards include CHIP-funded Medicaid expansions.
2. Children in separate CHIP programs are typically charged premiums. This table does not include notations of states that have elected to provide CHIP coverage from conception to birth.
3. In states that use dollar amounts rather than percentages of the federal poverty level (FPL) for 2013 to determine eligibility for parents, we converted those amounts to a percent of the FPL and selected the highest percentage to reflect eligibility level for the group. In addition, in states that are adopting the Medicaid expansion, we have indicated the upper income limit for parents to also be 133% of the FPL, since parents can be eligible for coverage under the new adult group. The actual dollar *standards that states will use to determine eligibility are quoted in the monthly income tables.*

Table 3: Montana Medicaid

State	Medicaid Expansion	Children - Medicaid			Separate CHIP	Pregnant Women		Parents	Other Adults
		Ages 0-1	Ages 1-5	Ages 6-18		Medicaid	CHIP		
MT	N	143%	143%	143%	261%	157%	N/A	47%	

The state has a section 1115 demonstration that provides Medicaid coverage to some low-income adults. The demonstration includes limitations on eligibility and/or benefits, is not offered to all residents of the state, and/or includes an enrollment cap.

Medicaid and CHIP Applications

The Affordable Care Act established a streamlined enrollment process through which individuals can gain access to affordable insurance coverage for which they are eligible. The law directed the Secretary of Health and Human Services (HHS) to develop a model application that will be used to apply for coverage through the Marketplace, Medicaid and CHIP. States have the option to adopt the Secretary of HHS's model application form for affordable insurance programs or to adopt an alternative application that meets federal requirements.

Targeted Enrollment Strategies

In response to CMS guidance provided on May 17, 2013, many states have adopted one or more "targeted enrollment strategies" designed to facilitate enrollment and retain coverage for eligible individuals in Medicaid / CHIP.

Medicaid/CHIP State Plan Amendments

The state Medicaid and CHIP plans spell out how each state has chosen to design its program within the broad requirements for federal funding. As always, states amend their Medicaid and CHIP state plans in order to inform CMS of programmatic and financing changes and to secure legal authority for those changes. The Affordable Care Act included many new opportunities for states to augment and improve their Medicaid and CHIP programs. As a result there has been a great deal of state plan amendment activity over the past several years in the areas of eligibility, benefits design and financing, as well as new approaches to providing health homes, long-term services and supports, and enrollment strategies like hospital presumptive eligibility.

Medicaid Delivery System

States have choices in their approach to delivery system design under the Medicaid and CHIP programs. States are increasingly moving to the use of managed care and other integrated care models in serving their Medicaid beneficiaries. On average, more than 70 percent of the Medicaid population is enrolled in some form of managed care.

CHIP Program Information

The Children's Health Insurance Program was established in 1997 to provide new coverage opportunities for children in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. Like Medicaid, CHIP is administered by the states, but is jointly funded by the federal government and states. States had the opportunity to design their CHIP programs as an expansion of Medicaid, as a stand-alone program or through a combined approach.

Medicaid/CHIP Participation Rates

The participation rate is the percentage of eligible children enrolled in Medicaid and CHIP in the state. Data from 2012 show **88.1 percent** of the eligible children in the United States are enrolled in Medicaid and CHIP programs.

Americans with Disabilities: 2010 Report

This report presents estimates of disability status and type and is the first such report with analysis since the Census Bureau published statistics in a similar report about the 2005 population of people with disabilities. According to the report, the total number of people with a disability increased by 2.2 million over the period, but the percentage remained statistically unchanged.

Both the number and percentage with a severe disability rose, however. Likewise, the number and percentage needing assistance also increased.

The statistics come from the **Survey of Income and Program Participation**, which contains supplemental questions on whether respondents had difficulty performing a specific set of functional and participatory activities. For many activities, if a respondent reported difficulty, a follow-up question was asked to determine the severity of the limitation, hence, the distinction between a “severe” and “non-severe” disability. The data were collected from May through August 2010. Disability statistics from this survey are used by agencies — such as the Social Security Administration, Centers for Medicare and Medicaid Services, and the Administration on Aging — to assist with program planning and management.

The report shows that **41 percent** of those age 21 to 64 with any disability were employed, compared with **79 percent** of those with no disability. Along with the lower likelihood of having a job came the higher likelihood of experiencing persistent poverty; that is, continuous poverty over a 24-month period. Among people age 15 to 64 with severe disabilities, **10.8 percent** experienced persistent poverty; the same was true for **4.9 percent** of those with a non-severe disability and 3.8 percent of those with no disability.

Other highlights: People in the oldest age group (80 and older) were about eight times more likely to have a disability (**71 percent**) as those in the youngest age group (younger than 15) at **8 percent**. The probability of having a severe disability is only one in 20 for those 15 to 24 while it is one in four for those 65 to 69.

- About **8.1 million people** had difficulty seeing, including 2.0 million who were blind or unable to see.
- About **7.6 million people** experienced difficulty hearing, including 1.1 million whose difficulty was severe. About **5.6 million people** used a hearing aid.
- Roughly **30.6 million** had difficulty walking or climbing stairs, or used a wheelchair, cane, crutches or walker.
- About **19.9 million** people had difficulty lifting and grasping. This includes, for instance, trouble lifting an object like a bag of groceries, or grasping a glass or a pencil.
- Difficulty with at least one activity of daily living was cited by **9.4 million non-institutionalized adults**. These activities included getting around inside the home, bathing, dressing and eating. Of these people, **5 million** needed the assistance of others to perform such an activity.
- About **15.5 million** adults had difficulties with one or more instrumental activities of daily living. These activities included doing housework, using the phone and preparing meals. Of these, **nearly 12 million** required assistance.
- Approximately **2.4 million** had Alzheimer’s disease, senility or dementia.
- Being frequently depressed or anxious such that it interfered with ordinary activities was reported by **7.0 million** adults.
- Adults age 21 to 64 with disabilities had median monthly earnings of **\$1,961** compared with **\$2,724** for those with no disability.
- Overall, the uninsured rates for adults 15 to 64 were not statistically different by disability status: **21.0 percent** for people with severe disabilities, **21.3 percent** for those with non-severe disabilities and **21.9 percent** for those with no disability.

In addition to the statistics from this report, the Census Bureau also produces annual disability estimates from the American Community Survey (ACS). While the ACS uses a different definition of disability than in this report, it is capable of producing estimates of the population with disabilities at sub-national geographies like states, counties, places and metropolitan areas. The Census Bureau has been collecting data about certain disabilities since 1830, when Congress added questions to the census on difficulty hearing, seeing and speaking.

Adults with disabilities face challenges in:

- **Employment:** Half as many adults with disabilities are employed as those without disabilities (**35% versus 78%**).
- **Employment Rate:** The percentage of non-institutionalized, male or female, with a disability, ages 16-20, all races, regardless of ethnicity, with all education levels in the United States who were employed in 2012.

Location	Estimate (%)	90% MOE	Base Population	Sample Size
United States	19.3	± 0.94	1,215,100	11,936
Montana	25.5	± 14.13	3,700	32 †

- **Economic status:** Three times as many adults with disabilities live in poverty with annual household incomes below \$15,000 (**26% versus 9%**).
- **Transportation & health care:** Adults with disabilities are twice as likely as those without disabilities to have inadequate transportation (**31% versus 13%**), and a much higher percentage go without needed health care (**18% versus 7%**).²⁹

The 2005 Surgeon General’s Call to Action³⁰ to improve the health and wellness of persons with disabilities defined disability as “a feature of the body, mind or senses that can affect a person’s daily life.” Key points of the Call to Action include the following:

- People with disabilities need health care and health programs for the same reasons anyone else does—to stay well, active, and a part of the community.
- People with or without disabilities can stay healthy by learning about and living healthy lifestyles.
- With good health, people with disabilities can work, learn, and be active in all areas of life.
- Health care professionals can improve the health and wellness of people with disabilities by meeting the needs of the whole person.
- People with disabilities must be able to get the care and services they need to help them be healthy.

²⁹ 2004 Nationwide Harris Survey

³⁰ <http://archive.hhs.gov/news/press/2005pres/20050726.html>

When the first *Montana Disability and Health Program Strategic Plan* was published in **2006**, it was estimated that nearly **54 million people** in the U.S. (about 20% of the civilian, non-institutionalized population over the age of 5 years) had a disability. According to **2010** Behavioral Risk Factor Surveillance System (BRFSS) 2010 data, there were approximately **53 million adults** with disabilities in the United States. The DHDS also provides data on disability-associated health care expenditures. The data are available in several formats, including standard contrast and high-contrast interactive maps and data tables that can be customized or downloaded. Users can easily identify location-specific data for a single year, for multiple years, and by state, territorial, division, regional, and national levels. For more information, go to <http://dhds.cdc.gov>

**Table 4:
Disability Prevalence and the Need for Assistance by Age:
2010 National Estimates³¹**

Prevalence: The percentage of non-institutionalized, male or female, all ages, all races, regardless of ethnicity, with all education levels in the United States reported a disability in 2012.

Location	Estimate (%)	90% MOE	Base Population	Sample Size
United States	12.1	± 0.05	309,936,400	3,035,296
Montana	12.7	± 0.66	993,100	9,895

State Profile

In 2012, **23.2%** of adults in Montana reported having a disability, compared with **21.4%** in the United States and Territories. The tables in this profile provide information on the percentage of adults with and without disability by age, sex, race/ethnicity, and veteran status. All data are from 2012.

Table 5: Disability Status among Age Groups

This table shows the percentage of adults in different age groups with and without a disability. For example, in **2012**, **14.9%** of adults 18-44 years of age, **29.2%** of adults 45-64 years of age, and **38.1%** of adults 65 years of age or older had a disability.

Disability status among age groups	18-44 year olds	45--64year olds	65+year olds
Disability	14.9%	29.2%	38.1%
No disability	85.1%	70.8%	61.9%

³¹ Source: U.S. Census Bureau, Survey of Income and Program Participation, May–August 2010.

Disability status among males & females	Men	Women	
Disability	23.2%	23.1%	
No Disability	76.8%	76.9%	

Table 6: Disability status among racial/ethnic groups

This table shows the percentage of adults in different racial/ethnic groups with and without a disability. For example, in **2012**, **22.1%** of white, **DS%** of black, **27.7%** of Hispanic, **DS%** of Asian, **DS%** of Native Hawaiian or other Pacific Islander, **29.6%** of American Indian or Alaska Native, and **39.3%** of other/multi-race adults had a disability.

	White	Black	Hispanic	Asian	NHPI	AIAN	Other
Disability	22.1%	DS%	27.7%	DS%	DS%	29.6%	39.3%
No disability	77.9%	DS%	72.3%	DS%	DS%	70.4%	60.7%

Persons with a Disability: Labor Force Characteristics 2013³²

In 2013, **17.6 percent** of persons with a disability were employed, the U.S. Bureau of Labor Statistics reported today. In contrast, the employment-population ratio for those without a disability was **64.0 percent**. The employment-population ratio was little changed from 2012 to 2013 for both groups.

The unemployment rate for those with a disability was **13.2 percent** in 2013, higher than the rate for persons with no disability (**7.1 percent**). The jobless rate for persons with a disability was little changed from 2012 to 2013, while the rate for those without a disability declined.

³² <http://www.bls.gov/news.release/pdf/disabl.pdf>

The data on persons with a disability are collected as part of the Current Population Survey (CPS), a monthly sample survey of about 60,000 households that provides information on employment and unemployment in the United States. The collection of data on persons with a disability is sponsored by the Department of Labor's Office of Disability Employment Policy.

Highlights from the 2013 data:

- Persons with a disability were over three times as likely as those with no disability to be age 65 and over.
- For all age groups, the employment-population ratio for persons with a disability was less than half that of those with no disability.
- In 2013, 34 percent of workers with a disability were employed part time, compared with 19 percent of those with no disability.
- Fifteen percent of workers with a disability were employed in federal, state, or local government, similar to the share for workers with no disability (14 percent).
- Employed persons with a disability were more likely to be self-employed than those with no disability. (See table 4.)

Demographic Characteristics

Persons with a disability tend to be older than persons with no disability, reflecting the increased incidence of disability with age. In 2013, 46 percent of persons with a disability were age 65 and over, compared with 14 percent of those with no disability. Overall, women were somewhat more likely to have a disability than men, partly reflecting the greater life expectancy of women. Among the major race and ethnicity groups, the prevalence of a disability was higher for blacks and whites than for Asians and Hispanics.

Employment

The employment-population ratio for persons with a disability was **17.6 percent** in 2013, little changed from 2012. The ratio for those with no disability showed little change in 2013, at **64.0 percent**. The lower ratio among persons with a disability is due, in part, to the large share of the population of persons with a disability that was age 65 and older, as older persons are less likely to be employed. However, across all age groups, persons with a disability were much less likely to be employed than those with no disability.

Among persons with a disability age 16 to 64, the employment-population ratio, at **26.8 percent in 2013**, changed little over the year and was unchanged for those age 65 and over, at **6.9 percent**.

In 2013, those who had higher levels of education were more likely to be employed than those with less education. At all levels of education, persons with a disability were much less likely to be employed than their counterparts with no disability.

Workers with a disability were more likely to be employed part time than those with no disability. Among those with a disability, **34 percent** usually worked part time in 2013, compared with **19 percent** of workers without a disability. The proportion of workers who were employed part time for economic reasons was slightly higher among those with a disability than among those without

a disability (7 percent versus 5 percent). These individuals were working part time because their hours had been cut back or because they were unable to find a full-time job.

In 2013, workers with a disability were more likely to be employed in production, transportation, and material moving occupations than those with no disability (**15 percent compared with 12 percent**). Those with a disability were less likely than their counterparts to work in management, professional, and related occupations (**33 percent compared with 38 percent**).

The share of workers with a disability employed in federal, state, and local government (**15 percent**) was about the same as the share for those with no disability (**14 percent**). Workers with a disability were less likely than those with no disability to be employed in private wage and salary jobs (**74 percent versus 80 percent**). The incidence of self-employment among workers with a disability was higher than among workers with no disability (**11 percent versus 6 percent**).

Unemployment

The unemployment rate for persons with a disability was **13.2 percent** in 2013, higher than the rate for those with no disability (**7.1 percent**). (Unemployed persons are those who did not have a job, were available for work, and were actively looking for a job in the 4 weeks preceding the survey.) The unemployment rate for persons with a disability was little changed from 2012 to 2013, while the rate for those without a disability was lower in 2013 than in the prior year.

In 2013, the unemployment rate for men with a disability (**13.0 percent**) was about the same as the rate for women (**13.5 percent**). As was the case among those without a disability, the unemployment rates for those with a disability were higher among blacks (**19.2 percent**) and Hispanics (**18.6 percent**) than among whites (**12.2 percent**) and Asians (**8.9 percent**).

Not in the Labor Force

Persons who are neither employed nor unemployed are not in the labor force. A large proportion of persons with a disability—about 8 in 10—were not in the labor force in 2013, compared with about 3 in 10 persons with no disability. In part, this reflects the fact that persons with a disability tend to be older than those without a disability and older persons are, in general, less likely to be labor force participants. However, for all age groups, persons with a disability were much more likely than those with no disability to be out of the labor force.

Among those not in the labor force with and without a disability, the vast majority reported that they do not want a job. In 2013, about 1 percent of persons with a disability were marginally attached to the labor force, compared with 3 percent of those with no disability. These individuals were not in the labor force, wanted and were available to work, and had looked for a job sometime in the prior 12 months. They were not counted as unemployed because they had not searched for work in the 4 weeks preceding the survey.

Table 7: Unemployment Rate

Montana		United States	
January, 2015	5.6%	January, 2015	15.4%
February, 2015	5.7%	Source: 2009-2013 American Community Survey 5-Year Profiles	

Table 8: Poverty in Montana and the Nation

Montana		United States	
January, 2015	5.6%	January, 2015	
February, 2015	5.7%	15.4 % <i>Source: 2009-2013 American Community Survey 5-Year Profiles</i>	

The Supplemental Poverty Measure³³ allows us to gauge the effectiveness of government programs in alleviating economic hardship. The data show that without any government interventions, the child poverty rate would nearly double from 18% to 33%. These programs have reduced economic hardship for millions of children. For example, tax credits (EITC and Child Tax Credit) alone have decreased the child poverty rate by nearly one-third. Social Security, SNAP and housing subsidies also have contributed to significantly fewer children living in poverty.

Interventions include the following:

- Supplemental Nutrition Assistance Program (SNAP)
- Food Stamps
- Women, Infants, and Children (WIC);
- School Lunch;
- Cash Welfare (TANF / AFDC);
- Housing Subsidies;
- Low-Income Home Energy Assistance Program (LIHEAP);
- Social Security;
- Unemployment Insurance;
- Workers' Compensation;
- Supplemental Security Income (SSI);
- Child Support;
- Earned Income Tax Credit (EITC); and
- Child Tax Credit.

To learn more, check out the latest KIDS COUNT data snapshot — [Measuring Access to Opportunity in the United States](#)³⁴ — highlighting the value of the Supplemental Poverty Measure.

Nearly half of the nation’s families with young children struggle to make ends meet. A new KIDS COUNT policy report³⁵ makes the case for creating opportunity for families by addressing the

³³ Supplemental Poverty Measure, <http://www.bing.com/seaSupplemental%20Poverty%20Measure>

³⁰ <http://www.bing.com/search?q=Creating+Opportunity+for+Families%3A+A+Two-Generation+Approach&src=IE->

³⁵ http://www.census.gov/hhes/povmeas/publications/kshort_sea2013.pdf

needs of parents and their children simultaneously. *Creating Opportunity for Families: A Two-Generation Approach* describes a new approach to reducing poverty, which calls for connecting low-income families with early childhood education, job training and other tools to achieve financial stability and break the cycle of poverty — and recommends ways to help equip parents and children with what they need to thrive.

<http://www.bing.com/search?q=Creating+Opportunity+for+Families%3A+A+Two-Generation+Approach&src=IE-TopResult&FORM=IETR02&conversationid=>

Poverty among American Indians and Alaska Natives

Nine states had poverty rates of about 30 percent or more for American Indians and Alaska Natives (Arizona, Maine, Minnesota, **Montana**, Nebraska, New Mexico, North Dakota, South Dakota and Utah).³⁶

Two racial groups had poverty rates more than 10 percentage points higher than the national rate of 14.3 percent: American Indian and Alaska Native (27.0 percent) and black or African-American (25.8 percent). Rates were above the overall national average for Native Hawaiians and Other Pacific Islanders (17.6 percent), while poverty rates for people identified as white (11.6 percent) or Asian (11.7 percent) were lower than the overall poverty rate. Poverty rates for Whites and Asians were not statistically different from each other. The Hispanic population had a poverty rate of 23.2 percent, about nine percentage points higher than the overall U.S. rate.³⁷

For example: In Montana, the Crow Nation covers 9,341 square miles with a population of about 7,000. About one-third of the families on the reservation (32%) live in poverty with 10% living in extreme poverty. The official unemployment rate is 10.5% with 39% of all adults out of the labor force. With regard to education, 31% have at least a high school

U.S. 65 and over Population³⁸

The current growth in the number and proportion of older adults in the United States is unprecedented in our nation's history. By 2050, it is anticipated that Americans aged 65 or older will number nearly 89 million people, or more than double the number of older adults in the United States in 2010. The rapid aging of the U.S. population is being driven by two realities: Americans are living longer lives than in previous decades and, given the post-World

³⁶ http://www.census.gov/newsroom/releases/archives/american_community_survey_acs/cb13-29.html

³⁷ Ibid.

³⁸ <http://www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf>

War II baby boom, there are proportionately more older adults than in previous generations. Many Americans are now living into their 70s, 80s, and beyond.

The leading edge of the baby boomers reached age 65 in 2011, launching an unparalleled phenomenon in the United States. Since January 1, 2011, and each and every day for the next 20 years, roughly 10,000 Americans will celebrate their 65th birthdays. In 2030, when the last baby boomer turns 65, the demographic landscape of our nation will have changed significantly. One of every five Americans—about 72 million people—will be an older adult.

The aging of our population has wide-ranging implications for virtually every facet of American society. At each point in the lifespan of baby boomers, the United States has felt and been changed by the impact of their numbers and needs—from booming sales in commercial baby food during the late 1940s, to the construction of thousands of new schools during the 1950s, to the housing construction boom of the 1970s and 1980s. The significant proportion of Americans represented by the baby boomers continues to exert its influence. In large measure, this influence will have its most profound effects on our nation’s public health, social services, and health care systems. Public health plays a key role in advocating for those in need, linking individuals and communities to available services, and promoting healthy aging because of its effects on personal, societal, cultural, economic, and environmental factors. The public health sector is ideally positioned to meet the growing needs and demands of a rapidly aging nation.

The State of Aging and Health in America 2013³⁹

“Twentieth-century advances in protecting and promoting health among older adults have provided many opportunities for overcoming the challenges of an aging society. The health indicators presented in *The State of Aging and Health in America 2013* highlight these opportunities. By working to meet the goals for each of these key indicators, our nation can help to ensure that all of its citizens can look forward to living longer and living well.”

The report “provides a snapshot of our nation’s progress in promoting prevention, improving the health and well-being of older adults, and reducing behaviors that contribute to premature death and disability. In addition, the report highlights mobility (referring to movement in all of its forms) and how optimal mobility is fundamental to healthy aging.

Demographic changes create an urgent need

The growth in the number and proportion of older adults is unprecedented in the history of the United States. Two factors—longer life spans and aging baby boomers—will combine to double the population of Americans aged 65 years or older during the next 25 years to about 72 million. By 2030, older adults will account for roughly 20% of the U.S. population.

Chronic conditions present a strong economic incentive for action

During the past century, a major shift occurred in the leading causes of death for all age groups, including older adults, from infectious diseases and acute illnesses to chronic

³⁹ <http://www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf>

diseases and degenerative illnesses. More than a quarter of all Americans and two out of every three older Americans have multiple chronic conditions, and treatment for this population accounts for 66% of the country’s health care budget.

The Report Cards

The National Report Card on Healthy Aging reports on 15 indicators of older adult health, 8 of which are identified in Healthy People 2020, the national health agenda of the U.S. Department of Health and Human Services. These 15 indicators are grouped into 4 areas: Health Status, Health Behaviors, Preventive Care and Screening, and Injuries. In addition, the report assigns a “met” or “not met” score to states on the basis of their attainment of Healthy People 2020 targets.

For most indicators, the Behavioral Risk Factor Surveillance System (BRFSS) is *not* the official data source for tracking Healthy People 2020 targets. Some of these targets are for all adults aged 18 or older, not just those aged 65 years or older. For this report, we use BRFSS data to report how well states are doing in meeting Healthy People 2020 targets for their older adult populations. Taken together, these indicators present a comprehensive picture of older adult health in the United States.

Table 9: Life Expectancy at birth, at age 65, and at age 75, by Sex⁴⁰

<i>At birth</i>	<i>Both Sexes</i>	<i>Male</i>	<i>Female</i>
1900	47.3	46.3	48.3
1950	68.2	65.6	71.1
2000	76.8	74.1	79.3
2010	78.7	76.2	81.0
<i>At Age 65</i>	<i>Both Sexes</i>	<i>Male</i>	<i>Female</i>
1950	13.9	12.8	15.0
2000	17.6	16.0	19.0
2010	19.1	17.7	20.3
<i>At Age 75</i>	<i>Both Sexes</i>	<i>Male</i>	<i>Female</i>
1980	10.4	8.8	11.5
2000	11.0	9.8	11.8
2010	12.1	16.0	12.9

Access to Long-term Care in Rural Areas

Ultimately, improving access to long-term care (LTC) services in rural areas requires addressing a range of factors from the system constraints to the unique rural barriers that impact provision of services and treatment seeking. Coordination of care, improved communication between providers and patients, the use of innovative technologies to bridge

⁴⁰ <http://www.cdc.gov/nchs/data/hus/hus13.pdf#018>

distance barriers, increased focus on recruitment and retention of LTC workers, support for informal care networks, and efforts to improve affordability are issues that need to be addressed.

Family Caregivers for People with Disabilities⁴¹

In 2011, the estimated economic value of informal care provided by family members was \$234 billion. According to another report in 2009, about 61 million family caregivers in the U.S. provided care to an adult with a disability or chronic health condition at some time during that year. It's clear that family caregivers play a major role in our nation's health care system as providers of long-term care. Considering their critical role, the Family Caregiver Alliance reminds us of one very important aspect of care giving, "First, care for yourself. Only when we first help ourselves can we effectively help others. Caring for yourself is one of the most important - and one of the most often forgotten - things you can do as a caregiver. When your needs are taken care of, the person you care for will benefit, too."

These general care-giving tips provide families with information on how to stay healthy and positive. Keep in mind that these tips can be used to address many family issues. Information, support, advocacy, empowerment, care, and balance can be the foundation for a healthy family and are appropriate no matter what the challenge.

Here are some "quick links" to get you started:

- [So Far Away: Twenty Questions & Answers about Long-Distance Caregiving](#)
- [Resources for Family Caregivers Who Are Managing the Health of a Loved One](#)
- [Family Care Navigator – State-by-State Help for Family Caregivers](#)
- [Eldercare Locator](#)
- [Medicare's "Helpful Contacts" Tool](#)
- [VA Caregiver Support](#)
- [Caregiving Tips for Families of People with Disabilities](#)
- [Paying for Long-Term Care](#)
- [State Respite Coalitions](#)
- [Medication Management Form](#)
- [What It Takes to Be a Caregiver](#)
- [Your Local Aging & Disability Resource Center](#)
- [AARP's Caregiving Resource Center](#)
- [AARP "Prepare to Care" Planning Guide for Families](#)
- [Caring for Someone with Alzheimer's](#) (video series)
- [Your Discharge Planning Checklist](#)
- [Managing Medications](#) (YouTube video)

⁴¹ <http://www.cdc.gov/ncbddd/disabilityandhealth/family.html>

Family caregivers take on [many different roles and tasks](#). A caregiver may be a child who takes care of an older parent, a parent caring for an adult child with a [developmental disability](#), or a spouse who provides for the daily needs of a husband or wife with a disability or chronic health condition. In addition to taking care of the basic emotional and physical needs of a loved one, family caregivers transport loved ones to medical appointments, provide daily personal care including bathing, dressing and meals preparation, manage finances and act as an overall “healthcare coordinator.”

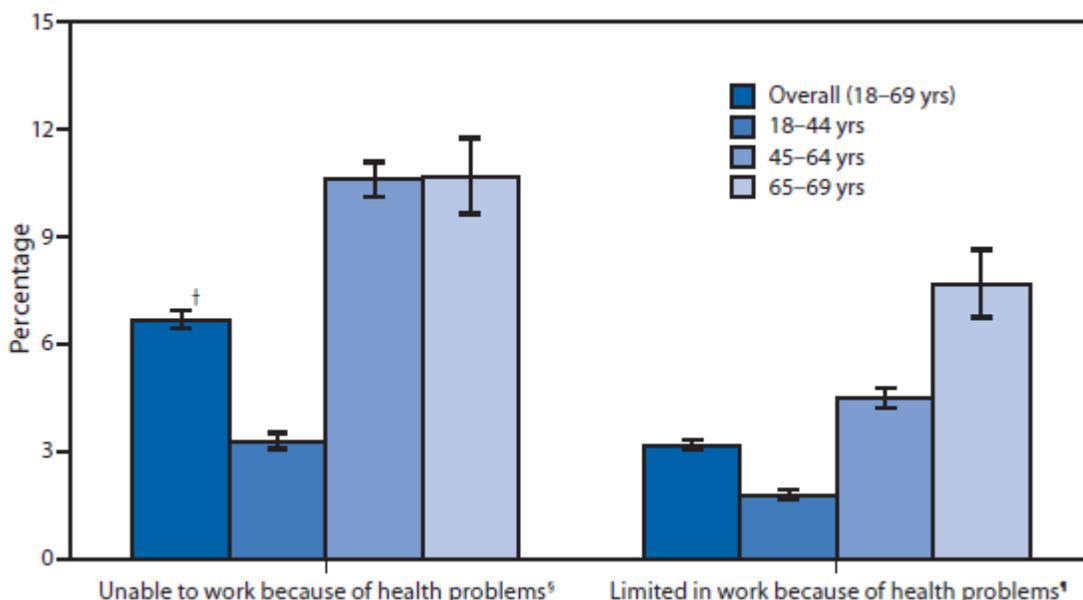
Disability.gov’s [caregiving section](#) contains a broad range of resources for family caregivers. The November 2013 edition of the *Disability Connection* newsletter also has information on [“10 Things You Need to Know about Caregiving.”](#) In addition, this guide connects you to programs, services, government agencies and organizations that can help you as you care for a spouse, child, parent or other family member.

For more information about caregiving, check out the following sections of “Disability.gov’s Guide for Family Caregivers”:

- [Are There Organizations that Help Caregivers?](#)
- [Where Can I Learn about Long-Term Care Options?](#)
- [Can I Get Paid to Be a Family Caregiver?](#)
- [What Does a Caregiver Need to Know about Medicare & Medicaid?](#)
- [Are Nursing Homes the Only Long-Term Care Option?](#)
- [What Do I Need to Consider in Choosing an Assisted Living Facility or Nursing Home?](#)
- [What Resources Are There for Parents Who Are Caregivers for a Child with a Disability?](#)
- [Are There Any Resources for People Who Are Caring for a Loved One with a Specific Disability, Such As Alzheimer’s or a Traumatic Brain Injury?](#)
- [I Live in a Different State Than My Family Member. Where Can I Learn about Caregiving from a Distance?](#)
- [What Types of Financial & Legal Matters Should a Caregiver Know about?](#)
- [What Can I Do to Take Care of Myself as a Caregiver?](#)

Table 10: Percentage of Adults Aged 18–69 Years with a Limitation in Their

Ability to Work Because of Health Problems, by Age Group⁴²



In 2012, approximately 7% of adults aged 18–69 years were unable to work, and approximately 3% were limited in their ability to work because of health problems. Adults aged 45–64 years and 65–69 years were about three times more likely than adults aged 18–44 years to be unable to work because of health problems. The percentage of adults limited in their ability to work because of health problems also increased with age.

Estimates are based on:

- Household interviews of a sample of the civilian, non-institutionalized U.S. population. Persons with unknown work limitation status were excluded from the denominators. 95% confidence interval.
- Responses to the question: "Does a physical, mental, or emotional problem now keep family members aged ≥ 18 years from working at a job or business?" Respondents were asked to answer regarding themselves and other family members living in the same household.
- For persons able to work, based on responses to the question, "Are [family members aged ≥ 18 years] limited in the kind or amount of work they can do because of a physical, mental, or emotional problem?" Respondents were asked to answer regarding themselves and other family members living in the same household.

⁴² Adams PF, Kirzinger WK, Martinez ME. Summary health statistics for the U.S. population: National Health Interview Survey; 2012. Vital Health Stat 2013;10 (259).

Social Security Income for People with Disabilities⁴³

“About 4.8 million people in the 18-to-64 age group—about 2.4 percent of the U.S. population in that age group—received SSI payments in 2011 who qualify for SSI. Those recipients must demonstrate that their disability prevents them from participating in “substantial gainful activity,” which in 2012 is considered to mean work that would produce earnings of more than \$1,010 a month. (That amount is adjusted annually for average wage growth.) Older adults are more likely than younger adults are to receive payments: Fewer than 2 percent of people between the ages of 18 and 29 receive payments; slightly more than 3 percent of people between the ages of 50 and 64 do. Especially among younger adults, eligibility for the program is determined most commonly on the basis of mental disability: Three quarters of participants ages 18 to 39 were awarded payments primarily because of a mental disorder. That share declines with age, as conditions such as spinal disorders and heart disease become more prevalent.

“The share of adults ages 18 to 64 receiving SSI payments has increased over time, rising from slightly more than 1 percent of the population 30 years ago to more than 2 percent today. The change accelerated in the early 1990s, in part because of a loosening of disability standards for mental and musculoskeletal disorders that was passed in the Social Security Disability Benefits Reform Act of 1984 and implemented in subsequent years. That rule change increased the weight placed on applicants’ ability to function, thus reducing the weight put on medical diagnoses. Applications for SSI also increased in the early 1990s because the Social Security Administration (SSA) stepped up its public outreach for the program.

Disabled Children under Age 18

“Children who qualify for SSI must be disabled and, in most cases, must live in a household with low income and few assets. To be considered disabled, a child must have a physical or mental impairment that results in marked and severe functional limitations and that is either expected to last for at least 12 consecutive months or to result in death. Most child recipients qualify because of a mental disorder. Disabled children normally require more support than other children do, and SSI payments help parents and other caregivers pay for disability-related expenses and help compensate for the lower wages that parents might earn because of the demands of caring for a disabled child. In all, 1.3 million disabled children are SSI recipients, or about 1 in 60 of those under the age of 18.

“Rising poverty also seems to have contributed to growth in the number of child SSI recipients. Simply being poor is not a guarantee that an applicant will meet the SSI income and asset tests, but poor people are more likely to meet those tests, so an increase in the poverty rate generally leads to an increase in the number of SSI recipients.

Adults Age 65 or Older

⁴³ Congressional Budget Office, Supplemental Security Income, and Overview, <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43759-SupplementalSecurity.pdf>

“People age 65 or older can qualify for SSI on the basis of low income and assets alone; they need not be disabled. As a result, people in that age group are more likely than younger people are to qualify for the program; about 2.1 million, or 5 percent of the elderly population, do. (About half of those recipients qualified as disabled recipients before they turned 65.)”

Healthy People 2010 Final Review⁴⁴

Healthy People 2010 Final Review presents a quantitative end-of-decade assessment of progress in achieving the Healthy People 2010 objectives and goals over the course of the decade. It continues the series of profiles of the nation's health objectives as an integral part of the Department of Health and Human Services' disease and health promotion initiative for the decade that began in 2000.

This report presents a summary of progress toward achieving the Healthy People 2010 goals of:

1. Increasing quality and years of healthy life, and
2. Eliminating health disparities.

This publication provides the final tracking data used to present a quantitative assessment of progress for the 969 objectives in the 28 Healthy People 2010 Focus Areas. A summary of progress for the Healthy People 2010 Leading Health indicators is also presented.

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Healthy People 2020 Disability and Health Objectives⁴⁵

⁴⁴ http://www.cdc.gov/nchs/healthy_people/hp2010/hp2010_final_review.htm

⁴⁵ <http://healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicid=9>

DH-1	Increase the number of population-based data systems used to monitor Healthy People 2020 objectives that include in their core a standardized set of questions that identify people with disabilities.
DH-2	Increase the number of Tribes, States, and the District of Columbia that have public health surveillance and health promotion programs for people with disabilities and caregivers.
DH-3	(Developmental) Increase the proportion of US master of Public Health (MPH) programs that offer graduate-level courses in disability and health.
DH-4	(Developmental) Reduce the proportion of people with disabilities who report delays in receiving primary and periodic preventive care due to specific barriers.
DH-5	Increase the proportion of youth with special health care needs whose health care provider has discussed transition planning for pediatric to adult health care.
DH-6	(Developmental) Increase the proportion of people with epilepsy and uncontrolled seizures who receive appropriate medical care.
DH-7	(Developmental) Reduce the proportion of older adults with disabilities who use inappropriate medications.
DH-8	(Developmental) Reduce the proportion of people with disabilities who report physical or program barriers to local health and wellness programs.
DH-9	(Developmental) Reduce the proportion of people with disabilities who encounter barriers to participating in home, school, work, or community activities.

DH-10	(Developmental) Reduce the proportion of people with disabilities who report barriers to obtaining the assistive devices, service animals, technology services, and accessible technologies that they need.
DH-11	Increase the proportion of newly constructed and retrofitted U.S. homes and residential buildings that have visitable features.
DH-12	Reduce the number of people with disabilities living in congregate care residences.
DH-13	(Developmental) Increase the proportion of PWD) who participate in social, spiritual recreational, community and civic activities to the degree that they wish.
DH-14	Increase the proportion of children and youth with disabilities who spend at least 80% of their time in regular education programs.
DH-15	Reduce unemployment among PWD.
DH-16	Increase employment among PWD.
DH-17	Increase the proportion of adults with disabilities who report sufficient social and emotional support.
DH-18	(Developmental) Reduce the proportion of PWD who report serious psychological distress.
DH-19	(Developmental) Reduce the proportion of PWD who experience nonfatal unintentional injuries that require medical care.
DH-20	Increase the proportion of children with disabilities, birth through age 2 years, who receive early intervention services in home or community-based settings.

Inequities in Education and Employment for Persons with Disabilities

Education, employment, and poverty are inextricably tied. A March 2012 report from the Department of Education, Office for Civil Rights summarizes information from the Civil Rights Data Collection (CRDC), the first national data tool for analyzing equity and educational opportunities. The CRDC, from school year 2009-10, is a representative sample covering approximately **85%** of the nation's students. Data are disaggregated by race and ethnicity, English learner status, sex, and by disability under the IDEA and Section 504 statutes. The report reveals that:

- Students with disabilities are much more likely to be subject to ***seclusion and restraint***;
- Students with disabilities from minority racial or ethnic backgrounds, as well as male students, are even ***more likely*** to be secluded or restrained;

- Students covered under IDEA are more than **twice as likely** to receive one or more out-of-school suspensions (Non-IDEA Students = 6%; IDEA Students = 13%).⁴⁶
- Students with disabilities (under the IDEA and Section 504 statutes) represent **12%** of students in the sample, but nearly **70%** of the students who are physically restrained by adults in their schools.⁴⁷

“Throughout the world there is an undeniable link between disability, poverty and exclusion. The denial of equal employment opportunities to people with disabilities forms one of the root causes of the poverty and exclusion of many members of this group. There is ample evidence that people with disabilities are more likely than non-disabled persons to experience disadvantage, exclusion and discrimination in the labor market and elsewhere. As a result of these experiences, people with disabilities are disproportionately affected by unemployment. When they work, they can often be found outside the formal labor market, performing uninspiring low-paid and low-skilled jobs, offering little or no opportunities for job promotion or other forms of career progression. Employees with disabilities are often under-employed.”⁴⁸

Montana Disability and Health (MTDH) Program Target Population

The MTDH Program has demonstrated advanced capacity in working with:

- 1) Adults with disabilities related to mobility impairments, and
- 2) Adults with developmental disabilities (I/DD) residing in supported living arrangements operated under contract with state agencies.

In 2011, the MTDH Program expanded to include **all** persons with disabilities across the lifespan. This population includes babies born with disabling conditions, children and adults with intellectual and developmental disabilities (I/DD), and hearing, vision, and/or mobility impairments.

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⁴⁶ Civil Rights Data Collection (CRDC), Department of Education, Office for Civil Rights, <http://www2.ed.gov/about/offices/list/ocr/data.html>

⁴⁷ Civil Rights Collection, Wide-ranging education access and equity data from a sample of our nation's public schools, <http://www.msn.com/?pc=skyp&ocid=skydhp>

⁴⁸ International Labor Office, Achieving Equal Employment Opportunities for People with Disabilities through Legislation Guidelines, http://www.ilo.org/global/publications/ilo-bookstore/order-online/books/WCMS_091340/lang-en/index.htm

Disability Report Summary and Highlights

"A life course approach to chronic disease epidemiology uses a multidisciplinary framework to understand the importance of time and timing in associations between exposures and outcomes at the individual and population levels. Such an approach to chronic diseases is enriched by specification of the particular way that time and timing in relation to physical growth, reproduction, infection, social mobility, and behavioral transitions, etc., influence various adult chronic diseases in different ways, and more ambitiously, by how these temporal processes are interconnected and manifested in population-level disease trends.

Researchers John Lynch and George Davey Smith have studied life course epidemiology and theoretical models of life course processes, and have reviewed the empirical evidence linking life course processes to coronary heart disease, hemorrhagic stroke, type II diabetes, breast cancer, and chronic obstructive pulmonary disease. A life course approach offers a way to conceptualize how underlying socio-environmental determinants of health, experienced at different life course stages, can differentially influence the development of chronic diseases, as mediated through proximal specific biological processes.⁴⁹

Child Development Guide⁵⁰

The Centers for Disease Control and Prevention (CDC) has developed the **Child Development Guide** to help parents determine children's intellectual, social, and emotional developmental needs from birth to age 19 as well as moral developmental needs after age two. The Guide also includes effective parenting techniques.

Developmental disabilities are a group of conditions due to an impairment in physical, learning, language, or behavior areas. About one in six children in the U.S. have one or more developmental disabilities or other developmental delays.

For more information, click on:

<http://www.dshs.wa.gov/ca/fosterparents/training/chidev/cd06.htm> and/or:

<http://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/infants.html>

⁴⁹ A Life Course Approach to Chronic Disease, *Epidemiology, Annual Review of Public Health*, Vol. 26: 1-35 (Volume publication date April 2005) DOI: 10.1146/annurev.publhealth.26.021304.144505, John Lynch and George Davey Smith

⁵⁰ <http://www.dshs.wa.gov/ca/fosterparents/training/chidev/cd06.htm>

Developmental Disabilities

The following data represent information on populations with disabilities in Montana across the life course and, when available, information regarding their health status and health risk behaviors.”⁵¹

“Skills such as taking a first step, smiling for the first time, and waving "bye bye" are called developmental milestones. Children reach milestones in how they play, learn, speak, behave, and move (crawling, walking, etc.)” For more information, click on: <http://www.cdc.gov/actearly>

Developmental disabilities include a diverse group of severe chronic conditions that are due to mental and/or physical impairments. People with developmental disabilities have problems with major life activities such as language, mobility, learning, self-help, and independent living. Developmental disabilities begin anytime during development up to 22 years of age and usually last throughout a person’s lifetime.”⁵²

Children’s Special Health Services

“*Children's Special Health Services (CSHS)*,⁵³ is charged by the Federal Maternal and Child Health Bureau to: "Support development and implementation of comprehensive, culturally competent, coordinated systems of care for children and youth who have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

CSHS focuses on building, measuring, and monitoring a complex system of care for *Children and Youth Special Health Care Needs (CYSHCN)* with the following goals:

- Assure family participation and satisfaction.
- Access to medical home so that CYSHCN have an identified source of ongoing routine health care in their community.
- Adequate insurance for CSHCN families. The state CHIP program can help address this need, but resources and partnerships with other programs to address under insurance and provide "wrap-around services" are needed.
- Access to community-based systems of care, organized in such a way that needs can be identified and services provided, and there are mechanisms to pay for them.
- Facilitate transition to adulthood so that youth with special health care needs can expect good health care, employment with benefits, and independence.

⁵¹ <http://www.annualreviews.org/doi/abs/10.1146/annurev.publhealth.26.021304.144505?journalCode=publhealth>

⁵² <http://www.opi.mt.gov/pdf/speced/sedata/09ChildCountData.pdf>

⁵³ <http://www.dphhs.mt.gov/publichealth/cshs/fundingandgoals.shtml>

- Support early and continuous screening so that infants and children with high-risk health conditions can be identified early.

Since January of 2008, Montana has screened **all** newborns via:

1. A **metabolic screen (bloodspot test)** for 28 conditions as recommended by the American Academy of Pediatrics and the American College of Medical Genetics. (Approximately 12,500 babies were born in Montana in 2008. Seventeen babies or **1 in 735** were treated for a condition detected by the newborn bloodspot screen.
2. A **hearing screen** to detect hearing loss. If the newborn does not pass the first hearing screen, another screen is performed. If the second screen is not passed, the screening facility informs the parent and the baby's primary care provider that an audiology assessment is recommended before the baby is three months of age. Because the early months of life are important to the development of language, it is critical that an infant with a hearing loss be diagnosed before four months of age so that appropriate intervention can be provided before six months of age.⁵⁴ In 2009, 95.8% of 11,697 babies born in Montana received hearing screenings. The prevalence rate for babies diagnosed with hearing loss was **2.14 per 1000** births. Of those babies, 84% were referred to / enrolled in Early Intervention Services.

Children with Special Health Care Needs (CSHCN) are defined by the U.S. Department of Health and Human Services, Maternal and Child Health Bureau as: "... those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."⁵⁵

"This definition of CSHCN is broad and inclusive, and it emphasizes the characteristics held in common by children with a wide range of diagnoses.

The National Survey of Children with Special Health Care Needs (NS-CSHCN), designed and sponsored by the Maternal and Child Health Bureau and carried out by the National Center for Health Statistics, provides detailed information on the prevalence of CSHCN in the nation and in each state, the demographic characteristics of these children, the types of health and support services that they and their families need, and their access to and satisfaction with the care that they receive."⁵⁶

This National Survey is a telephone survey that has been conducted three times—the first survey was conducted in 2001/02; the second in 2005/06; and the third in 2009/10. The survey is conducted in all 50 states and the District of Columbia by calling telephone numbers that are randomly generated to find households with one or more children under the age of 18. Trained

⁵⁴ Montana's Expanded Newborn Screening: www.mt.gov

⁵⁵ Pediatrics 1998;102(1):137–140, A new definition of children with special health care needs, McPherson M, Arango P, Fox H, Lauer C, McManus M, Newacheck P, Perrin J, Shonkoff J, Strickland B.

⁵⁶ <http://altarum.cvent.com/events/dataspeak-registration/event-summary-5041e07bfc543eb9e1f405f9ad19a2e.aspx>

interviewers ask parents or guardians a series of questions pertaining to all children in the household in order to identify children with special health care needs.

A minimum of 750 interviews are conducted in each state and the District of Columbia Oral Health Status. With funding and direction from the Maternal and Child Health Bureau, the National Survey of Children with Special Health Care Needs was conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics. CAHMI is responsible for the analyses, interpretations, presentations and conclusions included on this site.

For additional information, click on: www.childhealthdata.org

Children's Mental Health⁵⁷

On May 16, 2014 a CDC report was released that describes, for the first time, federal activities that track U.S. children's mental disorders.

The term *childhood mental disorder* means all mental disorders that can be diagnosed and begin in childhood (for example, attention-deficit/hyperactivity disorder (ADHD), Tourette syndrome, behavior disorders, mood and anxiety disorders, autism spectrum disorders, substance use disorders, etc.). Mental disorders among children are described as serious changes in the ways children typically learn, behave, or handle their emotions. Symptoms usually start in early childhood, although some of the disorders may develop throughout the teenage years. The diagnosis is often made in the school years and sometimes earlier. However, some children with a mental disorder may not be recognized or diagnosed as having one.

Childhood mental disorders can be treated and managed. There are many evidence-based treatment options, so parents and doctors should work closely with everyone involved in the child's treatment — teachers, coaches, therapists, and other family members. Taking advantage of all the resources available will help parents, health professionals and educators guide the child towards success. Early diagnosis and appropriate services for children and their families can make a difference in the lives of children with mental disorders.

An Important Public Health Issue

Mental health is important to overall health. Mental disorders are chronic health conditions that can continue through the lifespan. Without early diagnosis and treatment, children with mental disorders can have problems at home, in school, and in forming friendships. This can also interfere with their healthy development, and these problems can continue into adulthood.

Children's mental disorders affect many children and families. Boys and girls of all ages, ethnic/racial backgrounds, and regions of the United States experience mental disorders. Based on the National Research Council and Institute of Medicine report (Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities, 2009) that gathered findings from previous studies, it is estimated that 13 –20 percent of children living in the United States (up to 1 out of 5 children) experience a mental disorder in a given year and an estimated \$247 billion is spent each year on childhood mental disorders. Because of the impact on children,

⁵⁷ <http://www.cdc.gov/Features/ChildrensMentalHealth/>

families, and communities, children's mental disorders are an important public health issue in the United States.

Monitoring Children's Mental Health

Public health surveillance – which is the collection and monitoring of information about health among the public over time – is a first step to better understand childhood mental disorders and promote children's mental health. Ongoing and systematic monitoring of mental health and mental disorders will help:

- Increase understanding of the mental health needs of children;
- Inform research on factors that increase risk and promote prevention;
- Find out which programs are effective at preventing mental disorders and promoting children's mental health; and
- Monitor the effectiveness of treatment and prevention efforts.

Who is affected?

The following are key findings from this report about mental disorders among children aged 3–17 years:

- Millions of American children live with depression, anxiety, ADHD, autism spectrum disorders, Tourette syndrome or a host of other mental health issues.
- .ADHD was the most prevalent current diagnosis among children aged 3–17 years.
- The number of children with a mental disorder increased with age, with the exception of autism spectrum disorders, which was highest among 6 to 11 year old children.
- Boys were more likely than girls to have ADHD, behavioral or conduct problems, autism spectrum disorders, anxiety, Tourette syndrome, and cigarette dependence.
- Adolescent boys aged 12–17 years were more likely than girls to die by suicide.
- Adolescent girls were more likely than boys to have depression or an alcohol use disorder.

Data collected from a variety of data sources between the years 2005-2011 show that children aged 3-17 years currently had:

- ADHD (6.8%)
- Behavioral or conduct problems (3.5%)
- Anxiety (3.0%)
- Depression (2.1%)
- Autism spectrum disorders (1.1%)
- Tourette syndrome (0.2%) (among children aged 6–17 years)

Adolescents aged 12–17 years had:

- Illicit drug use disorder in the past year (4.7%)
- Alcohol use disorder in the past year (4.2%)
- Cigarette dependence in the past month (2.8%)

The estimates for current diagnosis were lower than estimates for "ever" diagnosis, meaning whether a child had ever received a diagnosis in his or her lifetime. Suicide, which can result

from the interaction of mental disorders and other factors, was the second leading cause of death among adolescents aged 12–17 years in 2010.

Looking to the Future

Public health includes mental health. CDC worked with several agencies to summarize and report this information. The goal is now to build on the strengths of these partnering agencies to develop better ways to document how many children have mental disorders, better understand the impacts of mental disorders, inform needs for treatment and intervention strategies, and promote the mental health of children. This report is an important step on the road to recognizing the impact of childhood mental disorders and developing a public health approach to address children's mental health.

What You Can Do

Parents: You know your child best. Talk to your child's health care professional if you have concerns about the way your child behaves at home, in school, or with friends.

Youth: It is just as important to take care of your mental health as it is your physical health. If you are angry, worried or sad, don't be afraid to talk about your feelings and reach out to a trusted friend or adult.

Health care professionals: Early diagnosis and appropriate treatment based on updated guidelines is very important. There are resources available to help diagnose and treat children's mental disorders.

Teachers/School Administrators: Early identification is important, so that children can get the help they need. Work with families and health care professionals if you have concerns about the mental health of a child in your school.⁵⁸

References

1. National Research Council and Institute of Medicine: Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities. Washington, DC: The National Academic Press; 2009.
2. Centers for Disease Control and Prevention, [Mental health surveillance among children United States, 2005–2011](#). MMWR 2013;62 (Supplement May 16, 2013):1-35.

⁵⁸ Centers for Disease Control and Prevention [Mental health surveillance among children — United States 2005–2011](#). MMWR 2013;62(Suppl; May 16, 2013):1-35

CDC Issues First Comprehensive Report on Children's Mental Health in the United States⁵⁹

A report from the Centers for Disease Control and Prevention (CDC), [Mental Health Surveillance Among Children —United States, 2005–2011](#), describes federal efforts on monitoring mental disorders, and presents estimates of the number of children with specific mental disorders. The report was developed in collaboration with key federal partners, the Substance Abuse and Mental Health Services Administration (SAMHSA), National Institute of Mental Health (NIMH), and Health Resources and Services Administration (HRSA). It is an important step towards better understanding these disorders and the impact they have on children.

This is the first report to describe the number of U.S. children aged 3–17 years who have specific mental disorders, compiling information from different data sources covering the period 2005–2011. It provides information on childhood mental disorders where there is recent or ongoing monitoring. These include ADHD, disruptive behavioral disorders such as oppositional defiant disorder and conduct disorder, autism spectrum disorders, mood and anxiety disorders including depression, substance use disorders, and Tourette syndrome. The report also includes information on a few indicators of mental health, specifically, mentally unhealthy days and suicide.

Who is affected?

The following are key findings from this report about mental disorders among children aged 3–17 years:

- Millions of American children live with depression, anxiety, ADHD, autism spectrum disorders, Tourette syndrome or a host of other mental health issues.
- ADHD was the most prevalent current diagnosis among children aged 3–17 years.
- The number of children with a mental disorder increased with age, with the exception of autism spectrum disorders, which was highest among 6 to 11 year old children.
- Boys were more likely than girls to have ADHD, behavioral or conduct problems, autism spectrum disorders, anxiety, Tourette syndrome, and cigarette dependence.
- Adolescent boys aged 12–17 years were more likely than girls to die by suicide.
- Adolescent girls were more likely than boys to have depression or an alcohol use disorder.

⁵⁹References:

- National Research Council and Institute of Medicine. Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities. Washington, DC: The National Academic Press; 2009.
- Centers for Disease Control and Prevention. [Mental health surveillance among children – United States, 2005–2011](#). MMWR 2013;62(Suppl; May 16, 2013):1-35.

Data collected from a variety of data sources between the years 2005-2011 show that children aged 3-17 years currently had:

- ADHD (6.8%)
- Behavioral or conduct problems (3.5%)
- Anxiety (3.0%)
- Depression (2.1%)
- Autism spectrum disorders (1.1%)
- Tourette syndrome (0.2%) (among children aged 6–17 years)

Adolescents aged 12–17 years had:

- Illicit drug use disorder in the past year (4.7%)
- Alcohol use disorder in the past year (4.2%)
- Cigarette dependence in the past month (2.8%)

The estimates for current diagnosis were lower than estimates for "ever" diagnosis, meaning whether a child had ever received a diagnosis in his or her lifetime. Suicide, which can result from the interaction of mental disorders and other factors, was the second leading cause of death among adolescents aged 12–17 years in 2010.

Looking to the Future

Public health includes mental health. CDC worked with several agencies to summarize and report this information. The goal is now to build on the strengths of these partnering agencies to develop better ways to document how many children have mental disorders, better understand the impacts of mental disorders, inform needs for treatment and intervention strategies, and promote the mental health of children. This report is an important step on the road to recognizing the impact of childhood mental disorders and developing a public health approach to address children's mental health.

What You Can Do

Parents: You know your child best. Talk to your child's health care professional if you have concerns about the way your child behaves at home, in school, or with friends.

Youth: It is just as important to take care of your mental health as it is your physical health. If you are angry, worried or sad, don't be afraid to talk about your feelings and reach out to a trusted friend or adult.

Health care professionals: Early diagnosis and appropriate treatment based on updated guidelines is very important. There are resources available to help diagnose and treat children's mental disorders.

Teachers/School Administrators: Early identification is important, so that children can get the help they need. Work with families and health care professionals if you have concerns about the mental health of a child in your school.

For more Information, check out the following resources:

- [CDC Mental health](#)
- [CDC Youth Suicide Prevention](#)

- [CDC Alcohol and Public Health](#)
- [CDC Health Related Quality of Life](#)
- [CDC ADHD](#)
- [CDC Tourette Syndrome](#)
- [CDC Autism](#)
- [CDC Learn the Signs Act Early](#)
- [Substance Abuse and Mental Health Services Administration](#)
- [Health Resources and Services Administration](#)
- [American Academy of Pediatrics](#)
- [American Academy of Child and Adolescent Psychiatry](#)
- [National Resource Center on ADHD](#)
- [Tourette Syndrome Association](#)

Children and Adolescent Immunizations⁶⁰

Immunizations have had an enormous impact on improving the health of children in the United States. Most parents today have never seen first-hand the devastating consequences that vaccine-preventable diseases have on a family or community. While these diseases are not common in the U.S., they persist around the world. It is important that we continue to protect our children with vaccines because outbreaks of vaccine-preventable diseases can and do occasionally occur in this country.

Vaccination is one of the best ways parents can protect infants, children, and teens from 16 potentially harmful diseases. Vaccine-preventable diseases can be very serious, may require hospitalization, or even be deadly – especially in infants and young children.

General Information

Infants and children need vaccines to protect them from harmful diseases. These diseases can have serious complications, especially for very young children, and even cause death.

Each year, the Centers for Disease Control and Prevention (CDC) sets the U.S. childhood immunization schedule based on recommendations from the Advisory Committee on Immunization Practices.

Your doctor can guide you in determining what vaccines your child needs and when he/she needs them. By the time your baby is 2 years old, he or she should get vaccines that will protect him/her from 14 vaccine-preventable diseases. For many of these vaccines, more than one dose is needed. Vaccination is one of the best ways parents can protect infants, children, and teens from

⁶⁰ <http://www.cdc.gov/vaccines/parents/index.html>

16 potentially harmful diseases. Vaccine-preventable diseases can be very serious, may require hospitalization, or even be deadly – especially in infants and young children.

“Immunizations have had an enormous impact on improving the health of children in the United States. Most parents today have never seen first-hand the devastating consequences that vaccine-preventable diseases have on a family or community. While these diseases are not common in the U.S., they persist around the world. It is important that we continue to protect our children with vaccines because outbreaks of vaccine-preventable diseases can and do occasionally occur in this country.”

Find out: 1) what vaccines your baby needs; and 2) when they are needed by becoming familiar with the Recommended Immunizations for Children from Birth through 6 Years of age.

Children and Influenza⁶¹

Influenza (“the flu”) is more dangerous than the common cold for children. Each year, many children get sick with seasonal influenza; some of those illnesses result in death. Children commonly need medical care because of influenza, especially before they turn 5 years old. Severe influenza complications are most common in children younger than 2 years old.

Children with chronic health problems like asthma, diabetes and disorders of the brain or nervous system are at especially high risk of developing serious flu complications.

Each year an average of 20,000 children under the age of 5 are hospitalized because of influenza complications.

Flu seasons vary in severity, however some children die from flu each year. During the 2013-2014 influenza season, more than 100 flu-related pediatric deaths were reported.

Starting in 2014-2015, CDC recommends use of the nasal spray vaccine (LAIV) for healthy* children 2 years through 8 years of age who do not have an underlying medical condition when it is immediately available and if the child has no contraindications or precautions to that vaccine. “Healthy” in this instance refers to children 2 years through 8 years old who do not have an underlying medical condition that predisposes them to influenza complications.

Recent studies suggest that the nasal spray flu vaccine may work better than the flu shot in younger children. However, if the nasal spray vaccine is not immediately available and the flu shot is, children 2 years through 8 years old should get the flu shot. Don’t delay vaccination to find the nasal spray flu vaccine.

For more information about the new CDC recommendation, see “[Nasal Spray Flu Vaccine in Children 2 through 8 Years Old](http://www.cdc.gov/flu/about/qa/nasalspray-children.htm) (<http://www.cdc.gov/flu/about/qa/nasalspray-children.htm>) or the [2014-2015 MMWR Influenza Vaccine Recommendations](#).

⁶¹ <http://www.cdc.gov/flu/protect/children.htm>

Youth Risk Behavior Surveillance, United States, 2013⁶²

Errata: Vol. 63, No. SS-4; July 4, 2014 / 63(26);576-576

In the MMWR Surveillance Summary "[Youth Risk Behavior Surveillance — United States, 2013](#)," the title for Table 23 on page 72 was incorrect. It should read, "TABLE 23. Percentage of high school students **who felt sad or hopeless**,^{*,†} by sex, race/ethnicity, and grade — United States, Youth Risk Behavior Survey, 2013."

Problem:

Priority health-risk behaviors contribute to the leading causes of morbidity and mortality among youth and adults. Population-based data on these behaviors at the national, state, and local levels can help monitor the effectiveness of public health interventions designed to protect and promote the health of youth nationwide.

Reporting Period Covered: September 2012–December 2013.

Description of the System:

The Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of priority health-risk behaviors among youth and young adults:

- 1) Behaviors that contribute to unintentional injuries and violence;
- 2) Tobacco use;
- 3) Alcohol and other drug use;
- 4) Sexual behaviors that contribute to unintended pregnancy and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV) infection;
- 5) Unhealthy dietary behaviors; and
- 6) Physical inactivity.

In addition, YRBSS monitors the prevalence of obesity and asthma.

YRBSS includes a national school-based Youth Risk Behavior Survey (YRBS) conducted by CDC and state and large urban school district school-based YRBSSs conducted by state and local education and health agencies. This report summarizes results for 104 health-risk behaviors plus obesity, overweight, and asthma from the 2013 national survey, 42 state surveys, and 21 large urban school district surveys conducted among students in grades 9–12.

Results:

Results from the 2013 national YRBS indicated that many high school students are engaged in priority health-risk behaviors associated with the leading causes of death among persons aged 10–24 years in the United States.

⁶² <http://www.cdc.gov/healthyyouth/yrbs/index.htm>

During the 30 days before the survey, **41.4%** of high school students nationwide among the **64.7%** who drove a car or other vehicle during the 30 days before the survey had texted or e-mailed while driving, **34.9%** had drunk alcohol, and **23.4%** had used marijuana.

During the 12 months before the survey, 14.8% had been electronically bullied, 19.6% had been bullied on school property, and 8.0% had attempted suicide.

Many high school students nationwide are engaged in sexual risk behaviors that contribute to unintended pregnancies and STIs, including HIV infection. Nearly half (46.8%) of students had ever had sexual intercourse, 34.0% had had sexual intercourse during the 3 months before the survey (i.e., currently sexually active), and 15.0% had had sexual intercourse with four or more persons during their life. Among currently sexually active students, 59.1% had used a condom during their last sexual intercourse.

Results from the 2013 national YRBS also indicate many high school students are engaged in behaviors associated with chronic diseases, such as cardiovascular disease, cancer, and diabetes. During the 30 days before the survey, 15.7% of high school students had smoked cigarettes and 8.8% had used smokeless tobacco. During the 7 days before the survey, 5.0% of high school students had not eaten fruit or drunk 100% fruit juices and 6.6% had not eaten vegetables. More than one-third (41.3%) had played video or computer games or used a computer for something that was not school work for 3 or more hours per day on an average school day.

Interpretation:

Many high school students engage in behaviors that place them at risk for the leading causes of morbidity and mortality. The prevalence of most health-risk behaviors varies by sex, race/ethnicity, and grade and across states and large urban school districts. Long term temporal changes also have occurred. Since the earliest year of data collection, the prevalence of most health-risk behaviors has decreased (e.g., physical fighting, current cigarette use, and current sexual activity), but the prevalence of other health-risk behaviors has not changed (e.g., suicide attempts treated by a doctor or nurse, having ever used marijuana, and having drunk alcohol or used drugs before last sexual intercourse) or has increased (e.g., having not gone to school because of safety concern and obesity and overweight).

Public Health Action:

YRBSS data are used widely to compare the prevalence of health-risk behaviors among subpopulations of students; assess trends in health-risk behaviors over time; monitor progress toward achieving 20 national health objectives for *Healthy People 2020* and one of the 26 leading health indicators; provide comparable state and large urban school district data; and help develop and evaluate school and community policies.

Youth Risk Behavior Surveillance, Montana, 2013⁶³

2013 Montana Youth Risk Behavior Survey Results included:

- High School Students
- Students in Grades 7-8
- American Indian Students on Reservations (AI-R)
- American Indian Students in Urban Schools (AI-U)
- Nonpublic Accredited Schools (NPA)
- Alternative Schools (ALT)
- Students with Disabilities (SWD)

Survey categories include the following:

- Injury and violence
- Tobacco Use
- Alcohol and other drug use
- Sexual behaviors
- Weight management and Dietary behaviors
- Physical activity
- Other

To view the full report, click on: <http://www.opi.mt.gov/pdf/YRBS/13/13FinalRpt.pdf>

Montana Produces First-Ever YRBS Reports on American Indian Youth Risk Behaviors⁶⁴

Problem Overview:

Although 10% of Montana's high school student population is American Indian (AI), the state did not have representative data on youth risk behaviors for this population group through the CDC's Youth Risk Behavior Survey (YRBS). As a result, Montana's schools and other youth-serving organizations and agencies lacked critical data necessary for developing effective health promotion and disease prevention programs and messages for the AI population—which is disproportionately affected by a number of different health problems.

For example, in the United States, the gonorrhea rate in 2010 among American Indians / Alaska Natives (AI/AN) was **4.6 times** the rate among whites, and overall, the rate of chlamydia among AI / AN was more than four times the rate among whites.

- A study showed the survival of youth 36 months after AIDS diagnosis was lower for AI /AN youth, compared with white youth.

Program/Activity Description:

⁶³ Montana Office of Public Instruction

⁶⁴ http://www.cdc.gov/healthyouth/stories/pdf/2012/success_12_montana.pdf

To address the lack of representative AI youth risk behavior data, the **Montana Office of Public Instruction (OPI)** worked closely with the CDC's Division of Adolescent and School Health surveillance staff to:

- Set up detailed procedures for surveying AI students during the 2011 YRBS data collection.
- Create step-by-step instructions for local school staff to follow in administering the YRBS.
- Conduct regular quality-assurance checks during the survey to ensure proper data collection methods were being followed.
- Provide complete, timely, and accurate data while working across multiple tribal organizations and within appropriate cultural contexts.

Program/Activity Results:

For the first time in 20 years, Montana collected representative (weighted) data about health risk behaviors among its AI students. The OPI then produced a series of special reports featuring the AI data, including reports documenting differences in risk behaviors between AI students living on or near a reservation, and AI students attending urban schools.

The YRBS AI reports were disseminated to 180 agencies and organizations across the state that work with, or have an interest in, the health of American Indian young people, their wellness, their education, and their futures. These new AI reports are being used to:

- Guide AI agencies in determining the type of interventions that will most benefit AI students in promoting healthy behaviors—based on their greatest needs and current risks.
- Increase awareness of the complex issues facing AI students, their families, and their communities, including the need for multiple layers of support to improve their health and academics.
- Help Native American public health agencies and other organizations design more effective prevention messages regarding sexual risk behaviors, drinking, drug use, and other unhealthy behaviors.

The Montana Board of Crime Control uses the YRBS data to monitor risk factors among AI/AN youth, who are disproportionately represented in the state's juvenile justice system. Having the AI/AN data better equips the state to educate these youth regarding sexual behaviors that put them at risk for STDs and HIV.

- One Montana school district hired a full-time staffer to work specifically with AI youth and their families on accessing community resources and improving academic achievement.

Note: This success story, including background data and outcomes, reflects information as reported by the participating program.

Child and Adolescent Obesity Facts⁶⁵

- Childhood obesity has more than doubled in children and quadrupled in adolescents in the past 30 years.
- The percentage of children aged 6–11 years in the United States who were obese increased from 7% in 1980 to nearly 18% in 2012. Similarly, the percentage of adolescents aged 12–19 years who were obese increased from 5% to nearly 21% over the same period.
- In 2012, ***more than one third of children and adolescents were overweight or obese.***
- Overweight is defined as having excess body weight for a particular height from fat, muscle, bone, water, or a combination of these factors.
- *Obesity* is defined as having excess body fat.
- Overweight and obesity are the result of “caloric imbalance”—too few calories expended for the amount of calories consumed—and are affected by various genetic, behavioral, and environmental factors.

Health Effects of Childhood Obesity

Childhood obesity has both immediate and long-term effects on health and well-being.

Immediate health effects:

- Obese youth are more likely to have risk factors for cardiovascular disease, such as high cholesterol or high blood pressure. In a population-based sample of 5- to 17-year-olds, 70% of obese youth had at least one risk factor for cardiovascular disease.
- Obese adolescents are more likely to have pre-diabetes, a condition in which blood glucose levels indicate a high risk for development of diabetes.
- Children and adolescents who are obese are at greater risk for bone and joint problems, sleep apnea, and social and psychological problems such as stigmatization and poor self-esteem.

Long-term health effects:

- Children and adolescents who are obese are likely to be obese as adults and are therefore more at risk for adult health problems such as heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis. One study showed that children who became obese as early as age 2 were more likely to be obese as adults.
- Overweight and obesity are associated with increased risk for many types of cancer, including cancer of the breast, colon, endometrium, esophagus, kidney, pancreas, gall

⁶⁵ <http://www.cdc.gov/healthyouth/obesity/facts.htm>

bladder, thyroid, ovary, cervix, and prostate, as well as multiple myeloma and Hodgkin's lymphoma.

Prevention

- Healthy lifestyle habits, including healthy eating and physical activity, can lower the risk of becoming obese and developing related diseases.
- The dietary and physical activity behaviors of children and adolescents are influenced by many sectors of society, including families, communities, schools, child care settings, medical care providers, faith-based institutions, government agencies, the media, and the food and beverage industries and entertainment industries.
- Schools play a particularly critical role by establishing a safe and supportive environment with policies and practices that support healthy behaviors. Schools also provide opportunities for students to learn about and practice healthy eating and physical activity behaviors.

Surgeon General's Report: Physical Activity and Health⁶⁶

Key Messages for Persons with Disabilities

- Physical activity need not be strenuous to achieve health benefits. Significant health benefits can be obtained with a moderate amount of physical activity, preferably daily. The same moderate amount of activity can be obtained in longer sessions of moderately intense activities (such as 30-40 minutes of wheeling oneself in a wheelchair) or in shorter sessions of more strenuous activities (such as 20 minutes of wheelchair basketball).
- Additional health benefits can be gained through greater amounts of physical activity. People who can maintain a regular routine of physical activity that is of longer duration or of greater intensity are likely to derive greater benefit.
- Previously sedentary people who begin physical activity programs should start with short intervals of physical activity (5-10 minutes) and gradually build up to the desired level of activity.
- People with disabilities should first consult a physician before beginning a program of physical activity to which they are unaccustomed.
- The emphasis on moderate amounts of physical activity makes it possible to vary activities to meet individual needs, preferences, and life circumstances.

FACTS

⁶⁶ National Center for Chronic Disease Prevention and Health Promotion

- People with disabilities are less likely to engage in regular moderate physical activity than people without disabilities, yet they have similar needs to promote their health and prevent unnecessary disease.
- Social support from family and friends has been consistently and positively related to regular physical activity.

BENEFITS OF PHYSICAL ACTIVITY

- Reduces the risk of dying from coronary heart disease and of developing high blood pressure, colon cancer, and diabetes.
- Can help people with chronic, disabling conditions improve their stamina and muscle strength.
- Reduces symptoms of anxiety and depression, improves mood, and promotes general feelings of well-being.
- Helps control joint swelling and pain associated with arthritis.
- Can help reduce blood pressure in some people with hypertension.

Adults with Disabilities⁶⁷

Adults with disabilities are 3 times more likely to have heart disease, stroke, diabetes, or cancer than adults without disabilities.

Nearly half of all adults with disabilities get no aerobic physical activity, an important health behavior to help avoid these chronic diseases.

Adults with disabilities were **82%** more likely to be physically active if a doctor recommended it.

More than 21 million US adults 18–64 years of age have a disability. These are adults with serious difficulty walking or climbing stairs; hearing; seeing; or concentrating, remembering, or making decisions. Most adults with disabilities are able to participate in physical activity, yet nearly half of them get no aerobic physical activity. Physical activity benefits all adults, whether or not they have a disability, by reducing their risk of serious chronic diseases, such as heart disease, stroke, diabetes and some cancers. Only 44% of adults with disabilities who visited a doctor in the past year were told by a doctor to get physical activity. Yet adults with disabilities were 82% more likely to be physically active if their doctor recommended it.

Doctors and other health professionals can:

- Ask adults with disabilities how much physical activity they get each week.

⁶⁷ <http://www.cdc.gov/vitalsigns/disabilities/>

- Remind adults with disabilities to get regular physical activity consistent with their abilities. They should try to get at least 2 1/2 hours a week of moderate-intensity physical activity. If this is not possible, some activity is better than none.
- Recommend physical activity options that match the specific abilities of each person and connect them to resources that can help each person be physically active.

Persons with a Disability: Labor Force Characteristics 2013⁶⁸

In 2013, **17.6 percent** of persons with a disability were employed, the U.S. Bureau of Labor Statistics reported today. In contrast, the employment-population ratio for those without a disability was **64.0 percent**. The employment-population ratio was little changed from 2012 to 2013 for both groups.

The unemployment rate for those with a disability was **13.2 percent** in 2013, higher than the rate for persons with no disability (**7.1 percent**). The jobless rate for persons with a disability was little changed from 2012 to 2013, while the rate for those without a disability declined.

The data on persons with a disability are collected as part of the Current Population Survey (CPS), a monthly sample survey of about 60,000 households that provides information on employment and unemployment in the United States. The collection of data on persons with a disability is sponsored by the Department of Labor's Office of Disability Employment Policy.

Highlights from the 2013 data:

- Persons with a disability were over three times as likely as those with no disability to be age 65 and over.
- For all age groups, the employment-population ratio for persons with a disability was less than half that of those with no disability.
- In 2013, 34 percent of workers with a disability were employed part time, compared with 19 percent of those with no disability.
- Fifteen percent of workers with a disability were employed in federal, state, or local government, similar to the share for workers with no disability (14 percent).
- Employed persons with a disability were more likely to be self-employed than those with no disability. (See table 4.)

Demographic Characteristics

Persons with a disability tend to be older than persons with no disability, reflecting the increased incidence of disability with age. In 2013, 46 percent of persons with a disability were age 65 and over, compared with 14 percent of those with no disability. Overall, women were somewhat more likely to have a disability than men, partly reflecting the greater life expectancy of women. Among the major race and ethnicity groups, the prevalence of a disability was higher for blacks and whites than for Asians and Hispanics.

⁶⁸ <http://www.bls.gov/news.release/pdf/disabl.pdf>

Employment

The employment-population ratio for persons with a disability was **17.6 percent** in 2013, little changed from 2012. The ratio for those with *no disability* showed little change in 2013, at **64.0 percent**. The lower ratio among persons with a disability is due, in part, to the large share of the population of persons with a disability that was age 65 and older, as older persons are less likely to be employed. However, across all age groups, persons with a disability were much less likely to be employed than those with no disability.

Among persons with a disability age 16 to 64, the employment-population ratio, at **26.8 percent in 2013**, changed little over the year and was unchanged for those age 65 and over, at **6.9 percent**.

In 2013, those who had higher levels of education were more likely to be employed than those with less education. At all levels of education, persons with a disability were much less likely to be employed than their counterparts with no disability.

Workers with a disability were more likely to be employed part time than those with no disability. Among those with a disability, **34 percent** usually worked part time in 2013, compared with **19 percent** of workers without a disability. The proportion of workers who were employed part time for economic reasons was slightly higher among those with a disability than among those without a disability (7 percent versus 5 percent). These individuals were working part time because their hours had been cut back or because they were unable to find a full-time job.

In 2013, workers with a disability were more likely to be employed in production, transportation, and material moving occupations than those with no disability (**15 percent compared with 12 percent**). Those with a disability were less likely than their counterparts to work in management, professional, and related occupations (**33 percent compared with 38 percent**).

The share of workers with a disability employed in federal, state, and local government (**15 percent**) was about the same as the share for those with no disability (**14 percent**). Workers with a disability were less likely than those with no disability to be employed in private wage and salary jobs (**74 percent versus 80 percent**). The incidence of self-employment among workers with a disability was higher than among workers with no disability (**11 percent versus 6 percent**).

Unemployment

The unemployment rate for persons with a disability was **13.2 percent** in 2013, higher than the rate for those with no disability (**7.1 percent**). (Unemployed persons are those who did not have a job, were available for work, and were actively looking for a job in the 4 weeks preceding the survey.) The unemployment rate for persons with a disability was little changed from 2012 to 2013, while the rate for those without a disability was lower in 2013 than in the prior year.

In 2013, the unemployment rate for men with a disability (**13.0 percent**) was about the same as the rate for women (**13.5 percent**). As was the case among those without a disability, the unemployment rates for those with a disability were higher among blacks (**19.2 percent**) and Hispanics (**18.6 percent**) than among whites (**12.2 percent**) and Asians (**8.9 percent**).

Not in the Labor Force

Persons who are neither employed nor unemployed are not in the labor force. A large proportion of persons with a disability—about 8 in 10—were not in the labor force in 2013, compared with about 3 in 10 persons with no disability. In part, this reflects the fact that persons with a disability tend to be older than those without a disability and older persons are, in general, less likely to be labor force participants. However, for all age groups, persons with a disability were much more likely than those with no disability to be out of the labor force.

Among those not in the labor force with and without a disability, the vast majority reported that they do not want a job. In 2013, about 1 percent of persons with a disability were marginally attached to the labor force, compared with 3 percent of those with no disability. These individuals were not in the labor force, wanted and were available to work, and had looked for a job sometime in the prior 12 months. They were not counted as unemployed because they had not searched for work in the 4 weeks preceding the survey.

Economic Picture of the Disability Community Project; Key points on Disability & Occupational Projections Tables⁶⁹

⁶⁹ <http://www.dol.gov/odep/pdf/20141022-KeyPoints.pdf>

This project is a joint initiative between DOL's Office of Disability Employment Policy, Employment and Training Administration, Chief Economist, Office of the Secretary, and the White House Council of Economic Advisors (CEA).

The tables produced (see associated excel file) are based on CEA analysis of the Census Bureau's 2010-2012 American Community Survey, matched to the Bureau of Labor Statistics' 2012-2022 occupational projections.

The key points are:

- **Employment levels of people with disabilities are low, and those who are employed tend to be in low-paying occupations.**
 - o Only one-third (32.0%) of working-age people with disabilities were employed on average in the 2010-2012 period, compared to over two-thirds (72.7%) of people without disabilities (Table 1).
 - o Employment rates among people with disabilities do not vary greatly by gender, but are particularly low among blacks and those with low levels of education (both absolutely and relative to people without disabilities)(Table 2).
 - o Employed people with disabilities are underrepresented in management and professional/technical jobs, and over-represented in service, production, and transportation jobs (Table 4).
- **People with disabilities are somewhat overrepresented in slower-growing occupations that lower their projected employment growth rate through 2022 assuming disability prevalence by occupation stays constant.**
 - o The projected job growth rate over the 2012-2022 period for people with disabilities is 10.4% compared to 10.8% overall, based on applying occupational projections to disability prevalence in the current occupational distribution (assuming disability prevalence stays constant within occupations)(Table 5). If the growth rates were equal there would be an additional 32,200 jobs for people with disabilities in 2022.
 - o People with disabilities are underrepresented in 16 of the top 20 fastest-growing occupations, but are overrepresented in the fastest-growing occupation of "personal and home care aides"
 - o People with disabilities are overrepresented in 17 of the top 20 fastest-declining occupations.
 - o The top 20 occupations with the greatest numerical job growth for people with disabilities tend to be low-paying (except secretaries, registered nurses, carpenters, postsecondary teachers, and LPN's)(Table 11).

- **There is nonetheless substantial potential for job growth among people with disabilities in well-paying occupations over the coming decade.**
 - o The greatest job growth in well-paying occupations (exceeding the median wage) for people with disabilities without a college degree will be among secretaries, carpenters, and bookkeepers. For those with a college degree, the greatest job growth will be among registered nurses, postsecondary teachers, and general and operations managers.
 - o Many people with disabilities appear to have the education for these new jobs. Of the 15.6 million new jobs overall, 3.2 million will be in occupations requiring a Bachelor's degree. Close to one-fourth (797,900) of these new jobs could theoretically be filled by current non-employed working-age people who have Bachelor's degrees. Also, 438,000 people with disabilities are enrolled as college undergraduates, which will prepare them for well-paying jobs.
 - o Prior analysis of occupational ability requirements from O*Net shows substantial job growth in occupations where many disabilities are likely to be irrelevant—for example, occupations where psychomotor and physical abilities have low or no importance.
 - o Most job growth is in occupations where computer use is important, and the rapid development of new computer and information technologies has particular benefits for many people with disabilities by helping overcome specific physical and cognitive limitations, and significantly increasing the workplace productivity of people with disabilities.
 - o Technology and corporate policies are also creating more possibilities for home-based and other flexible work arrangements that can especially benefit people with disabilities who deal with transportation difficulties and medical concerns.
- **Whether the potential for increased employment of people with disabilities will be realized depends in part on public and corporate policies regarding access to appropriate education, computer skills, and other training; disability income policies; and the availability of workplace accommodations and other employment supports.**

“Throughout the world there is an undeniable link between disability, poverty and exclusion. The denial of equal employment opportunities to people with disabilities forms one of the root causes of the poverty and exclusion of many members of this group. There is ample evidence that people with disabilities are more likely than non-disabled persons to experience disadvantage, exclusion and discrimination in the labor market and elsewhere. As a result of these experiences, people with disabilities are disproportionately affected by unemployment. When they work, they can often be found outside the formal labor market, performing

uninspiring low-paid and low-skilled jobs, offering little or no opportunities for job under-employed.”⁷⁰

Percent of objective in which population group had the “best” rate

- Non-Hispanic white: 51%
- Non-Hispanic black: 20%
- Hispanic or Latino: 17%
- American Indian or Alaska Native: 6%

Nearly half of all adults with disabilities get no aerobic physical activity, an important health behavior to help avoid these chronic diseases.

Adults with disabilities were 82% more likely to be physically active if their doctor recommended it.

More than 21 million US adults 18–64 years of age have a disability. These are adults with serious difficulty walking or climbing stairs; hearing; seeing; or concentrating, remembering, or making decisions. Most adults with disabilities are able to participate in physical activity, yet nearly half of them get no aerobic physical activity. Physical activity benefits all adults, whether or not they have a disability, by reducing their risk of serious chronic diseases, such as heart disease, stroke, diabetes and some cancers. Only 44% of adults with disabilities who visited a doctor in the past year were told by a doctor to get physical activity. Yet adults with disabilities were 82% more likely to be physically active if their doctor recommended it.

Doctors and other health professionals can:

- Ask adults with disabilities how much physical activity they get each week.
- Remind adults with disabilities to get regular physical activity consistent with their abilities. They should try to get at least 2 1/2 hours a week of moderate-intensity physical activity. If this is not possible, some activity is better than none.
- Recommend physical activity options that match the specific abilities of each person and connect them to resources that can help each person be physically active.

Preventing Falls among Older Adults

Each year, one in every three adults ages 65 or older falls and 2 million are treated in emergency departments for fall-related injuries. And the risk of falling increases with each decade of life. The long-term consequences of fall injuries, such as hip fractures and traumatic brain injuries (TBI), can impact the health and independence of older adults.

⁷⁰ International Labor Office, Achieving Equal Employment Opportunities for People with Disabilities through Legislation Guidelines, http://www.ilo.org/global/publications/ilo-bookstore/order-online/books/WCMS_091340/lang--en/index.htm

Thankfully, falls are not an inevitable part of aging. In fact, many falls can be prevented. Everyone can take actions to protect the older adults they care about.

Prevention Tips: You can play a role in preventing falls. Encourage the older adults in your life to:

- **Get some exercise.** Lack of exercise can lead to weak legs and this increases the chances of falling. Exercise programs such as Tai Chi can increase strength and improve balance, making falls much less likely.
- **Be mindful of medications.** Some medicines—or combinations of medicines—can have side effects such as dizziness or drowsiness. This can make falling more likely. Having a doctor or pharmacist review all medications can help reduce the chance of risky side effects and drug interactions.
- **Keep their vision sharp.** Poor vision can make it harder to get around safely. Older adults should have their eyes checked every year and wear glasses or contact lenses with the right prescription strength to ensure they are seeing clearly.
- **Eliminate hazards at home.** About half of all falls happen at home. A home safety check can help identify potential fall hazards that need to be removed or changed, such as tripping hazards, clutter, and poor lighting.

Safety

People with disabilities can be at higher risk for injuries and abuse. It is important for parents and other family members to teach their loved one how to stay safe and what to do if they feel threatened or have been hurt in any way.

Injuries at home and at play are not accidents. They can be prevented. CDC focuses on the science behind making people safe – working to prevent leading causes of injuries, including drowning, falls, fires, and poisoning. Home and recreation-related injuries affect people of all ages, from infants to older adults, and account for about a third of all injury-related emergency department visits. CDC works to ensure that all people have safe and healthy homes and places to play. Preventing unintentional injuries is a step toward ensuring that all Americans live to their full potential.

The Reality

Each year, one in every three adults ages 65 or older falls and 2 million are treated in emergency departments for fall-related injuries. And the risk of falling increases with each decade of life. The long-term consequences of fall injuries, such as hip fractures and traumatic brain injuries (TBI), can impact the health and independence of older adults. Thankfully, falls are not an inevitable part of aging. In fact, many falls can be prevented. Everyone can take actions to protect the older adults they care about.

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Steps for Home Safety

The following checklist can help older adults reduce their risk of falling at home:

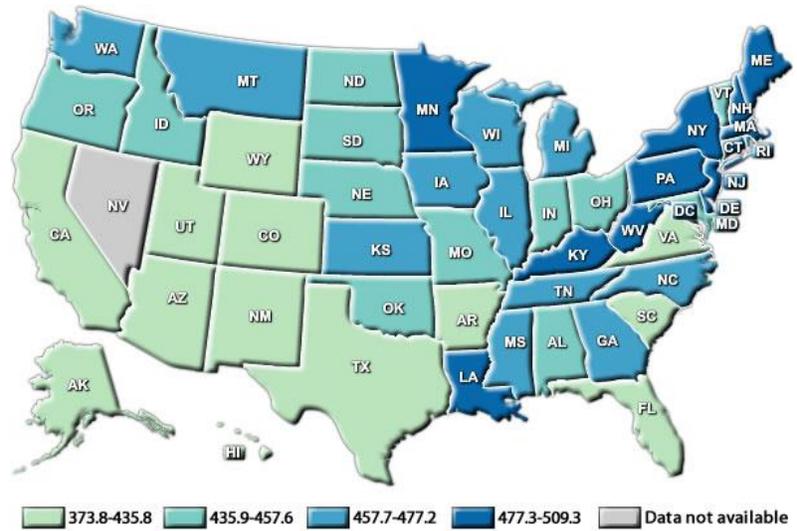
- Remove things you can trip over (such as papers, books, clothes, and shoes) from stairs and places where you walk.
- Install handrails and lights on all stair cases.
- Remove small throw rugs or use double-sided tape to keep the rugs from slipping.
- Keep items you use often in cabinets you can reach easily without using a step stool.
- Put grab bars inside and next to the tub or shower and next to your toilet.
- Use non-slip mats in the bathtub and on shower floors.
- Improve the lighting in your home. As you get older, you need brighter lights to see well. Hang lightweight curtains or shades to reduce glare.
- Wear shoes both inside and outside the house. Avoid going barefoot or wearing slippers.

For additional information, click on: <http://www.cdc.gov/HomeandRecreationalSafety/Falls/pubs.html>

Cancer Incidence Rates by State

The number of people who get cancer is called **cancer incidence**. In the United States, the rate of getting cancer varies from state to state.

All Cancers Combined Incidence Rates* by State, 2011†



Color on Map	Interval	States
	373.8 to 435.8	Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, New Mexico, South Carolina, Texas, Utah, Virginia, and Wyoming
	435.9 to 457.6	Alabama, Idaho, Indiana, Maryland, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, Oregon, South Dakota, Vermont
	457.7 to 477.2	Georgia, Illinois, Iowa, Kansas, Michigan, Mississippi, Montana , North Carolina, Rhode Island, Tennessee, Washington, Wisconsin
	477.3 to 509.3	Connecticut, Delaware, District of Columbia, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Pennsylvania, West Virginia
	Data not available‡	Nevada

*Rates are per 100,000 and are age-adjusted to the 2000 U.S. standard population.

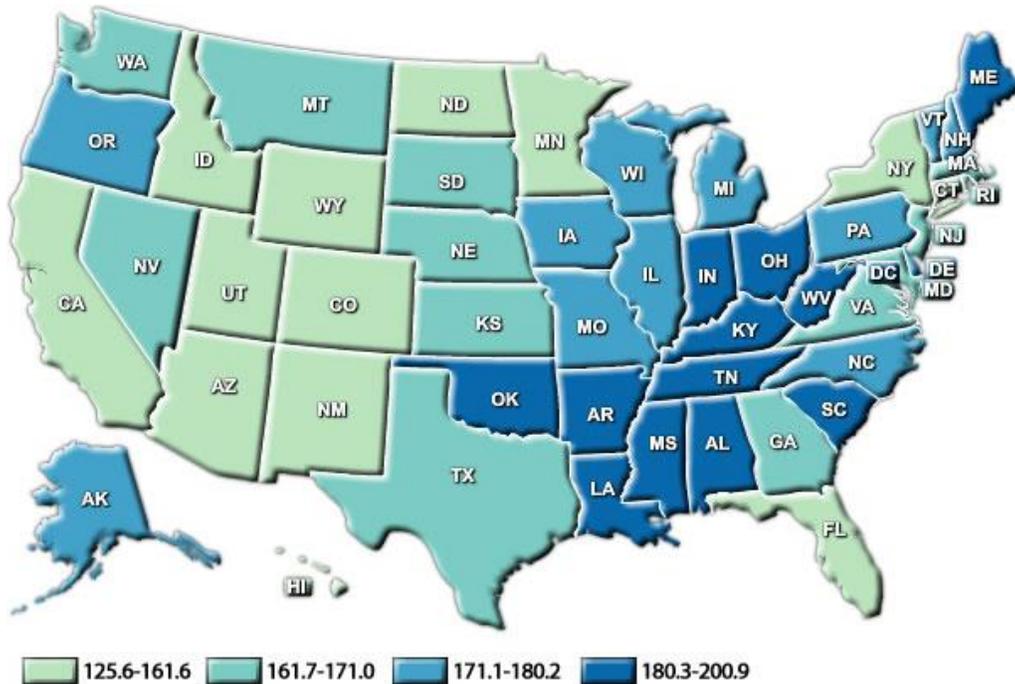
‡Rates are not shown if the state did not meet USCS publication criteria or if the state did not submit data to CDC.

†Source: U.S. Cancer Statistics Working Group. *United States Cancer Statistics: 1999–2011 Incidence and Mortality Web-based Report*. Atlanta (GA): Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute; 2014. Available at: www.cdc.gov/uscs.

Cancer Death Rates by State

Rates of dying from cancer also vary from state to state.

All Cancers Combined Death Rates* by State, 2011†



Preventable Deaths in Montana: Cancer Deaths by Region⁷¹

In 2012, cancer was the leading cause of death in Montana, followed closely by heart disease. Each year there are approximately 5,500 Montanans diagnosed with cancer. Cancer is common; in fact 1 in 2 men and 1 in 3 women will be diagnosed with cancer at some point in their life-times.

Cancer is a general term for over 100 unique diseases. Each type of cancer is associated with its own set of risk factors. Some of these risk factors are unchangeable, like age and genetics. However there are several actions individuals and communities can take to reduce the risk

Key Findings

- Cancer is the leading cause of death in Montana. An estimated 530 Montanans die prematurely (before age 80) each year of breast, colorectal, and lung cancers.
- Preventing tobacco use and helping current tobacco user to quit can prevent deaths due to lung and several other types of cancer.

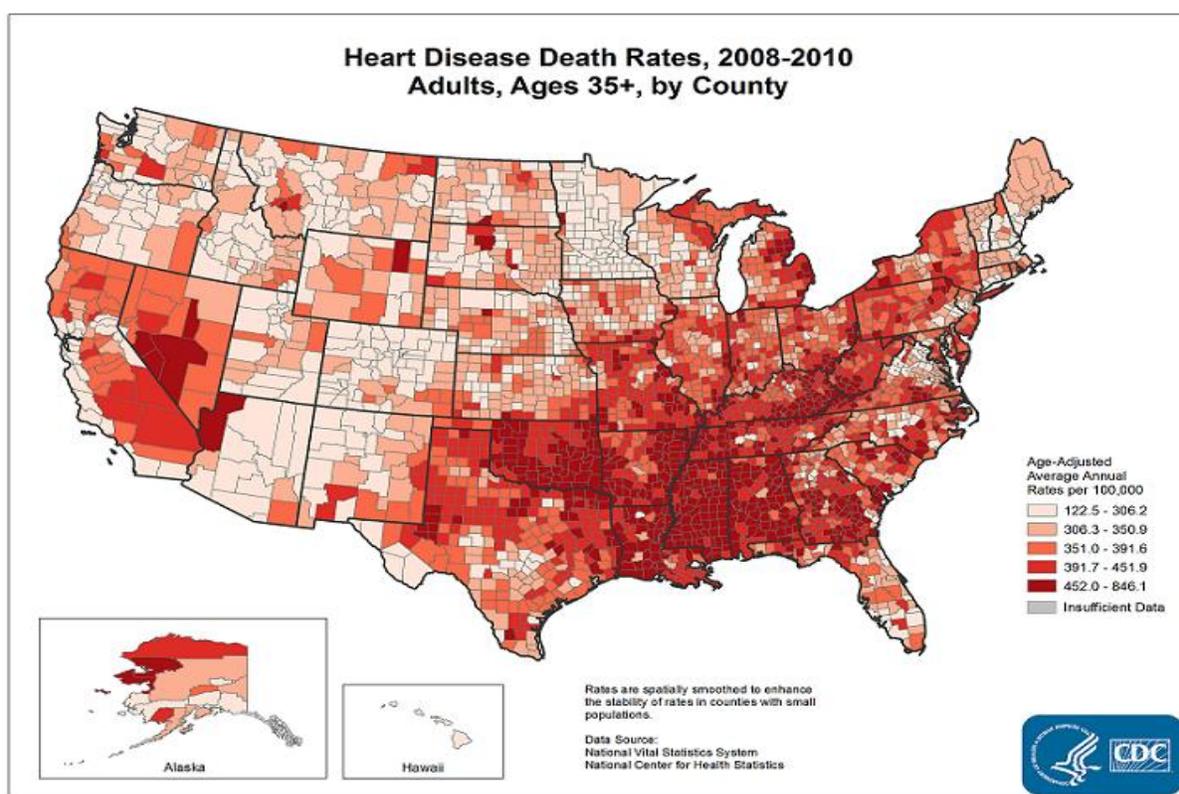
⁷¹

http://dphhs.mt.gov/Portals/85/publichealth/documents/Cancer/1_Data%20%26%20Statistics/Surveillance%20Reports/preventable%20deaths_cancer_final.pdf

Heart Disease Facts: America's Heart Disease Burden⁷²

About 610,000 people die of heart disease in the United States every year—that's 1 in every 4 deaths.

- Heart disease is the leading cause of death for both men and women. **More than half** of the deaths due to heart disease in 2009 were in men.
- Coronary heart disease is the most common type of heart disease, killing over **370,000 people** annually.
- Every year about **735,000 Americans** have a heart attack. Of these, 525,000 are a first heart attack and 210,000 happen in people who have already had a heart at



Early Action is Key

Knowing the warning signs and symptoms of a heart attack is key to preventing death, but many people don't know the signs.

- In a 2005 survey, most respondents—92%—recognized chest pain as a symptom of a heart attack. **Only 27%** were aware of all major symptoms and knew to call 9-1-1 when someone was having a heart attack.

⁷² <http://www.cdc.gov/diabetes/prevention/pdf/vulnerablepopulationsfactsheet.pdf>

- **About 47%** of sudden cardiac deaths occur outside a hospital. This suggests that many people with heart disease don't act on early warning signs.

Heart attacks have several **major warning signs** and symptoms:

- Chest pain or discomfort.
- Upper body pain or discomfort in the arms, back, neck, jaw, or upper stomach.
- Shortness of breath.
- Nausea, lightheadedness, or cold sweats.

Americans at Risk

High blood pressure, high LDL cholesterol, and smoking are key risk factors for heart disease. About **half of Americans** (49%) have at least one of these three risk factors.

Several other medical conditions and lifestyle choices can also put people at a higher risk for heart disease, including:

- Diabetes
- Overweight and obesity
- Poor diet
- Physical inactivity
- Excessive alcohol use

Lowering your blood pressure and cholesterol will reduce your risk of dying of heart disease.

Here are some tips to protect your heart:

- Follow your doctor's instructions and stay on your medications.
- Eat a healthy diet that is low in salt, low in total fat, saturated fat, and cholesterol, and rich in fresh fruits and vegetables.
- Take a brisk 10-minute walk, 3 times a day, 5 days a week.
- Don't smoke. If you smoke, quit as soon as possible.
- Visit www.cdc.gov/tobacco and www.smokefree.gov for tips on quitting.

Diabetes ⁷³

The Centers for Disease Control and Prevention (CDC) funds the ***National Program to Eliminate Diabetes-Related Disparities in Vulnerable Populations***, a five-year cooperative agreement to reduce health disparities associated with type 2 diabetes.

What Are Diabetes-Related Health Disparities?

Diabetes affects over 29 million people, or 9% of the population, in the United States. It is the seventh leading cause of death in the country and can cause serious health complications, including heart disease, blindness, kidney failure, and lower-extremity amputations. The highest rates of type 2 diabetes and its complications exist across particular groups of the population, such as adults 60 and older, racial and ethnic minority groups (i.e., African Americans, Hispanic/Latino Americans, American Indians, Native Hawaiians and other Pacific Islanders, and some Asian Americans), and people with low socioeconomic status and rural populations.

How is CDC working to reduce diabetes-related health disparities in communities?

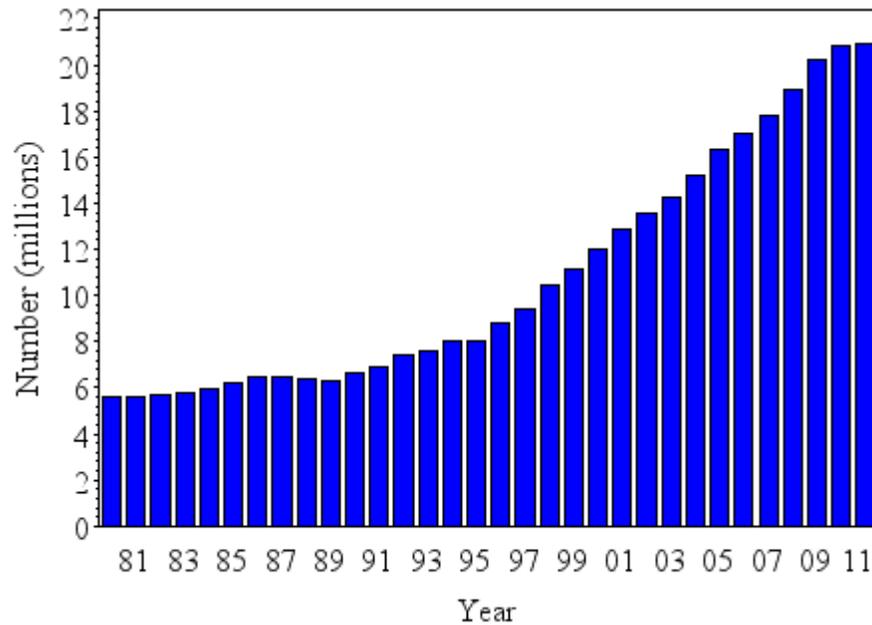
Variations in type 2 diabetes rates often occur across different communities and populations because of complex individual, social, cultural, economic, and environmental factors. To address these factors, CDC funds and supports six national organizations to engage and collaborate with local partners in 18 communities by:

- establishing multi-sector partnerships and coalitions
- conducting needs assessments and strategic planning
- identifying and implementing culturally relevant, evidence-based interventions
- building community infrastructure and capacity
- evaluating approaches implemented in the communities
- sharing lessons learned and disseminating findings about effective strategies to reduce diabetes-related disparities

Number (in Millions) of Civilian, Non-institutionalized Persons with Diagnosed Diabetes, United States, 1980–2011

Diabetes is becoming more common in the United States. From 1980 through 2011, the number of Americans with diagnosed diabetes has more than tripled (from 5.6 million to 20.9 million).

⁷³ <http://www.cdc.gov/diabetes/prevention/pdf/vulnerablepopulationsfactsheet.pdf>



Of the 29 million adults with diabetes in the United States in 2012, 13.4 million were women. The risk of heart disease, the most common complication of diabetes, is more serious among women than men. Among people with diabetes who have had a heart attack, women have lower survival rates and a poorer quality of life than men. Women with diabetes have a shorter life expectancy than women without diabetes, and women are at greater risk of blindness from diabetes than men.

An important part of managing your diabetes is knowing your diabetes ABCs – A1C, Blood Pressure, and Cholesterol.

- A is for the A1C test. It measures your average blood glucose level over the past three months. The goal for many people with diabetes is below 7. Ask what your goal should be.
- B is for blood pressure. If your blood pressure gets too high, it makes your heart work too hard. It can cause a heart attack, stroke and kidney disease. Ask what your goal should be.
- C is for cholesterol. There are two kinds of cholesterol in your blood: LDL and HDL. LDL or “bad cholesterol” can build up and clog your blood vessels. HDL or “good” cholesterol helps remove the “bad” cholesterol from your blood vessels. Ask what your cholesterol numbers should be.

If you smoke, get help to stop smoking. Talk to your health care team about your ABC numbers and what you can do to reach your ABC goals. The NDEP offers tips to help you take action to manage your diabetes. An important first step is to set a goal.. Choose something that is important to you and that you believe you can do. Then make a plan by choosing the small steps you will take. For example, start working towards getting 30 minutes of physical activity, such as brisk walking, most

days of the week. If you have not been very active in the past, start slowly and try adding a few minutes each day. Ask others for help with your plan.

See more at: <http://www.diabetes.org/in-my-community/local-offices/billings-montana/#sthash.ihrm3f6j.dpuf>

Diabetes Complications

- Cardiovascular Disease (CVD)
- Mortality Due to Hyperglycemic Crises
- Hospitalization for Diabetic Ketoacidosis (DKA)
- End-Stage Renal Disease (ESRD)
- Lower Extremity Conditions

Montana Diabetes Statistics and Death Rates⁷⁴

5.3 out of every 100 adults in Montana has diabetes, ranking it 43rd lowest in the nation for the ratio of people with diabetes to the general population.

21 out of every adult 100,000 deaths in Montana are due to diabetes, ranking Montana the 43rd lowest in the nation for diabetes-related deaths

In 2005, 41,000 Montana adults were diagnosed with diabetes and, by 2007, 7% of the total adult population had been diagnosed with diabetes.

⁷⁴ <http://www.pre-diabetes.com/statistics-2/montana-diabetes-statistics.html>

State and National Progress

Since 2010, several national and statewide initiatives have been initiated or improved.

In 2010:

- President Obama signed the Patient Protection and Affordable Health Care Act into law On March 23.
- July 26 marked the 20th anniversary of the Americans with Disabilities Act (ADA), landmark legislation that transformed the American landscape by requiring the installation of ramps, lifts, curb cuts, widened doorways and more to make America more accessible to individuals with disabilities.⁷⁵ The revised 2010 ADA Standards for Accessible Design assure that recreation facilities, play areas, fitness centers, and state and local government facilities have a legal obligation to adhere to these accessible design standards.⁷⁶
- The Association on Intellectual and Developmental Disabilities (AAIDD) presented its first official definition of the term “intellectual disability” (formerly mental retardation) in the 11th edition of its much-awaited Definition Manual written by a committee of 18 international experts in disability.⁷⁷
- The six item set of questions used by the American Community Survey (ACS) and other major federal surveys to characterize functional disability is proposed as the *minimum* standard for collecting population survey data on disability. The question set was developed by a federal interagency committee and reflects how disability is conceptualized consistent with the International Classification of Functioning, Disability, and Health. The question set went through several rounds of cognitive testing and has been adopted in most major federal data collection systems.⁷⁸
- On September 23, the House Financial Services Committee held a hearing on the Livable Communities Act that would fund regional planning to make communities more livable and would eliminate barriers to federal agencies working together.⁷⁹
- In October, the Administration on Aging (AoA) funded Aging and Disability Resource Center (ADRC) programs in 20 states to work with AoA and each other in a collaborative process to develop national minimum standards. These standards guide how Options Counseling (OC) is delivered, who delivers it, under what circumstances,

⁷⁵ Providing Individuals with Disabilities the Tools to Live Independently
http://harkin.senate.gov/issue/equalrights/Live_Independently.cfm

⁷⁶ National Center on Physical Activity and Disability, <http://www.ncpad.org/>

⁷⁷ Intellectual Disability: Definition, Classification, and Systems of Support, 11th Edition
<http://www.aaidd.org/intellectualdisabilitybook/>

⁷⁸ For more information on improving data collection to reduce health disparities, click on:
<http://www.healthcare.gov/news/factsheets/disparities06292011a.html>

⁷⁶ <http://www.cdc.gov/diabetes/statistics/prev/national/figpersons.htm>

⁷⁹ For more information, click on: <http://ntl.bts.gov/DOCS/livbro.html>

and how outcomes are tracked across the ADRC network. Through the grant, states will also design, implement and test draft standards for Options Counseling.⁸⁰

- Fifty years after President Kennedy assembled a 27-member Panel to prescribe a plan of action in the field of Intellection and Developmental Disabilities (I/DD) report, the Arc⁸¹ launched a national online survey of Family and Individual Needs for Disability Supports (FINDS) that confirmed the extraordinary progress that has been made from the days of social isolation and segregated institutions. Today, 98% of people with I/DD report living in the community. However, the survey also indicated that our efforts as a nation have fallen short in education, employment; and providing services and supports for people with I/DD and their families.⁸²

In 2011:

- On January 14, the MMWR (Morbidity and Mortality Weekly Report) focused on the *CDC Health Disparities and Inequalities in the United States—2011*, the first in a periodic series of reports examining disparities in selected social and health indicators.⁸³
- On February 10, the *National Center on Birth Defects and Development Disabilities* (NCBDDD) released the 2011—2015 strategic plan to prevent major birth defects attributable to maternal risk factors.⁸⁴
- In April, the NCBDDD celebrated its 10th anniversary with notable achievements, including autism and sickle cell awareness.⁸⁵
- On June 29, US Department of Health and Human Services (HHS) Secretary Kathleen Sebelius announced new draft standards for collecting and reporting data on race, ethnicity, sex, primary language and **disability status** to help federal agencies refine their population health surveys in ways that will help researchers better understand health disparities and zero in on effective strategies for eliminating them.⁸⁶
- On September 8, the Centers for Medicare & Medicaid Services (CMS) announced that more seniors and people with disabilities on Medicare are seeing reduced costs for important health care—through 1) discounts on brand-name drugs in the Medicare Part D "donut hole" coverage gap, and 2) free preventive care.⁸⁷

In 2012:

⁸⁰ Administration on Aging, Draft National Options Counseling Standards, www.adrc-tae.org/tiki-wnload_file.php?fileId=29256

⁸¹ The Arc is a national organization devoted to the needs of people with intellectual and/or developmental disabilities.

⁸² The Arc, Still in the Shadows with Their Future Uncertain, a Report on Family and Individual Needs for Disability Supports (FINDS, June 2011, <http://www.thearc.org/document.doc?id=3140>)

⁸³ MMWR, Supplement/Vol.60, January 14, 2011, <http://www.cdc.gov/mmwr/pdf/other/su6001.pdf>

⁸⁴ National Center on Birth Defects and Developmental Disabilities (NCBDDD) Strategic Plan, <http://www.cdc.gov/NCBDDD/AboutUs/birthdefects.html>

⁸⁵ Bright Futures: Family Matters, Volume 12, Issue 2, Summer 2011 <http://www.brightfuturesforfamilies.org/pdf/BFFM-NCBDDDSummer2011.pdf>

⁸⁶ HHS press release, June 29, 2011, <http://www.hhs.gov/news/press/2011pres/06/20110629a.html>

⁸⁷ HHS Press Office, <http://www.hhs.gov/news/press/2011pres/09/20110908a.html>

- In January, the Henry J. Kaiser Family Foundation Published a Women’s Issue Brief entitled *Medicaid’s Role for Women across the Lifespan: Current Issues and the Impact of the Affordable Care Act*.⁸⁸
- On February 8, the Alaska Health Policy Review published findings of the first Commonwealth Fund Health Insurance Tracking Survey of U.S. adults, indicating that 57% of adults in low-income families were uninsured for some time in the past year, as were 36% of those in moderate-income families.⁸⁹
- In March, the Aging and Disability Resource Center (ADRC), an initiative of the US Department of Health and Human Services, published criteria to assist states and stakeholders in measuring and assessing state progress toward developing fully functioning single entry point systems for long-term services and supports. Core functions include:
 - Information, referral and awareness
 - Options counseling
 - Streamlined eligibility determination for public programs
 - Person-Centered Transition Support
- In April, the Administration for Community Living (ACL) was established, creating a single agency charged with developing policies and improving support for seniors and people with disabilities. ACL collaborates with entities across the Administration to promote the goals of the Americans with Disabilities Act: to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for individuals with disabilities.

In 2013:

- On December 11, the American Association of People with Disabilities (AAPD), the nation’s largest disability rights organization, announced the publication of the *2013 Compendium on Disability Statistics*. The gap in employment for people with disabilities compared to people without disabilities still remains around 40.8 percentage points with 32.7 percent of people with disabilities employed versus 73.6 percent of people without disabilities employed.⁹⁰

In 2014:

- On May 29, the American Association of People with Disabilities (AAPD) and the US Business Leadership Network® (USBLN®) announced the public release of the first Annual **Disability Equality Index** (DEI). Created by leaders in the business and disability communities, the DEI is an online benchmarking tool that offers businesses the opportunity to receive an objective score, on a scale of zero to 100, on their disability inclusion policies and practices.⁹¹

⁸⁸ To read the entire article, click on: <http://www.kff.org/womenshealth/upload/7213-03.pdf>

⁸⁹ <http://akhealthpolicy.org/2012/02/08/new-study-finds-profound-income-divide-in-health-care-reform-law-will-help/>

⁹⁰ <http://www.aapd.com/resources/press-room/aapd-releases-the-2013.html>

⁹¹ <http://www.aapd.com/resources/press-room/press-releases/disability-equality-index-1.html>

- The 7th Session of the United Nations Convention on the Rights of Persons with Disabilities took place at United Nations Headquarters in June of 2014. The thematic discussions for this session were: Incorporating the CRPD provisions into the post-2015 development agenda: 1) Youth with disabilities; and 2) National implementation and monitoring.⁹²
- In preparation for the anniversary of the Americans with Disabilities Act (ADA) in July, the U.S. Census Bureau released its collection of the most recent data pertaining to Americans with disabilities. The numbers are striking. Approximately **57 million** Americans have a disability. Since this figure may be difficult to comprehend, let's take a look at some facts for comparison: There are more people with disabilities living in America than the entire population of Canada or the Caribbean. The number of Americans with vision impairments is comparable to the entire population of Switzerland, and there are more Americans with hearing impairments than in all of Denmark, Paraguay or Hong Kong. If you take the population of Ireland and cut it in half, that's roughly the number of Americans living with Alzheimer's or other neuro-cognitive disorders. Additionally, more Americans with disabilities require the assistance of others to perform basic activities of daily living than the entire population of Greece.⁹³
- The **Disability Inclusion Act 2014**, which replaces the Disability Services Act of 1993, has two main roles:
 - 1) Committing the government to making communities more inclusive and accessible for people with disability now and into the future; and
 - 2) Regulating specialist disability supports and services to people with disability and introducing better safeguards for these services until the change over to the NDIS.

In 2015:

- The Wings for Life Spinal Cord Research Foundation and the Christopher & Dana Reeve Foundation have joined forces to expand groundbreaking work regarding spinal cord injury. The partnership will enable researchers to move forward with a breakthrough clinical study that will likely commence in mid-2015.⁹⁴
- On February 10, a case before the U.S. Supreme Court that seeks police exemption from the Americans with Disabilities Act has critical importance for all those seeking to stop unwarranted police killings. This case involves police shootings of people with mental illness.
- On February 20, 2015, the National Wheelchair Basketball Association presented the 17th annual All-Star Wheelchair Classic, featuring top players from NBA-affiliated teams across country.
- In the **Bureau of Labor Statistics' Jobs Report** released Friday, March 6, the labor force participation rate increased substantially for working-age people with disabilities—

⁹³ disability.gov@service.govdelivery.com

⁹⁴ <http://www.disabled-world.com/disability/types/spinal/groundbreaking.php#sthash.T7r4uj36.dpuf>

from **29.5 percent** in February 2014 to **31.1 percent** in February 2015 (up 5.4 percent; 1.6 percentage points).⁹⁵

- Also on March 6, Human Rights Watch released information on gender-based violence, noting that women and girls with disabilities are too often the victims of violence, yet get too little information on where to go for help.

⁹⁵ <http://globenewswire.com/news-release/2015/03/06/713222/10123641/en/nTIDE-Jobs-Report-Rising-Tide-Continues-to-Raise-Workers-with-Disabilities.html#sthash.6SGSiamz.dpuf>

Vision, Mission, Goal, and Strategies

Vision

The Montana Disability and Health (MTDH) Program Advisory Board envisions a state where *all* people with disabilities are healthy in body, mind and spirit and have equal opportunities to participate in their communities—a place where people with disabilities go where they want to go, do what they want to do, have their individual needs met, and are treated with respect.⁹⁶ This vision for Montana includes:

- A commitment to people with disabilities (PWD) across the entire life span.
- Advocating for successful life transitions for PWD through education as well as policy and systems change.
- An increased awareness that preventing secondary health conditions (such as pain, depression, obesity, oral health problems, diabetes, and injuries such as pressure sores) is an important component of quality of life for people with disabilities in Montana.
- Strong alliances among people with disabilities, the MTDH Program and other agencies and organizations.
- No health care disparities. Resources and efforts to promote healthy lifestyles.
- Integration of people with disabilities in all physical, social and economic aspects of Montana. Public awareness of success stories about people with disabilities living healthy lives.

Mission

The mission of the Montana Disability and Health Program is to reduce secondary conditions, eliminate health disparities, and improve the health of people with disabilities across the entire life span.

Long-Term Outcome Goal

Reduce/eliminate health disparities experienced by populations with disabilities in Montana and promote/maximize health, prevent chronic disease, improve emergency preparedness and increase the quality of life among Montanans with disabilities in across the life course.

Strategies

The MTDH will achieve this goal via the following five strategies:

1. Build capacity of the MTDH program and partnerships,

⁹⁶ Rule 5 of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (General Assembly resolution 48/96 of 20 December 1993 annex) considers “accessibility” with reference both to the physical environment and to information and communications services. <http://www.un.org/esa/socdev/enable/disacc.htm>

2. Support direct health promotion services and programs that meet the specific health promotion needs of people with disabilities,
3. Increase access to generic health promotion services, ensuring civil rights of PWD,
4. Improve access to community environments, ensuring civil rights of PWD; and improve community planning to optimize resilience of PWP (e.g. emergency preparedness), and
5. Integrate disability and health agenda into public policies that influence the health of PWD.

The vision, mission, long-term outcome goal, and strategies are based on the history and forward momentum of the national disability and health movement as well as the recognized expertise of the *University of Montana Rural Institute* (UMRI) to provide leadership for this effort.

Primary Partners

The Montana Disability and Health (MTDH) Program, established in 2002, is a partnership of: the Chronic Disease Prevention and Health Promotion Bureau of the Montana Department of Public Health and Human Services (MDPHHS) and the University of Montana Rural Institute (UMRI).

Four divisions of MDPHHS are represented on the MTDH Disability and Health Community Planning Group as well as the Core Management Team:

1. The Public Health and Safety Division
2. The Developmental Services Division
3. The Senior and Long-Term Care Division, and
4. The Disability Transitions Program Division

The *Rural Institute: Center for Excellence in Disability Education, Research, and Service* (established in 1979) is part of the national network of programs funded by the Federal Administration on Developmental Disabilities (ADD) committed to increasing and supporting the independence, productivity, and inclusion of people with disabilities into the community.

These primary partnerships facilitate the collection of data, dissemination of information, training of professionals, and other activities designed to prevent secondary conditions, promote health, and reduce health disparities existing between Montanans with and without disabilities.

The *MTDH Program* is the result of a cooperative agreement between the Centers for Disease Control and Prevention (CDC); and the Chronic Disease Prevention and Health Promotion Bureau (CDHPB) of the Montana Department of Public Health and Human Services (MDPHHS) in partnership with the University of Montana Rural Institute (UMRI): Center for Excellence in Disability Education, Research, and Service.

All four divisions are represented on the Disability and Health Community Planning Group (formerly the MTDH Advisory Board) and the Core Management Team of the MTDH Program.

These primary partnerships facilitate the collection of data, dissemination of information, training of professionals, and other activities that relate to more than one program or one division. The MTDH Program provides a mechanism whereby people with disabilities are included in policy advisory boards within the three partnering divisions so that their unique needs are factored into any efforts to prevent secondary conditions.

National Partners

The Montana Disability and Health Program, in collaboration with national partners, develops services to:

1. Enhance program infrastructure and capacity;
2. Improve state level surveillance and monitoring activities;
3. Increase awareness of health-related disability policy initiatives;
4. Increase health promotion opportunities for people with disabilities to maximize health;
5. Improve access to health care for people with disabilities;
6. Improve emergency preparedness among people with disabilities; and
7. Effectively monitor and evaluate program activities.

National partners include the following

- Research and Training Center on Disability in Rural Communities
- National Center on Birth Defects & Developmental Disabilities
- Amputee Coalition of America
- Special Olympics, Inc.
- The Arc
- The National Center on Physical Activity & Disability (NCHPAD)
- Christopher & Dana Reeve Foundation Paralysis Resource Center
- Living Well with a Disability

The logic model developed for the MTDH Program State Plan reflects the program’s “theory of the problem.” Specifically, five key intermediate goals or “pathways of influence” are accepted by public health practitioners as having a high probability for achieving the long-term outcome goal of improved health, prevention and management of secondary conditions, and elimination of health disparities experienced by people with disabilities.

The first intermediate goal—*Building capacity*—focuses on strengthening the abilities of the MTDH Program and its partners to implement the remaining four intermediate outcome goals. It involves ongoing systems of data collection and dissemination, education of current and future partners, and procurement of additional funding.

The next two intermediate goals are designed to increase health promotion opportunities available to Montanans with disabilities.

The second intermediate goal—*Support direct health promotion services and programs that meet the specific health promotion needs of PWD*—focuses on: a) training partners to implement programs and provide services, and b) supporting mentoring programs.

The third intermediate goal—*Increase access to generic health promotion services, ensuring civil rights of PWD*—focuses on: a) increased awareness of public health partners about barriers experienced by PWP, b) increased awareness of PWD regarding the benefits of generic services, and c) support removal of barriers.

The fourth intermediate goal—*Improve access to community environments, ensuring civil rights of PWD, and improving community planning to optimize resilience (Emergency Preparedness)*—acknowledges that all impairments, disabilities, and health problems are dynamic experiences. In interaction with environmental barriers, these factors result in more isolation and less community participation for people experiencing them. Removal of such barriers is one way to support people with long-term disability and chronic conditions to live more independent lives and to find the resources they need to be healthier. Adding design features that facilitate community participation is a proactive strategy that is often a direct outcome of people with disabilities’ involvement in community planning.

The fifth intermediate outcome goal—*Integrate disability and health agenda into public policies that influence the health of PWD*—focuses on: a) educating policy professionals, b) partnering with other agencies and programs, and c) integrating disability and health into long-range plans.

Table 11: Outcome Goals

Long-term Outcome Goal				
Reduce/eliminate health disparities experienced by populations with disabilities in Montana and promote/maximize health, prevent chronic disease, improve emergency preparedness and increase the quality of life among Montanans with disabilities in across the life course.				
Intermediate Outcome Goal				
↑	↑	↑	↑	↑
<ul style="list-style-type: none"> • Build capacity of the MTDH program & partnerships 	<ul style="list-style-type: none"> • Support direct health promotion services and programs that meet the specific health promotion needs of PWD 	<ul style="list-style-type: none"> • Increase access to generic health promotion services, ensuring civil rights of PWD 	<ul style="list-style-type: none"> • Improve access to community environments, ensuring civil rights of PWD • Improve comm. Planning to optimize resilience of PWP (EP) 	<ul style="list-style-type: none"> • Integrate disability and health agenda into public policies that influence the health of PWD
Short Term Outcome Goals				
↑	↑	↑	↑	↑
<ul style="list-style-type: none"> • Increase availability of disability and health data ▪ Educate partners about disability and health issues ▪ Additional funding 	<ul style="list-style-type: none"> • Train partners to implement programs and provide services (such as <i>Living Well with a Disability</i>) ▪ Support peer mentoring programs (such as <i>Have Healthy Teeth</i>) 	<ul style="list-style-type: none"> ▪ Increase awareness of public health partners about barriers experienced by PWP. ▪ Increase awareness of PWD regarding the benefits of generic services. ▪ Support removal of barriers 	<ul style="list-style-type: none"> • Increase community awareness of barriers experienced by PWD. ▪ Support removal of barriers 	<ul style="list-style-type: none"> • Educate policy professionals ▪ Partner with other agencies and programs ▪ Integrate disability and health into long-range plans
Outputs, Products Activities				
↑	↑	↑	↑	↑
<ul style="list-style-type: none"> ▪ Surveillance ▪ Disability Advisors ▪ Epidemiology studies ▪ New partnerships 	<ul style="list-style-type: none"> ▪ Nutrition ▪ Oral health ▪ Funding ▪ LWD Program 	<ul style="list-style-type: none"> ▪ Assessment tool ▪ Curriculum ▪ Information and materials ▪ Technical assistance ▪ Disability advisors ▪ Awareness 	<ul style="list-style-type: none"> ▪ Surveys ▪ Training ▪ Accessibility Ambassador program ▪ Architectural design ▪ Resources & tools (EP planning) 	<ul style="list-style-type: none"> ▪ Establish partnerships & collaborative arrangements

Outcome Goal One: Enhance Program Infrastructure and Capacity

The [United Nations Development Programme](#) (UNDP) defines capacity building as a long-term continual process of development that involves *all* stakeholders (including ministries, local authorities, non-governmental organizations, professionals, community members, academics and more). Capacity building uses a country's human, scientific, technological, organizational, institutional and resource capabilities. The goal of capacity building is to tackle problems related to policy and methods of development, while considering the potential, limits and needs of the people of the area concerned. The UNDP outlines capacity building as taking place on an individual level, an institutional level and the societal level.⁹⁷

Objective 1A

By June 30, 2015, the MTDH Core Management Team⁹⁸ will develop 10 written processes and/or agreements to assure that the MTDH Strategic Plan is integrated with other state plans pertaining to persons with disabilities.

Rationale

The Core Management Team for the MTDH Program is composed of representatives from:

1. The Montana Department of Public Health and Human Services (MDPHHS), the largest department in state government, contains the programs and services cited in the *National Center on Birth Defects and Developmental Disabilities* (NCBDDD) Strategic Plan for 2011-2015. Pertinent MDPHHS divisions, bureaus and offices are listed in Appendix A.
2. The University of Montana Rural Institute (UMRI), a Center for Excellence in Disability Education, Research, and Service employs nine faculty and over 50 staff members who are currently working on 30+ projects that cover a broad range of disability related topics.

Activities

Core Management Team:

- Determine a process to coordinate the MDPHHS chronic disease plan with other relevant state plans.
- Assure that people with disabilities are adequately represented in the 5-year health incentives grant awarded in September of 2011.

⁹⁷ United Nations Environment Programme (UNEP), Discussion Paper presented at the 2006 IAIA Annual Conference, Stavanger, Norway, [Ways to Increase the Effectiveness of Capacity Building for Sustainable Development](#)

⁹⁸ See Appendix A, page 64

MTDH: Meg Traci, PhD, PI, MTDH Program Director

- Explore *National Institute of Health (NIH)* new intervention research priorities for children with mobility impairments.
- Design modules for data-based decision making.
- Explore the possibility of UM Psychology Department graduate students collecting original data that could be used to draft analytical reports for the MDPHHS.
- Act as liaison between MTDH staff and MDPHHS staff.

PHSD Chronic Disease & Health Promotion Bureau

- Prepare a state chronic disease plan that includes collaborative projects with MTDH.
- Identify six Montana communities (funded through the Healthy Homes grant) to conduct home visiting assessments. Group homes and/or small assisted living facilities will be included.
- Collaborate with MTDH to measure the effectiveness of a five-year CMS grant to provide incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in health risks and outcomes, including the adoption of healthy behaviors.

Developmental Services Division

- Provide surveillance and data on health-related issues that impact the lives of people with disabilities.
- Collaborate with MTDH to design modules for data-based decision making.

Objective 1B

By June 30, 2015, MTDH staff and partners will have successfully acquired at least \$300,000 of ongoing funding for implementation of this strategic plan. Opportunities to expand the program will be identified and incorporated into the plan as funding is secured.

Rationale

Because of increased populations of persons with disabilities, the MTDH Program must expand the capacity to meet its overall mission of improving the health and independence of people with disabilities.

Activities

MTDH: Meg Traci, PhD, PI, MTDH Program Director

- Continuously identify and pursue opportunities for collaboration
- Identify and apply for relevant competitive grants
- Seek support from private foundations, corporations and community partners.
- Develop two grant proposals focused on early intervention strategies targeted toward children with disabilities and submit to the National Institutes of Health (NIH) as well as other funders who may be interested in this work.

Outcome Goal Two: Support Direct Services and Programs

Increasing the availability of direct services and programs designed specifically for people with disabilities has been shown to improve health, prevent secondary conditions, and create greater consumer participation in health promotion activities.

MTDH Program staff has designed specific programs to fit the needs and strengths of people with disabilities including *Living Well with a Disability (LWD)* and *MENU-AIDDS*.⁹⁹ These programs are effective in improving participant health and well being and are slated for expansion over the next five years.

Objective 2A

By June 30, 2015, offer 10 nutritional health promotions/ programs/ events/ activities, at a variety of educational venues and through innovative dissemination routes, with relevant and appropriate information to at least 500 Montanans with disabilities, focusing on persons with intellectual and developmental disabilities and their supporters and health care teams.

Rationale

Adults with intellectual or developmental disabilities experience poorer nutritional health than the general population. In 2002, the U.S. Surgeon General declared improved nutrition (including the purpose of reducing obesity and improving chronic disease for this population) to be a national priority.

Dietary intake in community-dwelling adults with IDD is inadequate, with diets high in fat and empty calories and deficient in fruits and vegetables, whole grains, and dairy products. Such poor diets lead to the nutrition-related concerns that are so prevalent in this population, like weight problems (over- or underweight), bowel and gastrointestinal dysfunction, diabetes, nutrient deficits, cardiovascular disease, and osteoporosis.

Activities

⁹⁹ **M**aterials Supporting **E**ducation and **N**utrition for **A**dults with **I**ntellectual and **D**evelopmental **D**isabilities

MTDH:

- a) Continue to offer one MENU-AIDDs basic training in Montana per year.
 - b) Support current MENU-AIDDs users via booster trainings, online information and support material, and short webinars.

 - c) When possible, make the nutrition education and support materials applicable to Montanans of a variety of ages, individuals living in residential types other than community-based group homes, and persons with disabilities other than IDD.
- Integrate the MENU-AIDDs program evaluation into the statewide data monitoring systems, such as Therap.

Objective 2B

By June 30, 2015, provide: 12 facilitator training workshops for the *Living Well with a Disability (LWD)* Program, & 12 facilitator training workshops for the *Working Well with a Disability (WWD)* Program to increase the percentage of trained Montana facilitators by at least 5%.

Rationale

“Researchers at the *UMRI* and the *University of Kansas, Research and Training Center on Independent Living* developed the LWD program in collaboration with centers for independent living and their consumers. The program is the culmination of 20 years of research and program development aimed at reducing the severity and incidence of secondary conditions. Program evaluation indicates that LWD workshop graduates report less limitation from secondary conditions, fewer unhealthy days and less health care utilization. Ongoing research indicates that people with disabilities can manage and even prevent the negative effects of secondary conditions through health promotion activities (Ravesloot, et. al., 2007).¹⁰⁰

Findings also suggest that the people most affected by secondary conditions who actively participated in the *Working Well with a Disability* program experienced significant reductions in limitation from secondary conditions. Past studies indicate that higher rates of secondary conditions are associated with worse employment outcomes.¹⁰¹

Activities

MTDH /Craig Ravesloot, PhD, PI, Director, Rural Health Research

¹⁰⁰ [Living Well with a Disability](#)

¹⁰¹ [Findings from a Study of the Working Well with a Disability Program, Research Report 2010](#)

- Work with Vocational Rehabilitation to orchestrate consistent referrals and reimbursement for both LWD and WWD.
- Solicit feedback and ideas from CILs regarding the best ways to make LWD and WWD sustainable to steer activities.
- Increase outreach to and establish partnerships with American Indian reservations in Montana.
- Actively seek funding to develop LWD for youth.
- Connect WWD to Vocational Rehabilitation for youth.
- Promote LWD to Disability Student Services on college campuses by:
 - Including a self-management component in new student orientation,
 - Including all students, not just students with disabilities, and
 - Partnering with CILs to provide facilitators.
- Explore the possibility of LWD being incorporated into continuing education classes on college campuses while assuring the integrity of the program.
- Partner with County Extension Offices to make referrals to LWD and WWD Programs.
- Collect outcome data from specific sentinel sites and collect process evaluation data from other sites in the state to address need for both effectiveness data and impact data.
- Identify other evidence-based peer support programs.
- Develop and execute a survey to determine existing peer support groups for persons with disabilities living in Montana.
- Assess the need for peer support networks throughout Montana.
- Offer Peer Training, Peer Support Training and Peer Specialist Training through the LWD Program.
- Contact the VA hospital in Helena to identify viable peer support programs for amputees in Montana.
- Determine best practices for peer support networks.

“People with disabilities face many barriers to good health. Studies show that individuals with disabilities are more likely than people without disabilities to report:

- Poorer overall health,
- Less access to adequate health care,
- No access to health insurance,
- Skipping medical care because of cost, and

- Engaging in risky health behaviors, including smoking and lack of physical inactivity.”¹⁰²

Outcome Goal Three: Improve Access to Generic Services

“Today, about 57 million Americans are living with at least one disability, and most Americans will experience a disability some time during the course of their lives. Anyone can have a disability.”¹⁰³

“People with disabilities face many barriers to good health. Studies show that individuals with disabilities are more likely than people without disabilities to report:

- Poorer overall health,
- Less access to adequate health care,
- No access to health insurance,
- Skipping medical care because of cost, and
- Engaging in risky health behaviors, including smoking and lack of physical inactivity.”¹⁰⁴

Objective 3A

By June 30, 2015, enroll at least 2,000 Montana health care providers (public health professionals, physicians, nurses, mental health professionals, psychologists, etc.) who earn online and / or in-person continuing education credits that enhance the understanding of the competencies in disability awareness, cultural sensitivity, health care knowledge of conditions regarding people with disabilities, and the importance of accessible buildings and accessible medical equipment.

Activities

MTDH Staff

- Continue to provide training and technical assistance to the 46 Montana Community Health Centers (CHCs) and Rural Health Clinics (RHCs).

¹⁰² Ibid.

¹⁰³ [People with Disabilities: Living Healthy](#)

¹⁰⁴ Ibid.

- Continue to Increase CHC and RHC staff awareness of available resources and materials.
- Identify specific curricula that have been vetted and approved for continuing education credits for health care providers.
- Provide opportunities for health care providers to earn continuing education credits.
- In collaboration with local and national partners, identify resources and materials that assist health care facilities and providers in addressing accessibility barriers to receiving health care services.
- Work with Vocational Rehabilitation to orchestrate consistent referrals and reimbursement for both LWD and WWD.
- Solicit feedback and ideas from CILs regarding the best ways to make LWD and WWD sustainable to steer activities.
- Increase outreach to and establish partnerships with American Indian reservations in Montana.
- Increase awareness of accessible gymnasiums throughout the state.

Objective 3B

By June 30, 2015, the MTDH Accessibility Ambassadors will assist in developing and promoting at least four inclusive strategies to meet or exceed the ADA accessibility requirements to Montana community health centers and rural health clinics.

Activities

MTDH Staff:

- Host regular meetings of the Accessibility Ambassadors to gather their input on a number of accessibility issues.
- Evaluate current infrastructure capacity to identify and promote accessible health resources within the network.
- Work with MDPHHS to identify infrastructure and partners to improve accessibility.
- Promote funding opportunities for capital improvements and policy work.
- Investigate other states' policies about the use of state of the art technology (e.g., hearing aids).
- Continue to work with the Montana Builders Association.
- Call attention to unsafe or unacceptable practices.

Accessibility Ambassadors

- Provide input regarding:
 - Accessibility issues and ways to address those issues

- Customer-based services for persons with disabilities; and
- Strategies to eliminate barriers.

Outcome Goal Four: Improve Access to Community Environments

In 1990, Congress passed the Americans with Disabilities Act (ADA), prohibiting discrimination on the basis of disability and requiring places of public accommodation and commercial facilities to be designed, constructed, and altered in compliance with the accessibility standards established within the law. On September 15, 2010, revised regulations for Titles II and III of the ADA were published in the Federal Register.¹⁰⁵ Final rules were effective March 15, 2011.

These updated standards set minimum requirements for newly designed and constructed or altered State and local government facilities, public accommodations, and commercial facilities to be readily accessible to and usable by individuals with disabilities. Compliance with the [2010 Standards for Accessible Design](#) was required by March 15, 2012.

In addition to ADA requirements, a number of organizations have emerged to design and promote accessible communities by encouraging the use of Universal Design—the concept that “all new environments and products, to the greatest extent possible, should be usable by everyone regardless of their age, ability, or circumstance.”¹⁰⁶

National initiatives such as the *Public Health Preparedness Capabilities: National Standards for State and Local Planning* and the *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* recognize the importance of including experts knowledgeable about accessibility and inclusion for assuring safer, more resilient and better prepared communities.

Objective 4A

Through June 30, 2015, support the Emergency Preparedness (EP) Section of the Public Health and Safety Division of MTDPHHS and its partners (Montana Disaster and Emergency Services and Hospital Preparedness Program) to assure that Montanans with functional needs¹⁰⁷ are adequately represented in state and county Emergency Preparedness plans.

Rationale

¹⁰⁵ [Revised ADA Regulations Implementing Title II and Title III](#)

¹⁰⁶ [Center for Universal Design, an initiative of the College of Design at North Carolina State University \(NCSU\)](#),

¹⁰⁷ A function-based definition reflects the capabilities of the individual, not the condition, label or medical diagnosis.

“There are significant vulnerable populations in Montana who may need special assistance during times of emergency. According to 2010 US Census data, nearly 14.8% of the state's population is 65 years of age and over. Approximately 12.8% of Montana's civilian non-institutionalized residents have been identified as a person with a disability. About 4.6% of the state's population speaks a second language at home. According to the Institute for Tourism and Recreation Research at the University of Montana, roughly 10 million non-resident travelers, unfamiliar with local conditions and emergency response capabilities, visit Montana each year. All special needs populations represent a unique emergency planning and response challenge to both state and local government that must be met.”¹⁰⁸

Activities:

The Montana Department of Health and Human Services (MTDPHHS) acts as the lead State agency for what the National Response Framework calls (ESF) #8: Public Health & Medical Services as well as a supporting agency for ESF #6: Mass Care, Emergency Assistance, Housing, and Human Services. In this capacity, DPHHS will assist with coordinating the State's health, medic and human services assets in the event of a major natural or man-made disaster, including:

- Coordination of timely and appropriate support to individuals in need of *additional* assistance. These “Special Needs populations” may include those who:
 - Have disabilities or certain medical conditions
 - Live in institutional settings
 - Are elderly
 - Are from diverse cultures
 - Have limited English proficiency or are non-English speaking
 - Are minors
 - Do not have transportation¹⁰⁹
 - Assist local and tribal health jurisdictions to prepare for and respond to health emergencies, coordinate local surveillance and response systems, and keep Montana citizens informed of any public health related emergencies.¹¹⁰
- Coordination of human services to meet **non-housing** needs of victims, including:
 - Disaster case management and social services (Medicaid, Food Stamps, etc.)
 - Behavioral Health, and
 - Unmet needs assistance, as appropriate

Office of Public Health Emergency Preparedness and Training: Luke Fortune, Preparedness & Training Program Supervisor

- Assure that all Local and Tribal Health Department EP plans include ARSP, their caregivers, and service animals.

¹⁰⁸ Montana Emergency Response Framework (MERF), 2012;
http://montanadma.org/sites/default/files/MERF_2012_v1.2_0.pdf

¹⁰⁹ DPHHS Emergency Operations Plan, <http://www.dphhs.mt.gov/publichealth/phep/documents/dphhseop.pdf>

¹¹⁰ Public Health Emergency Preparedness, Dec., 2010, <http://www.dphhs.mt.gov/publichealth/phep/index.shtml>

- Partner with Montanan’s Area Agencies on Aging to address the needs and concerns of older Montanans at the local level.
- Develop tools and materials to assist local administrators in accomplishing deliverable goals.
- Identify and commit public health personnel for ARSP EP awareness training.
- Provide EP information to special, vulnerable, and at-risk populations, including people with disabilities and elders.
 - Collect information that: 1) identifies strengths, weaknesses and gaps in local community efforts; and 2) demonstrates local level accomplishments for ARSP.
- Assure that a description is included in all emergency response plans of how Local and Tribal Health Departments will serve ARSP in the event of an emergency.
- Assure that all Local and Tribal Health Department EP plans include ARSP, their caregivers, and service animals.
 - Collect information that: 1) identifies strengths, weaknesses, and gaps in EP efforts in local communities; and 2) demonstrates work already done at the local level for ARSP.
- Assure that a description is included in all emergency response plans of how Local and Tribal Health Departments will serve ARSP in the event of an emergency.
- Assure that all Local and Tribal Health Department EP plans include ARSP, their caregivers, and service animals.
- Collect information that: 1) identifies strengths, weaknesses, and gaps in EP efforts in local communities; and 2) demonstrates work already done at the local level for ARSP.
- Assure that a description is included in all emergency response plans of how Local and Tribal Health Departments will serve ARSP in the event of an emergency
- Assure that a description is included in all emergency response plans of how Local and Tribal Health Departments will serve ARSP in the event of an emergency.
- Assure that all Local and Tribal Health Department EP plans include ARSP, their caregivers, and service animals.

Local / Tribal Health Departments: County and Tribal Health Directors

ARSP-1: Training

- Identify / commit public health personnel for ARSP EP and awareness training.
- Select and attend a communications-related training.
- Promote the inclusion of PWD and their caregivers, attendants or other key people in emergency preparedness training and education exercises.

ARSP-2: Outreach

- Work with local organizations to: a) register with the Montana Volunteer Registry; and b) assist ARSP during a public health emergency.

- Maintain the list of community service organizations and contacts for ARSP with the jurisdiction.
- Identify and develop a collaborative partnership with the DPHHS Area Agency on Aging representative for the community, county or jurisdiction.

ARSP-3: Planning

- Provide a description of how the Local or Tribal Health Department will serve ARSP individuals in the event of a health emergency.
 - Integrate citizen participation in the planning process at all levels.
 - Develop and provide community preparedness public education programs and materials for ARSP.
 - Support community infrastructure to achieve appropriate levels of preparedness
 - Collaborate with local community service organizations and other agencies for ARSP within the jurisdiction.
 - Provide messaging, planning, vaccine distribution and protocols for accommodating ARSP through collaboration with identified community services.
 - Determine locations of ARSP who need assistance with evacuation from an affected area.

Red Cross of Montana: Rodd Kopp, Regional CEO, Montana

- Create a roster of all designated emergency shelters in Montana.
- Assess shelter capacity to meet the needs of PWD in accordance with ADA recommendations.

MTDH: Meg Traci, PhD, PI, MTDH Program Director

- Serve as a resource within the state by providing technical assistance (e.g. advise, consultation, presentations, tools, training, assessments and materials).
- Promote and provide trainings addressing the various needs of PWD in emergency situations to emergency responders and emergency shelter managers.
- Support Montana’s Emergency Support Function (ESF#8) partners to take a “Whole Communities” approach to prevent, protect against, respond to, mitigate, and rapidly recover from these threats¹¹¹ while attending to the needs of ARSP, defined as “those with critical functional health needs that are beyond their capability to maintain during an emergency.”¹¹²
- Periodically update the MTDH website on Emergency Preparedness¹¹³ and encourage people with disabilities and/or functional needs to access information on the website.

¹¹¹ [Public Health Preparedness Capabilities, National Standards for State and Local Planning](#)

¹¹² Montana Emergency Preparedness Plan for At-Risk/Special Populations, Version 2.3, Aug. 29,2008, [Preparedness for Functional Needs](#)

¹¹³ http://mtdh.ruralinstitute.umt.edu/?page_id=123

- Identify approaches for developing and disseminating tools to create an emergency preparedness plan to care providers of PWD.
- Identify approaches for developing and disseminating tools to create an emergency preparedness plan to care providers of PWD.
- Partner with the Montana Red Cross to assure that emergency shelters are accessible to persons with disabilities.
- Partner with existing networks to collect baseline data regarding the number of PWD who have an emergency plan and/or kit.
 - Create a personal support network or self-help team that can help identify needs and obtain necessary resources for meeting those needs during and after an emergency
- Increase awareness of state, county and tribal health departments of the importance of including people with disabilities and their caregivers, attendants or other key people in emergency preparedness exercise planning, training and education activities.
- Assure that local and tribal health departments include people with disabilities in emergency exercise planning and exercises.

Objective 4B:

By June 30, 2015, support Montana Independent Living Centers in assisting 150 people with disabilities to return from nursing homes, state institutional hospitals, and rehabilitation hospitals to community-based living.

Rationale

In 2008, the *UMRI Research and Training Center on Disability in Rural Communities* conducted a national survey of Centers for Independent Living (CILs) to provide baseline data regarding the status of CIL nursing home emancipation resources, issues, practices, and accomplishments. Nursing home emancipation or transition was defined as "...activities and services that directly assist individuals living in a nursing home to relocate successfully from a nursing home to community based living arrangements."

Overall, the data illustrate that centers for independent living are successfully helping people with disabilities return from nursing homes to community-based living. It is particularly noteworthy that only about 2% of those emancipated return to nursing homes for any reason.¹¹⁴

¹¹⁴ Seekins, T., Katz, M. R., & Ravesloot, C. (2008, March). Nursing home emancipation: Accomplishments of urban and rural centers for independent living. Rural Disability and Rehabilitation Research Progress Report #39. Missoula: The University of Montana Rural Institute.

Activities

MTDH: Meg Traci, PhD, PI, MTDH Program Director

- Collect and analyze CIL policies governing nursing home emancipation services.
- Explore the role of secondary conditions and other barriers in nursing home emancipation.
- Work with Vocational Rehabilitation Services to educate community employers about work life wellness strategies for persons with disabilities such as Health Plans for Employment.

Objective 4C

Through June 30, 2012, partner with the *Montana League of Cities and Towns* to increase accessibility in at least 20 towns and cities across the state.

Activities

MTDH: Tom Seekins, PhD, PI, Director, Rural Institute on Disabilities

- In 2012, prepare and distribute surveys for each of the 129 member municipalities to provide baseline information regarding accessibility for people with disabilities.
- Prepare written accessibility materials to be dispersed through the Montana League of Cities and Towns.
- Provide technical assistance regarding accessibility.
- In 2016, re-survey the member municipalities, determine progress, and publish the results.
- Identify and publish names of businesses and services that exemplify best practices.

Objective 4D

By June 30, 2015, the MTDH Program will expand the capacity of the Montana Association of Realtors (MAR), the Montana Building Industry Association (MBIA), and the Montana Home Choice Coalition (MHCC) to increase the number of visitable homes in Montana from 19.3% to 24% as measured by the Montana Behavioral Risk Factor Surveillance System (BRFSS).

Activities

MTDH: Meg Traci, PhD, PI, MTDH Program Director

- Partner with Montana CILs to provide visitability awareness trainings.

- Support the *AWARE Montana Home Choice Coalition* in creating accessible, community- integrated housing choices for persons with disabilities across the age and ability spectrum.
- Form recommendations to increase the proportion of visitable homes in the state.
- Continue to work with the Montana Building Industry Association to provide input regarding universal design and visitability.
- Provide input to the 5-year *Montana Housing Consolidation Plan* that addresses issues related to affordable housing, homelessness, infrastructure, public facilities, economic development, and other community development needs.
- Support the Statewide Independent Living Council (SILC) *Housing Task Force*.
- Collect, analyze and disseminate BRFSS data regarding the number of visitable homes in the state.
- Work with the Montana legislature to develop and evaluate a system of state tax incentives for building modifications to improve visitability.
- Encourage policy makers and licensing agencies to add visitability items to licensing tests for architects and builders.
- Remain active members of the *Task Force on Epidemiology, Surveillance, and Evaluation* to meet surveillance and evaluation needs specified in the cooperative agreement and MTDH State Plan.

Update the percentage of Montana’s private residences that are visitable (baseline of **19.3%** established in 2004 through a Montana BRFSS questionnaire). While results were similar for most sub-populations, people who were older or who reported using special equipment were more likely to report living in a visitable home. Respondents with a disability who reported living in a visitable home were less likely to report any days of poor mental health in the past month than those who did *not* live in a visitable house (Traci, Seekins, Oreskovich, & Cummings, 2007

Outcome Goal Five: Integrate Disability and Health Agenda

“Insufficient evidence exists regarding effectiveness of particular interventions in reducing specific disparities among certain defined populations. To fill this gap in evidence of programmatic effectiveness, the *Task Force on Community Preventive Services* recently embarked on a series of systematic reviews of interventions that might help reduce disparities. However, until more evidence of effectiveness is available, certain actions are prudent in support of efforts to reduce health disparities and their antecedents in the United States. Such actions include:

1. Increasing community awareness of disparities as problems with solutions;
 - Setting priorities among disparities to be addressed at the federal, state, tribal, and local levels;

- Articulating valid reasons to expend resources to reduce and ultimately eliminate priority disparities;
- Implementing dual strategy of universal and targeted intervention programs on the basis of lessons learned from success in reducing selected disparities (e.g., racial/ethnic disparities in measles vaccination coverage); and
- Aiming to achieve a faster rate of improvement among disadvantaged groups by allocating resources in proportion to need and a commitment to closing modifiable gaps in health, longevity, and quality of life among all segments of the U.S. population.”¹¹⁵

Objective 5A

By June 30, 2015, the MTDH program will assist MDPHHS in implementing 10 evidence-based and / or practice-based programs designed to improve health and wellness for people with disabilities.

Activities

MTDH: Meg Traci, PhD, PI, MTDH Program Director

- Recruit additional Disability Advisors to build the confidence to serve PWD and to exemplify/ encourage healthy lifestyles for PWD.
- Continue to monitor priority health issues in the state for *all* children and adults in Montana.
- Build competency of partners to deliver programs to persons with disabilities.
- Assess the accessibility of venues and resources provided through the program.

MDPHHS: Joanne Oreskovich, PhD, BRFSS Program Manager

- Provide quarterly BRFSS reports on priority health issues.
- In collaboration with MTDH staff, provide special reports on topics of particular concern.

¹¹⁵ Ibid. Conclusion, page 9.

Objective 5B

Through June 30, 2015, the MTDH Program, in partnership with the Chronic Disease Prevention and Health Promotion Bureau of MDPHHS, will continue to:

1. Inform people with disabilities (PWD) and the general public about risk factors for and symptoms of arthritis, diabetes, high blood pressure, high blood cholesterol, cardio-vascular disease, and asthma; and
2. Encourage *all* Montanans to adopt healthy behaviors including diet, exercise, social networks, and regular medical check-ups.

Activities

MTDH: Meg Traci, PhD, PI, MTDH Program Director

- Recruit additional Disability Advisors to build the confidence to serve PWD and to exemplify / encourage healthy lifestyles for. PWD.
- Continue to monitor priority health issues in the state for *all* children and adults in Montana.
- Build competency of partners to deliver programs to persons with disabilities.
- Assess the accessibility of venues and resources provided through the program.
- Partner with the Public Health and Safety Division Administrator and Bureau Chiefs to determine/delegate the appropriate staff person(s) to keep MDHP and others (e.g. federal agencies, other state agencies, the Veterans Administration, Indian Health Services, and Montana Centers for Independent Living) apprised of information and issues surrounding the aforementioned secondary conditions.
- Partner with other departments within the University of Montana to include disability and health information and materials within specific curricula in order to increase knowledge about people with disabilities, prevention of secondary conditions, and access to resources.
- Partner with the Montana Office of Public Instruction to include information about disability and health within high school health curricula.
- Host annual forums for state and national partners to identify best practices as well as priority issues, resolutions, and policies for people with disabilities.

MDPHHS: Joanne Oreskovich, PhD, BRFSS Program Manager

- Provide quarterly BRFSS reports on priority health issues.
- In collaboration with MTDH staff, provide special reports on topics of particular concern.

Objective 5C

Through June 30, 2015, the MTDH program will partner with the Addictive and Mental Disorders (AMDD) Division of MDPHHS to:

1. Inform people with disabilities (PWD) and the general public about risk factors for and symptoms of depression, anxiety, and other mental health disorders; and
2. Encourage *all* Montanans to adopt validated stress-reduction and emotional self-management techniques.

Activities

MTDH / Meg Traci, PhD, PI, MTDH Program Director

- Collaborate with stakeholders and partners to develop comprehensive mental health plans that enhance coordination of health care and the integration of mental health services and primary healthcare.
- Encourage primary care practitioners to incorporate the PHQ-8 module (used to assess depression and anxiety) into annual primary care physical exams.
- Incorporate mental health promotion into chronic disease prevention efforts.
- Incorporate mental health concerns into the treatment of other chronic diseases.
- Conduct health promotion campaigns that educate the public about the symptoms of depression and anxiety and the potential ways to treat these illnesses.
- Develop relationship with AMDD. Add a mental health professional to the Advisory Group.
- Recruit a person from the Veterans Administration (VA) to join the Advisory Group. Such as Lee Wilkinson, veterans services representative. He can be reached at 406-442-6410.
- Encourage adults with these disorders to seek treatment in order to prevent increased severity or progression of the illnesses.

Objective 5D

Through June 30, 2015, the MTDH Program will continue to collaborate with Core Management Team members to provide information and education regarding secondary condition prevention strategies and health resources available in Montana communities. Education will be targeted to at least 5,000 professionals, service providers, and people with disabilities.

Activities

MTDH Staff: Meg Traci, PhD, PI, MTDH Program Director

- Participate in long-term care conferences and present information regarding disability and health.
- Provide information and training to care givers and health professionals regarding disability and health.
- Keep professionals and the general public apprised of disability and health issues and effective prevention efforts.

Objective 5E

By June 30, 2015, increase by 10% the number of DPHHS Health Programs (Chronic Disease Prevention/Health Promotion and Child Health); Montana University System Wellness Programs; and local health jurisdictions healthy communities task forces/coalitions that have at least one Disability Advisor as a member.

Activities

MTDH and current Disability Advisors / Meg Traci, PhD, PI, MTDH Program Director

- Work with additional state agencies, private non-profit groups and University programs to identify additional opportunities for Disability Advisors.
- Recruit and train additional Disability Advisors, including high school and college-age youth.
- Evaluate the effectiveness of this approach and identify improvements that can be made.
- Incorporate a Youth Leadership forum. (Check with June Hermanson, Bob Maffet or Deborah Swingley at the Montana Disability Council.)
 - Go back to Friday meetings (do a doodle poll).