

# Introduction (2014 Strategic Plan)

## *The Big Picture*

“Disability has been defined in many ways. In general, a disability is a feature of the body, mind, or senses that can affect a person’s daily life. Some people are born with a disability. Some people get hurt or sick and have a disability as a result. Some people develop a disability as they age. Some people have a disability that lasts a short time. Other people have a disability that lasts a lifetime. “More than 50 million Americans (1 in 6 individuals), report having a disability. As the nation’s population ages, these numbers are expected to grow.”<sup>1</sup>

Adults with disabilities face challenges in:

- **Employment:** Half as many adults with disabilities are employed as those without disabilities (35% versus 78%).
- **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%).<sup>2</sup>

The 2005 Surgeon General’s Call to Action<sup>3</sup> 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.

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-

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<sup>1</sup> <http://www.cdc.gov/ncbddd/disabilityandhealth/pdf/aboutdhprogram508.pdf>

<sup>2</sup> 2004 Nationwide Harris Survey

<sup>3</sup> <http://archive.hhs.gov/news/press/2005pres/20050726.html>

institutionalized population over the age of 5 years) had a disability. According to Behavioral most recent estimates, 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 1: Disability Prevalence and the Need for Assistance by Age: 2010 National Estimates<sup>4</sup>**

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

### **Affordable Care Act (ACA) Update<sup>1</sup>**

The Affordable Care Act is providing better options, better value, better health, and a stronger Medicare program to the people of Montana by offering better options. Through the Health Insurance Marketplace, Montanans can compare qualified health plans, get answers to questions, find out if they are eligible for lower costs for private insurance or health programs like Medicaid and the Children’s Health Insurance Program (CHIP), and enroll in health coverage.

At the end of the first annual open enrollment period, enrollment in the Marketplace surged to eight million people nationwide. In Montana alone, 36,584 individuals selected a Marketplace plan between October 1, 2013 and March 31, 2014 (including additional special enrollment period activity through April 19, 2014).

Of the 36,584 Montanans who selected a plan:

- 53% are female and 47% are male;
- 34% are under age 35;
- 28% are between the ages of 18 and 34;

<sup>4</sup> Source: U.S. Census Bureau, Survey of Income and Program Participation, May–August 2010.

- 56% selected a Silver plan, while 27% selected a Bronze plan; and,
- 86% selected a plan with financial assistance.

Although open enrollment for 2014 coverage is over, the next open enrollment period begins on November 15, 2014 for coverage that can begin as early as January 1, 2015.

Montana has received \$1,000,000 in grants for research, planning, information technology development, and implementation of its Marketplace.

### ***Medicaid***

Enrollment in Medicaid and CHIP is open year round. An additional 14,132 Montanans enrolled in Medicaid and CHIP through the end of March 2014. Twenty-six states and Washington, D.C. have expanded Medicaid so far, with the federal government providing 100 percent of the funds for the newly eligible population for the next three years, and never less than 90 percent after that. Montana has not taken advantage of the new opportunity to expand Medicaid coverage under the Affordable Care Act.

### ***Mental Health***

The Affordable Care Act increases access to comprehensive coverage by requiring most health plans to cover ten essential health benefit categories, to include hospitalization, prescription drugs, maternity and newborn care, and mental health and substance use disorder services. The health care law expands mental health and substance use disorder benefits and federal parity protections for 62 million Americans nationwide, including 251,912 Montanans.

### ***New coverage options for young adults***

Under the health care law, if your plan covers children, you can now add or keep your children on your health insurance policy until they turn 26 years old. Thanks to this provision, over 3 million young people who would otherwise have been uninsured have gained coverage nationwide, including 12,000 young adults in Montana.

### ***Ending discrimination for pre-existing conditions***

As many as 426,361 non-elderly Montanans have some type of pre-existing health condition, including 52,222 children. Today, most insurers can no longer deny coverage to anyone because of a pre-existing condition, like asthma or diabetes, under the health care law. And they can no longer charge women more because of their gender.

### ***Providing better value for your premium dollar through the 80/20 Rule<sup>5</sup>***

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<http://montana.gov/search.mcpx?q=Number%20of%20Montanans%20enrolled%20in%20Medicaid%20Program&via=homepage&cx=013380590290877010950%3A3ubczas3i44&cof=FORID%3A11&ie=UTF-8>

## ***Olmstead Plan***<sup>6</sup>

Olmstead is used here to describe the 1999 Supreme Court judgment in the case of *Olmstead v. L.C.* (US Supreme Court 1999). The case was brought against the Georgia State Commissioner of Human Resources (Tommy Olmstead) on behalf of two women with developmental disabilities (known as L.C. and E.W.) who were diagnosed with mental illness (schizophrenia and personality disorder respectively). They were voluntarily admitted to Georgia Regional Hospital for treatment in a psychiatric unit (Atlanta Legal Aid Society 2004). After some time, they indicated their preference for discharge and the professionals working with them assessed that they were ready to move into a community setting with appropriate support.

However, they were not successfully discharged from the hospital and in 1995 the Atlanta Legal Aid Society brought forth the lawsuit that was eventually heard by the Supreme Court. The Supreme Court ruled that under Title II of the Americans with Disabilities Act (ADA, 1990) the women had the right to receive care in the most integrated setting appropriate and that their unnecessary institutionalization was discriminatory and violated the ADA.

The Olmstead ruling provides an important clarification about how states should comply with Title II of the ADA. The ADA applies to all public bodies and to the use of public funds and therefore has implications for publicly-funded Medicaid services to people with disabilities (Rosenbaum and Teitelbaum 2004). The Olmstead decision confirmed that states must ensure that Medicaid-eligible persons do not experience discrimination by being institutionalized when they could be served in a more integrated (community) setting (Rosenbaum and Teitelbaum 2004). This obligation is sometimes known as the ADA 'integration mandate'.

The Supreme Court made limited recommendations for how states might ensure compliance with the ADA in light of Olmstead. The Court indicated that states should make 'reasonable accommodations' to their long-term care systems, but should not be required to make 'fundamental alterations'. It suggested that compliance might be demonstrated by 'comprehensive, effectively working plans' (Olmstead Plans) to increase community-based services and reduce institutionalization, and by ensuring that waiting lists for services move at a 'reasonable pace' (Smith and Calandrillo 2001). An analysis of rulings in community integration lawsuits after Olmstead has shown that lower courts have generally decided that "evidence of active engagement and slow progress" towards more community-integrated long-term care satisfies the ADA (Rosenbaum and Teitelbaum 2004).

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<sup>6</sup> [http://pascenter.org/state\\_based\\_stats/olmstead/olmstead\\_home.php?state=montana](http://pascenter.org/state_based_stats/olmstead/olmstead_home.php?state=montana) (updated May, 2013)

## ***Money Follows the Person: Expanding Options for Long-Term Care<sup>7</sup>***

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 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, Mathematica has supported CMS 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. Mathematica is 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.

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<sup>7</sup> Mathematica Policy Research, <http://www.mathematica-mpr.com/health/moneyfollowsperson.asp>

## ***Basic Features of the MFP Program<sup>8</sup>***

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

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<sup>8</sup> Money Follows the Person 2012 Annual Report, page 1

[http://www.mathematica-mpr.com/publications/pdfs/health/MFP\\_2012\\_Annual.pdf](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.

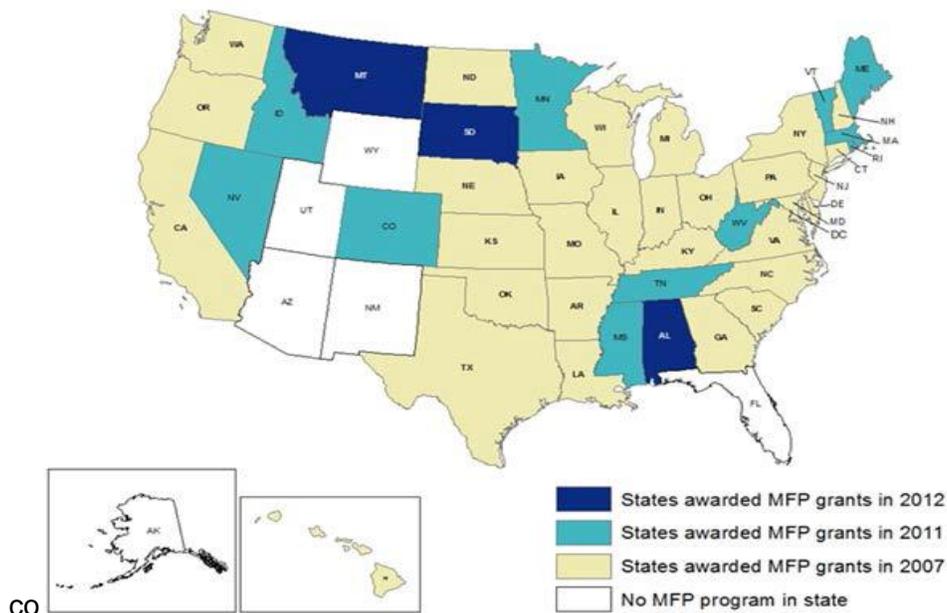
Qualified HCBS are services that beneficiaries would have received regardless of their status as MFP participants, such as personal assistance services available through a 1915(c) waiver program or the state plan.

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.



## **Montana Medicaid** <sup>9</sup>

Medicaid is health care coverage for some low-income Montanans administered by the Montana Department of Public Health and Human Services (DPHHS).

To be eligible for Medicaid in Montana, you must meet income and resource limits. You must also fit into at least one of these groups:

- Families with dependent children
- Pregnant women
- Children and youth up to age 19
- Women with breast or cervical cancer or pre-cancer
- People 65 and over
- People who are disabled (based on Social Security standards)
- Former foster care children age 18 up to 26

**The Healthy Montana Kids Plan** is the program name for two health care coverage groups for children. It is a free or low-cost health coverage plan for eligible Montana children up to age 19. Healthy Montana Kids Plan groups are:

**1. Healthy Montana Kids Plus** coverage group (formerly Montana Medicaid)

In 1965, Congress created the medical assistance program for low-income people, known as Medicaid. This program pays the medical bills of people who meet certain income-based criteria, with the federal government and state governments sharing the costs.

**2. An average of 81,600 Montanans** were enrolled in Montana's Medicaid program each month in state fiscal year (SFY) 2009, the most recent year for which full enrollment and spending figures are available. About 60% were children. Federal and state spending on medical benefits totaled about \$844 million that year. In May of 2011, enrollment in the Montana Medicaid program had increased to **104,600** Montana recipients.

Over the years, Montana has generally chosen to keep Medicaid eligibility guidelines in sync with or lower than those required by federal law and has rarely expanded the Medicaid program to cover additional people. The state provides Medicaid coverage to able-bodied adults *only* if the adults have dependent children and a very limited income.

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<sup>9</sup> <http://www.dphhs.mt.gov/medicaid/>

## Table 2: Medicaid Income Eligibility Limits for Adults at Application by State<sup>10</sup>

Three areas had eligibility limits over 200% of poverty:

- 1) The **District of Columbia's** eligibility limit is **221%** of poverty;
- 2) **Minnesota's** eligibility limit is **205%** of poverty; and
- 3) **Connecticut's** eligibility limit is **201%** of poverty.

Twenty-four states have eligibility limits of **138%** of poverty (Arizona, Arkansas, California, Colorado, Delaware, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington, and West Virginia).

Four states have eligibility limits between **134%** and **100%** of poverty:

- 1) **Alaska:** 134%
- 2) **Tennessee:** 110%
- 3) **Maine:** 105% and
- 4) **Wisconsin:** 100%.

Five states have eligibility limits between **74%** and **61%** of poverty:

- 1) **New Hampshire:** 74%;
- 2) **South Carolina:** 67%;
- 3) **South Dakota:** 63%;
- 4) **Nebraska:** 62%; and
- 5) **Wyoming:** 61%.

Four states have eligibility limits between **56%** and **50%** of poverty:

- 1) **Utah:** 56%;
- 2) **Virginia:** 54%;
- 3) **Montana:** 52%; and
- 4) **North Carolina:** 50%.

Eleven states have eligibility limits below 50% of poverty:

- 1) **Oklahoma:** 47%;
- 2) **Georgia:** 40%;
- 3) **Kansas:** 38%;
- 4) **Pennsylvania:** 38%;
- 5) **Florida:** 35%;
- 6) **Idaho:** 29%;
- 7) **Mississippi:** 28%;
- 8) **Indiana:** 25%;
- 9) **Louisiana:** 24%;
- 10) **Missouri:** 23%; and
- 11) **Texas:** 20% of poverty.

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<sup>10</sup> <http://kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-adults-at-application-as-of-april-1-2014/>

## **Montana's Economy<sup>11</sup>**

Montana's seasonally-adjusted unemployment rate for April 2014 dropped to 4.8% from March's rate of 5.1%. The national unemployment rate also decreased significantly since March, moving to 6.3% from 6.7% over the month.

Montana's seasonally-adjusted, non-agricultural payroll employment decreased by **500 jobs** or **10.1%** over the month, for a total of 453,000 in April 2014. The largest loss occurred in the Leisure and Hospitality sector, with 1,100 fewer jobs (**11.8%**).

Industries showing gains included:

- Construction: 300 new jobs (+1.3%)
- Education and Health Services: also added 300 new jobs (+0.4%)

## **U. S. and Montana Poverty 2000 and 2012**

According to the 2000 American Community Survey, about **33.3 million** people or **12.2** percent of the U.S. population had income below their respective poverty level. In 2012, the number of people in poverty increased to about **48.8 million** people or **15.9** percent.

Poverty rates ranged from a low of **5.3 percent** in New Hampshire to a high of **20.0 percent** in Louisiana. Among the 50 states and the District of Columbia, 17 states had poverty rates lower than 11 percent, while only 4 states and the District of Columbia had poverty rates of 16 percent or higher.

Area	Below poverty in 2000	Below poverty in 2012	Change in poverty (2012 less 2000)
<b>United States</b>	<b>33,311,473</b>	<b>48,760,123</b>	<b>15,448,650</b>
<b>Montana</b>	<b>117,262</b>	<b>152,199</b>	<b>34,937</b>

## **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).<sup>12</sup>

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

<sup>11</sup> [http://www.ourfactyourfuture.org/admin/uploadedPublications/5559\\_eag-0414.pdf](http://www.ourfactyourfuture.org/admin/uploadedPublications/5559_eag-0414.pdf)

<sup>12</sup> [http://www.census.gov/newsroom/releases/archives/american\\_community\\_survey\\_acs/cb13-29.html](http://www.census.gov/newsroom/releases/archives/american_community_survey_acs/cb13-29.html)

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.<sup>13</sup>

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 education.

### ***U.S. 65 and over Population***<sup>14</sup>

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 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

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<sup>13</sup> Ibid.

<sup>14</sup> <http://www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf>

## ***The State of Aging and Health in America 2013<sup>15</sup>***

“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 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.

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<sup>15</sup> <http://www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf>

**Table 3: Life Expectancy at birth, at age 65, and at age 75, by Sex<sup>16</sup>**

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

### ***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 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 Disabilities<sup>17</sup>***

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.

#### ***Be Informed***

- Gather information about your family member's condition, and discuss issues with others involved in the care of your family member. Being informed will help you make more knowledgeable health decisions and improve your understanding about any challenges your family might face.

<sup>16</sup> <http://www.cdc.gov/nchs/data/hus/13.pdf#018>

<sup>17</sup> <http://www.cdc.gov/ncbddd/disabilityandhealth/family.html>

- Notice how others care for the person with special needs. Be aware of signs of mental or physical abuse.

### ***Get Support***

- Family members and friends can provide support in a variety of ways and oftentimes want to help. Determine if there are big or small things they can do to assist you and your family.
- Join a local or online support group. A support group can give you the chance to share information and connect with people who are going through similar experiences. A support group may help combat the isolation and fear you may experience as a caregiver.
- Don't limit your involvement to support groups and associations that focus on a particular need or disability. There are also local and national groups that provide services, recreation, and information for people with disabilities.
- Friends, family, health care providers, support groups, community services, and counselors are just a few of the people available to help you and your family.

### ***Be an Advocate***

- Be an advocate for your family member with a disability. Caregivers who are effective advocates may be more successful at getting better service.
- Ask questions. For example, if your family member with a disability uses a wheelchair and you want to plan a beach vacation, find out if the beaches are accessible via a car, ramp, portable walkway mat, or other equipment. Inform other caregivers of any special conditions or circumstances. For example, if your family member with a disability has a latex allergy, remind dental or medical staff each time you visit them.
- Document the medical history of your family member with a disability, and keep this information current.
- Make sure your employer understands your circumstances and limitations. Discuss your ability to travel or to work weekends or evenings. Arrange for flexible scheduling when needed.
- Become familiar with the Americans with Disabilities Act, the Family Medical Leave Act, and other state and national provisions. Know how and when to apply them to your situation.

### ***Be Empowering***

- Focus on what you and your family member with a disability *can* do.
- Find appropriate milestones and celebrate them.
- If someone asks you questions about the family member with a disability, let him or her answer when possible. Doing so may help empower the individual to engage with others.
- When appropriate, teach your family member with a disability to be as independent and self-assured as possible. Always keep health and safety issues in mind.

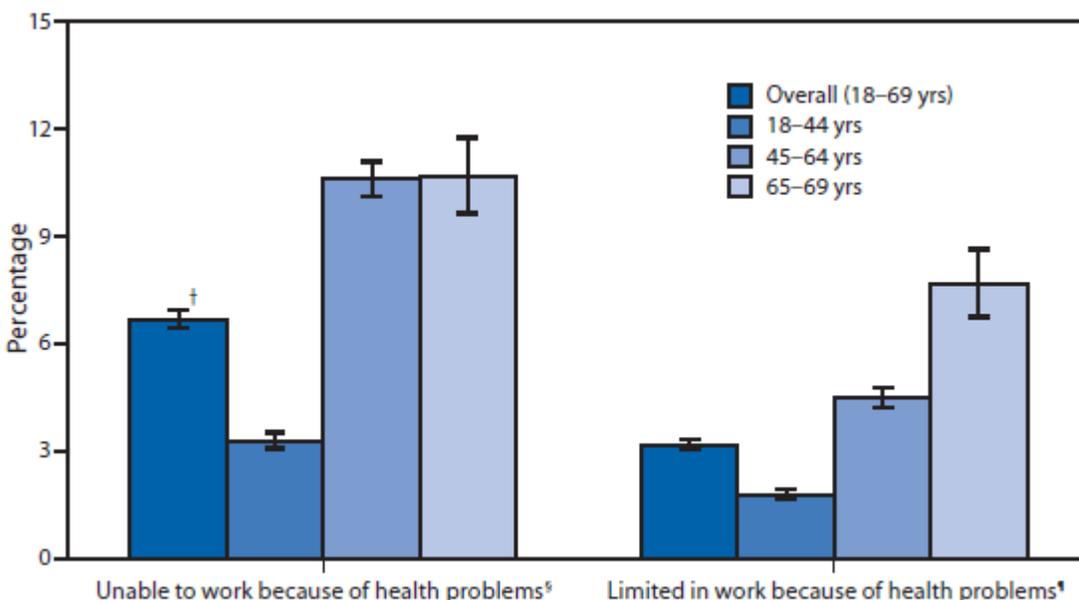
### ***Take Care of Yourself***

- Caring for a family member with a disability can wear out even the strongest caregiver. Stay healthy for yourself and those you care for.
  - Allow yourself not to be the perfect caregiver. Set reasonable expectations to lower stress and make you a more effective caregiver.
  - Delegate some care-giving tasks to other reliable people.
  - Take a break. Short breaks, like an evening walk or relaxing bath, are essential. Long breaks are nurturing.
  - Arrange a retreat with friends or get away with a significant other when appropriate.
  - Don't ignore signs of illness: if you get sick, see a health care provider.
- Pay attention to your mental and emotional health as well. Remember, taking good care of yourself can help the person you care for as well. Exercising and eating healthy also are important.

### ***Keep Balance in the Family***

- Family members with a disability may require extra care and attention. Take time for all family members, taking into account the needs of each individual. For example, it's important for parents of a child with a disability to also spend time with each other and with any other children they might have.
- Consider respite care. "Respite" refers to short-term, temporary care provided to people with disabilities so that their families can take a break from the daily routine of care-giving.

**Table 4: Percentage of Adults Aged 18–69 Years with a Limitation in Their Ability to Work Because of Health Problems, by Age Group<sup>18</sup>**



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  $\geq 18$  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  $\geq 18$  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.

<sup>18</sup> 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 Disabilities<sup>19</sup>***

”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.

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<sup>19</sup> Congressional Budget Office, Supplemental Security Income, and Overview, <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43759-SupplementalSecurity.pdf>

## Adults Age 65 or Older

“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 2020 Disability and Health Objectives<sup>20</sup>

<b>DH-1</b>	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.
<b>DH-2</b>	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.
<b>DH-3</b>	(Developmental) Increase the proportion of US master of Public Health (MPH) programs that offer graduate-level courses in disability and health.
<b>DH-4</b>	(Developmental) Reduce the proportion of people with disabilities who report delays in receiving primary and periodic preventive care due to specific barriers.
<b>DH-5</b>	Increase the proportion of youth with special health care needs whose health care provider has discussed transition planning for pediatric to adult health care.
<b>DH-6</b>	(Developmental) Increase the proportion of people with epilepsy and uncontrolled seizures who receive appropriate medical care.
<b>DH-7</b>	(Developmental) Reduce the proportion of older adults with disabilities who use inappropriate medications.
<b>DH-8</b>	(Developmental) Reduce the proportion of people with disabilities who report physical or program barriers to local health and wellness programs.
<b>DH-9</b>	(Developmental) Reduce the proportion of people with disabilities who encounter barriers to participating in home, school, work, or community activities.
<b>DH-10</b>	(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.
<b>DH-11</b>	Increase the proportion of newly constructed and retrofitted U.S. homes and residential buildings that have visitable features.
<b>DH-12</b>	Reduce the number of people with disabilities living in congregate care residences.
<b>DH-13</b>	(Developmental) Increase the proportion of PWD) who participate in social, spiritual recreational, community and civic activities to the degree that they wish.

<sup>20</sup> <http://healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicid=9>

<b>DH-14</b>	Increase the proportion of children and youth with disabilities who spend at least 80% of their time in regular education programs.
<b>DH-15</b>	Reduce unemployment among PWD.
<b>DH-16</b>	Increase employment among PWD.
<b>DH-17</b>	Increase the proportion of adults with disabilities who report sufficient social and emotional support.
<b>DH-18</b>	(Developmental) Reduce the proportion of PWD who report serious psychological distress.
<b>DH-19</b>	(Developmental) Reduce the proportion of PWD who experience nonfatal unintentional injuries that require medical care.
<b>DH-20</b>	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%).<sup>21</sup>
- 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.<sup>22</sup>

“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

<sup>21</sup> Civil Rights Data Collection (CRDC), Department of Education, Office for Civil Rights, <http://www2.ed.gov/about/offices/list/ocr/data.html>

<sup>22</sup> 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>

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.”<sup>23</sup>

## ***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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<sup>23</sup> 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](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.<sup>24</sup>

### *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."<sup>25</sup>

"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."<sup>26</sup>

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<sup>24</sup> 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

<sup>25</sup> <http://www.annualreviews.org/doi/abs/10.1146/annurev.publhealth.26.021304.144505?journalCode=publhealth>

<sup>26</sup> <http://www.opi.mt.gov/pdf/speced/sedata/09ChildCountData.pdf>

## Children's Special Health Services

"Children's Special Health Services (CSHS),<sup>27</sup> 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.
- 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.<sup>28</sup> 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

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<sup>27</sup> <http://www.dphhs.mt.gov/publichealth/cshs/fundingandgoals.shtml>

<sup>28</sup> Montana's Expanded Newborn Screening: [www.mt.gov](http://www.mt.gov)

also require health and related services of a type or amount beyond that required by children generally.”<sup>29</sup>

“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.”<sup>30</sup>

The *National Survey of Children with Special Health Care Needs* 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 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.<sup>31</sup>

**Table 5: Estimated Number of CSHCN in Montana<sup>32</sup>**

<i>Estimated Number of CSHCN in 2007:</i>	<i>Estimated Number of non-CSHCN in 2007:</i>	
<b>40,975</b>	<b>186,991</b>	
<i>Estimated Number of CSHCN in 2014:</i>	<i>Estimated Number of non-CSHCN in 2014:</i>	

<b>Child Population</b>	<b>Montana</b>	<b>US</b>
Number of children	231,600	78,170,600
Children as a percentage of the total population	23%	25%

Source: Kaiser Family Foundation (2012)

<b>Race/Ethnicity</b>	<b>Montana</b>	<b>US</b>
Percentage of children, by race/ethnicity		
White alone	80.3%	53.5%
Black/African American alone	0.5%	14.0%
Hispanic/Latino alone	5.0%	26.9%
American Indian/Alaska Native alone	9.4%	0.9%
Asian alone	0.6%	4.3%

<sup>29</sup> 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.

<sup>30</sup> <http://altarum.cvent.com/events/dataspeak-registration/event-summary-5041e07bfce543eb9e1f405f9ad19a2e.aspx>

<sup>31</sup> Data Resource Center for Child and Adolescent Health (DRC) <http://childhealthdata.org/browse/survey?s=2>

<sup>32</sup> Children with Special Health Care Needs in Context: A Portrait of States and the Nation 2007, <http://mchb.hrsa.gov/nsch/07cshcn/index.html>

Native Hawaiian/Other Pacific Islander alone	0.1%	0.2%
Another race/ethnicity alone	0.1%	0.3%
2 or more races/ethnicities	4.2%	3.8%

Source: U.S. Census Bureau (2010)

Household	Montana	US
Among households with children, percentage of households with one, two, or three or more adults		
1 adult	16.0%	14.9 %
2 adults	67.7%	63.4 %
3 or more adults	16.3%	21.7%

Source: National Survey of Children with Special Health Care Needs (2009-2010)

Urban/Rural	Montana	US
Percentage of population living in urban areas	34%	84%

Source: Kaiser Family Foundation (2012)

Special Health Care Needs	Montana	US
Percentage of children who have special health care needs	14.0%	15.1%

Source: National Survey of Children with Special Health Care Needs (2009-2010)

Percentage of children with reported special health care needs, by age group		
0-5	7.6%	9.3%
6-11	15.9%	17.7%
12-17	18.2%	18.4%

Source: National Survey of Children with Special Health Care Needs (2009-2010)

Percentage of households with one or more children with special health care needs	20.9%	23.0%
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Source: National Survey of Children with Special Health Care Needs (2009-2010)

Low Birth Weight	Montana	US
Percentage of live births that are low birth weight	7.1%	8.2%

Source: U.S. Dept. of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (2012)

Special Education	Montana	US
Percentage of public school students enrolled in Special Education	12.1	13.1

Source: U.S. Dept. of Education (2011)

## ECONOMICS

Income	Montana	US
Median annual household income	\$41,753	\$50,443

Source: Kaiser Family Foundation (2009-2011)

Percentage of children in families with income below 200% of the federal poverty level	45.8%	42.4%
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Source: National Survey of Children with Special Health Care Needs (2009-2010)

Percentage of CSHCN in families with income below 200% of the federal poverty level	51.6%	44.3%
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Source: National Survey of Children with Special Health Care Needs (2009-2010)

Unemployment	Montana	US
Unemployment rate	5.2%	7.3%

Source: Kaiser Family Foundation (2013)

<b>Financial Impact of Caregiving</b>	<b>Montana</b>	<b>US</b>
Percentage of families who report they have reduced work hours or stopped working to care for their CYSHCN	23.1%	25.0%

Source: National Survey of Children with Special Health Care Needs (2009-2010)

<b>Employer Size</b>	<b>Montana</b>	<b>US</b>
Distribution of employers, by number of employees		
<20	89.4%	89.8%
20-99	6.4%	8.5%
100+	4.2%	1.7%

Source: U.S. Census Bureau (2011)

<b>Employer-Sponsored Health Insurance</b>	<b>Montana</b>	<b>US</b>
Percentage of private sector employers offering health insurance	39.0%	50.1%

Source: Kaiser Family Foundation (2012)

Percentage of private sector employers offering health insurance, by number of employees		
<50	28.6%	35.2%
50+	95.6%	95.9%

Source: Kaiser Family Foundation (2012)

<b>Medicaid Eligibility</b>	<b>Montana</b>	<b>US</b>
Maximum allowed income for Medicaid enrollment, as a percentage of the federal poverty level, compared to the federal minimum requirement		
Pregnant women	164%	Required minimum: 185%
Children, aged 0-1	164%	Required minimum: 133%
Children, aged 1-5	148%	Required minimum: 133%
Children, aged 6-18	148%	Required minimum: 133%

Source: Kaiser Family Foundation (2013)

<b>Federal Match for Medicaid</b>	<b>Montana</b>	<b>US</b>
Federal Medical Assistance Percentage (FMAP)	66.00%	50.00%

Source: Kaiser Family Foundation (2013)

<b>Education Expenditures</b>	<b>Montana</b>	<b>US</b>
Combined local, state and federal per pupil education expenditures	\$10,986	\$11,339

Source: U.S. Dept. of Education (2011)

Federal per pupil IDEA expenditures for children aged 3-21 in Special Education	\$2,146	\$1,774
Source: U.S. Dept. of Education, Office of Special Education and Rehabilitative Services (2010)		

## CHILD HEALTH SERVICES

Health Care	Montana	US
Number of children's hospitals	0	234

Source: National Association of Children's Hospitals and Related Institutions

Number of pediatricians per 1,000 children	0.69	1.05
Source: American Board of Medical Specialties (2012)		

Number of family practitioners	440	82,387
Source: American Board of Medical Specialties (2012)		

Number of child and adolescent psychiatrists per 1,000 children	0.06	0.06
Source: American Board of Medical Specialties (2012)		

Early Intervention Eligibility	Montana	US
Eligibility for Early Intervention services includes infants and toddlers "at risk" of developmental delay	No	Yes=6

Source: Early Childhood Technical Assistance Center (2012)

Mental Health	Montana	US
Number of children served by state mental health authority, per 1,000 children		
Aged 0-12	54.6	21.4
Aged 13-17	75.5	41.2
Aged 18-20	38.6	26.0

Source: SAMHSA National Mental Health Information Center (2012)

Percentage of CSHCN with emotional, behavioral or developmental issues whose families have adequate private and/or public insurance to pay for the services they need	62.6%	65.7%
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Source: National Survey of Children with Special Health Care Needs (2009-2010)

Oral Health	Montana	US
Percentage of children receiving preventive dental care in the past year	76.6%	77.2%

Source: National Survey of Children's Health (2011-2012)

Percentage of CSHCN receiving preventive dental care in the past year	82.2%	83.1%
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Source: National Survey of Children's Health (2011-2012)

Percentage of children with teeth in excellent or very good condition	72.9%	71.3%
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Source: National Survey of Children's Health (2011-2012)

Percentage of CSHCN with teeth in excellent or very good condition	63.3%	64.9%
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Source: National Survey of Children's Health (2011-2012)

Foster Care	Montana	US
Number of children in foster care	1,937	397,122

Source: U.S. Dept. of Health and Human Services, Administration for Children and Families, Children's Bureau (2013)

Percentage of children in foster care	0.8%	0.5%
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Source: U.S. Dept. of Health and Human Services, Administration for Children and Families, Children's Bureau (2013)

<b>FACTORS INFLUENCING HEALTH INSURANCE COVERAGE</b>		
<b>Uninsured</b>	<b>Montana</b>	<b>US</b>
Percentage of children without health insurance at some point in the past year	15.9%	11.3%

Source: National Survey of Children's Health (2011-2012)

Percentage of CYSHCN without health insurance at some point in the past year	16.1%	9.3%
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Source: National Survey of Children with Special Health Care Needs (2009-2010)

<b>Underinsured</b>	<b>Montana</b>	<b>US</b>
Percentage of children with inadequate health care coverage	24.7%	23.5%

Source: National Survey of Children's Health (2011-2012)

Percentage of CYSHCN with inadequate health care coverage	37.4%	34.3%
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Source: National Survey of Children with Special Health Care Needs (2009-2010)

**Tip:** Relatively few CYSHCN lack insurance completely. However, private coverage is often too limited to meet their health needs. Thus, in many states, underinsurance is the major financial barrier to health care access for CYSHCN.

<b>Private Insurance Coverage</b>	<b>Montana</b>	<b>US</b>
Percentage of children with private health insurance coverage	56.8%	57.4%

Source: National Survey of Children's Health (2011-2012)

Percentage of CYSHCN with private health insurance coverage	48.0%	52.4%
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Source: National Survey of Children with Special Health Care Needs (2009-2010)

<b>Public Coverage: Medicaid, CHIP and SSI</b>	<b>Montana</b>	<b>US</b>
Number of children enrolled in Medicaid	63,628	30,746,220
Percentage of Medicaid enrollees who are children	55%	49%

Source: Kaiser Family Foundation (2012)

Percentage of children enrolled in Medicaid or CHIP	34.6%	37.1%
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Source: National Survey of Children's Health (2011-2012)

Percentage of CYSHCN enrolled in Medicaid or CHIP	38.0%	35.9%
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Source: National Survey of Children with Special Health Care Needs (2009-2010)

Maximum allowed income for CHIP eligibility as a percentage of the FPL	266%	N/A
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Source: Kaiser Family Foundation (2013)

Number of children enrolled in CHIP	28,570	8,148,397
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Source: Kaiser Family Foundation (2012)

Percentage of children enrolled in CHIP	12.3%	10.4%
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Source: Kaiser Family Foundation (2012)

Number of children enrolled in Supplemental Security Income (SSI)	2,568	1,277,122
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Source: Kaiser Family Foundation (2011)

Percentage of children enrolled in Supplemental Security Income (SSI)	1.2%	1.7%
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Source: Kaiser Family Foundation (2011) and U.S. Census Bureau (2010)

TEFRA Medicaid state plan option/Katie Beckett waiver for children	No	Yes=23
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Source: American Journal of Law and Medicine (2011)

Premium Assistance Programs Source: U.S. Department of Labor, Employee Benefits Security Administration (2014)	Yes	Yes=38
<b>Dual Public and Private Coverage</b>	<b>Montana</b>	<b>US</b>
		8.2%

Tip: Dual coverage is an option in states which permit privately insured families to enroll their children in Medicaid in order to receive supplemental coverage, sometimes known as "wrap-around" coverage. This type of secondary Medicaid enrollment may be offered free or through the payment of premiums based on a sliding scale. Dual coverage helps address underinsurance, which is a significant problem for many privately insured CYSHCN whose coverage is too limited to meet their health needs.

Health Care Reform	Montana	US
Exchange overview		
Exchange decision	Fed run	State run=17; State/fed partnership =7; Fed run=27
Type of exchange Source: Kaiser Family Foundation (2014)  Tip: The term Health Insurance "Exchange" is also used interchangeably with Health Insurance "Marketplace."	N/A	N/A
Recommended benchmark plan Source: Center for Consumer Information and Insurance Oversight (2012)	Blue Cross and Blue Shield of Montana Blue Dimensions	N/A
Plan type Source: National Academy for State Health Policy (2014)	Default	N/A
Approved Section 2703 Health Home State Plan Amendments (SPAs)		
Approved SPA	No	Yes=12
Target population	N/A	N/A
Geographic area	N/A	N/A

Source: Kaiser Family Foundation (2013)

State Mandated Insurance Benefits (for private ins)	Montana	US
Autism	Yes	Yes=35
Source: Autism Speaks (2013)		
Bone Marrow Transplants	No	Yes=9
Cleft Palate	No	Yes=17
Congenital Bleeding Disorders	No	Yes=3
Dental Anesthesia	No	Yes=31
Diabetes Self-Management	Yes	Yes=38
Diabetic Supplies	Yes	Yes=47

Source: Center for Affordable Health Insurance (2010)

Early Intervention	No	Yes=9
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Source: Catalyst Center communications with state agency contacts and review of state statutes (2011)

Emergency Services	No	Yes=45
Hearing Aids	No	Yes=17
Home Health Care	Yes	Yes=20
Hospice Care	No	Yes=12
Kidney Disease Treatment	No	Yes=2
Mental Health, General	Yes	Yes=42

Source: Center for Affordable Health Insurance (2010)

Mental Health Parity	Yes	Yes=23
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Source: National Conference of State Legislatures (2014)

Neurodevelopment Therapy	No	Yes=1
Newborn Hearing Screening	Yes	Yes=18
Newborn Sickle-Cell Testing	No	Yes=4
PKU/Formula	Yes	Yes=33
Prescription Drugs	No	Yes=4
Rehabilitation Services	No	Yes=6
Telemedicine	No	Yes=9

Source: Center for Affordable Health Insurance (2010)

Tip: For updated information on each state's specific mandated benefits, go to <http://www.cms.gov/ccio/resources/data-resources/ehb.html>

<b>Catastrophic Coverage</b>	<b>Montana</b>	<b>US</b>
High-Risk Pool Programs	Yes	Yes=34

Source: Kaiser Family Foundation (2011)

## EXPERIENCE WITH THE SYSTEM OF CARE FOR CSHCN

<b>Federal MCHB Core Outcomes for CSHCN</b>	<b>Montana</b>	<b>US</b>
Percentage of CSHCN whose families are partners in shared decision-making for child's optimal health	72.9%	70.3%

Source: National Survey of Children with Special Health Care Needs (2009-2010)

Tip: Corresponds with the MCHB Block Grant Performance Measure: The percent of CSHCN age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive.

Percentage of CSHCN who receive coordinated, ongoing, comprehensive care within a medical home	39.1%	43.0%
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Source: National Survey of Children with Special Health Care Needs (2009-2010)

Tip: Corresponds with the MCHB Block Grant Performance Measure: The percent of CSHCN age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

Percentage of CSHCN whose families have consistent and adequate private and/or public insurance to pay for the services they need	53.3%	60.6%
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Source: National Survey of Children with Special Health Care Needs (2009-2010)

Tip: Corresponds with the MCHB Block Grant Performance Measure: The percent of CSHCN age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.

Percentage of CSHCN who are screened early and continuously for special health care needs	70.6%	78.6%
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Source: National Survey of Children with Special Health Care Needs (2009-2010)  
 Tip: Corresponds with the MCHB Block Grant Period

Performance Measure: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs. Percentage of CSHCN who can easily access community based services	54.3%	65.1%
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Source: National Survey of Children with Special Health Care Needs (2009-2010)

Tip: Corresponds with the MCHB Block Grant Performance Measure: Percent of CSHCN age 0 to 18 whose families report that community-based service systems are organized so they can use them easily..

Percentage of youth with special health care needs who receive the services necessary to make appropriate transitions to adult health care, work, and independence -- CSHCN ages 12-17 only	48.6%	40.0%
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Source: National Survey of Children with Special Health Care Needs (2009-2010)

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

Percentage of families who report their child's doctors or other health care providers are sensitive to the family's values and customs		
Always	66.9%	69.6%
Usually	22.2%	19.3%
Sometimes or Never	10.9%	11.1%

Source: National Survey of Children with Special Health Care Needs (2009-2010)

Tip: A list of the Healthy People 2010 six core performance outcomes can be found on the [Catalyst Center History and Background](#) page.

<b>TITLE V PROGRAM</b>		
<b>Financing</b>	<b>Montana</b>	<b>US</b>
Percentage of Title V Block Grant Partnership Budget from State Funds	20.6%	42.3%
<b>Family Involvement</b>	<b>Montana</b>	<b>US</b>
Family Participation in Title V CYSHCN Program Score (Maximum Possible = 18)	12	14.2

Source: U.S. Dept. of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (2014)

For more information, click on

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

## Special Education Services for Preschoolers with Disabilities<sup>33</sup>

<sup>33</sup> National Dissemination Center for Children with Disabilities,  
<http://www.parentcenterhub.org/repository/preschoolers>

Special education is instruction specifically designed to meet the educational and developmental needs of children with disabilities, or those who are experiencing developmental delays.

Services for preschool children (ages 3 through 5) are provided free of charge through the public school system. These services are available through the same law—the *Individuals with Disabilities Education Act*—that makes available:

- Early intervention services (Part C of IDEA), and
- Services for school-age children, in grades K through 12 (Part B of IDEA)

There are several ways that children may begin receiving services. Children who are receiving early intervention services may begin special education preschool services: upon their transition out of early intervention, typically at age three; or, at the State’s discretion, two-year-olds who will turn three during the school year may receive special education preschool services. Still other children are first identified and found eligible between the ages of two and five, and thus, may begin receiving services as preschoolers.

One of the more common ways that very young children become identified as needing special services lies in the process of attending regular well-baby and child check-ups with a **pediatrician**. Often a referral to a Developmental Pediatrician or other specialist is made if there’s a question or concern about a child’s development. This can, in turn, lead to comprehensive evaluations to fully determine if a child has a significant delay or disability and as a result needs specialized help.

Another way for very young children to become identified is through the **local Child Find office**. In keeping with IDEA, each State must have comprehensive systems of child find in order to identify, locate, and evaluate children with disabilities residing in the State and who are in need of special education and related services. Before children are old enough to attend public school, however, it’s not uncommon for a babysitter, a daycare provider, or preschool staff to express concern to a child’s parents about a possible developmental or learning delay. They may suggest that the parents contact the appropriate agency to have the child screened and/or evaluated to determine if there is an underlying problem or delay that might need to be addressed. Such screenings cover a range of skill areas—vision and hearing, gross and fine motor skills, speech and language use, social and emotional behavior, and more.

**Parents don’t have to wait until someone suggests that their child be screened**, though. If you are concerned about your child’s development, you can contact the local child find office (through your local school system) and arrange to have your child screened. Such screenings are free of charge to parents. They are considered part of the State’s responsibility toward the well-being of its resident children.

## ***Special Education in Montana***

In Montana, children three years of age and older who need significant modifications in their educational programs may be eligible for special-education services through their school district.

For preschool-age children, parents should contact the special-education department of the public school district in which they live. Public schools have an obligation, called **Child Find**, to find and identify all children with disabilities who live within the district boundaries. For students who are

enrolled in school but not yet eligible for special-education services, the parent should contact the school principal. In Montana, either the school or the parents can refer a student for a comprehensive educational evaluation for special education services. If the parent makes the referral, it must in writing and it must contain specific information.

Parents can contact **PLUK** (Parents Let's Unite for Kids) for information about referrals, evaluations, and all aspects of the special education process.<sup>34</sup>

Each student's special-education placement and services are determined by his or her Individual Education Plan (IEP). The IEP is based on the student's unique needs and is developed by a team that includes the parents as equal partners. In Montana, parents must sign consent to approve and implement the IEP. A student's placement should be based on his / her needs and should take place in the least restrictive environment (LRE) possible with supplementary supports and services. The IEP team determines LRE for individual students.

Montana has a full continuum of special education placements, from students who spend 100 percent of their time in general-education classrooms to students who spend the majority of their time receiving instruction in special-education classrooms. Some students may be pulled out of the general-education classroom to receive special instruction in specific subjects or skill areas. Individual districts have local control over how they deliver services, and not every school provides all placements. Parents can contact PLUK for information about their role in the IEP and placement process or download PLUK's *Montana Parent's Handbook to Special Education*.

### ***Children and Youth with Disabilities in the Nation***<sup>35</sup>

The number of children and youth ages 3–21 receiving special education services was 6.4 million in 2011–12, or about 13 percent of all public school students. Some 36 percent of the students receiving *special education services had specific learning disabilities*.

Enacted in 1975, the Individuals with Disabilities Education Act (IDEA), formerly known as the Education for All Handicapped Children Act (EAHCA), mandates the provision of a free and appropriate public school education for eligible children and youth ages 3–21. Eligible children and youth are those identified by a team of professionals as having a disability that adversely affects academic performance and as being in need of special education and related services. Data collection activities to monitor compliance with IDEA began in 1976.

From school years 1990–91 through 2004–05, the number of children and youth ages 3–21 who received special education services increased, as did their percentage of total public school enrollment: 4.7 million children and youth ages 3–21, or about 11 percent of public school enrollment, received special education services in 1990–91, compared with 6.7 million, or about 14 percent, in 2004–05. The number and percentage of children and youth served under IDEA have declined each year from 2005–06 through 2011–12. By 2011–12, the number of children and youth receiving services had declined to 6.4 million, corresponding to 13 percent of total public school enrollment.

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<sup>34</sup> <http://specialchildren.about.com/od/Special-Education/a/Special-Education-Services-In-Montana.htm>

<sup>35</sup> [http://nces.ed.gov/programs/coe/pdf/coe\\_cgg.pdf](http://nces.ed.gov/programs/coe/pdf/coe_cgg.pdf)

A higher percentage of children and youth ages 3–21 received special education services under IDEA for specific learning disabilities than for any other type of disability in 2011–12. A specific learning disability is a disorder in one or more of the basic psychological processes involved in understanding or using language, spoken or written, that may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations. In 2011–12, some 36 percent of all children and youth receiving special education services had specific learning disabilities, 21 percent had speech or language impairments, and 12 percent had other health impairments (includes having limited strength, vitality, or alertness due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes).

Students with autism, intellectual disabilities, developmental delay, and emotional disturbances each accounted for between 6 and 7 percent of children and youth served under IDEA. Children and youth with multiple disabilities, hearing impairments, orthopedic impairments, visual impairments, traumatic brain injury, and deaf-blindness each accounted for 2 percent or less of those served under IDEA.

About 95 percent of school-age children and youth ages 6–21 who were served under IDEA in 2011–12 were enrolled in regular schools. Three percent of children and youth ages 6–21 who were served under IDEA were enrolled in separate schools (public or private) for students with disabilities; 1 percent were placed by their parents in regular private schools; and less than 1 percent each were in separate residential facilities (public and private), homebound or in hospitals, or in correctional facilities. Among all children and youth ages 6–21 who were served under IDEA, the percentage of children and youth who spent most (80 percent or more) of their school day in general classes in regular schools was higher in 2011–12 than in any other year. For example, in 1990–91 some 33 percent of children and youth ages 6–21 spent most of their school day in general class, compared with 47 percent in 2000–01 and 61 percent in 2011–12. In 2011–12, the percentage of students served under IDEA who spent most of their school day in general classes was highest for students with speech or language impairments (87 percent). Sixty-six percent of students with specific learning disabilities and 64 percent of students with visual impairments spent most of their school day in general classes. In contrast, 17 percent of students with intellectual disabilities and 13 percent of students with multiple disabilities spent most of their school day in general classes.

In school year 2011–12, the number of children and youth ages 3–21 who were served under IDEA as a percent of total enrollment in public schools differed by race/ ethnicity. The percentage of children and youth served under IDEA was highest for American Indians/Alaska Natives (16 percent), followed by Blacks (15 percent), Whites (13 percent), children and youth of two or more races (13 percent), Hispanics (12 percent), Pacific Islanders (11 percent), and Asians (6 percent). For each racial/ethnic group, the percentages of children and youth receiving services for specific learning disabilities and for speech or language impairments together accounted for over 50 percent of children and youth served under IDEA.

The percentage distribution of children and youth ages 3–21 who received various types of special education services in 2011–12 varied by race/ethnicity. For example, the percentage of students with disabilities served under IDEA for specific learning disabilities was lower among Asian

children (23 percent) than among children overall (36 percent). However, the percentage of students with disabilities who were served for autism was higher among Asian children (17 percent) than among children overall (7 percent). Additionally, students who received services for emotional disturbances accounted for 8 percent of Black children served under IDEA, compared with 6 percent of children overall. Among children and youth that received services, the percentages of American Indians/Alaska Natives (9 percent), Pacific Islanders (9 percent), and students of two or more races (10 percent) who received services for developmental delay under IDEA were higher than the percentage of children overall (6 percent).

### ***Children and Youth with Disabilities in Montana***<sup>36</sup>

The Montana Division of Special Education has responsibility for assuring that children with disabilities receive a free and appropriate public education in the least restrictive environment. Division staff provides training, technical assistance and monitor special education services provided by public schools and state-operated programs. The Division is also responsible for managing the flow of state and federal dollars for special education programs.

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### ***Montana State Nutrition, Physical Activity, and Obesity Profile 2012***<sup>37</sup>

Obesity has important consequences on our nation's health and economy. It is linked to a number of chronic diseases, including coronary heart disease, stroke, diabetes, and some cancers (NIH Clinical Guidelines, 1998). Among adults, the medical costs associated with obesity are estimated at 147 billion dollars (Finkelstein, 2009). Many American communities are characterized by unhealthy options when it comes to diet and physical activity. We need public health approaches that make healthy options available, accessible, and affordable for all Americans.

#### **ADULTS**

#### **Overweight and Obesity**

- 60.3% were overweight, with a Body Mass Index of 25 or greater.
- 23.0% were obese, with a Body Mass Index of 30 or greater.

#### **Dietary Behaviors**

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<sup>36</sup> <http://opi.mt.gov/Programs/SpecialEd/>

<sup>37</sup> Montana <http://www.cdc.gov/obesity/stateprograms/fundedstates/pdf/Montana-State-Profile.pdf>

- 33.5% of adults reported having consumed fruits at the recommended level of 2 or more times per day.
- 28.0% of adults reported having consumed vegetables at the recommended level of 3 or more times per day.

### Physical Activity

- 53.1% of adults achieved at least 300 minutes a week of moderate-intensity aerobic physical activity or 150 minutes a week of vigorous-intensity aerobic activity (or an equivalent combination).
- 22.0% of Montana's adults reported that during the past month, they had not participated in any physical activity.

## ADOLESCENTS

### Overweight and Obesity

- 11.9% were overweight ( $\geq$  85<sup>th</sup> and  $<$  95<sup>th</sup> percentiles for BMI by age and sex, based on reference data).
- 10.4% were obese ( $\geq$ 95<sup>th</sup> percentile BMI by age and sex, based on reference data).

### Unhealthy Dietary Behaviors

- **Fruit consumption:**  
72.6% ate fruits or drank 100% fruit juice less than 2 times per day during the 7 days before the survey.
- **Vegetable consumption:**  
89.6% ate vegetables less than 3 times per day during the 7 days before the survey (green salad; potatoes, excluding French fries, fried potatoes, or potato chips; carrots; or other vegetables).
- **Sugar-sweetened beverage consumption:**  
25.7% drank a can, bottle, or glass of soda or pop (not including diet soda or diet pop) at least one time per day during the 7 days before the survey.

### Physical Activity

- **Achieved recommended level of activity:**  
Only 21.1% were physically active\* for a total of at least 60 minutes per day on each of the 7 days prior to the survey.
- **Participated in daily physical education:**  
32.2% of adolescents attended daily physical education classes in an average week (when they were in school).

### Physical Inactivity

- **No activity:**  
13.4% did not participate in at least 60 minutes of physical activity on any day during the 7 days prior to the survey.
- 23.7% watched television 3 or more hours per day on an average school day.

## CHILDREN

### Overweight and Obesity

- **Breastfeeding**

Increasing breastfeeding initiation, duration, and exclusivity is a priority strategy in CDC's efforts to decrease the rate of childhood obesity throughout the United States.

- 82.8% of infants were ever breastfed;
- 61.1% of infants were Breastfed for at least 6 months.

- **Body Mass Index**

Among Montana's children aged 2 years to less than 5 years\*

- 15.9% were overweight (85th to < 95th percentile BMI-for-Age).
- 12.2% were obese (≥ 95th percentile BMI-for-Age).

### *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; and
- 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%).<sup>38</sup>
- 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.<sup>39</sup>

"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

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<sup>38</sup> Civil Rights Data Collection (CRDC), Department of Education, Office for Civil Rights, <http://www2.ed.gov/about/offices/list/ocr/data.html>

<sup>39</sup> 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>

uninspiring low-paid and low-skilled jobs, offering little or no opportunities for job under-employed.”<sup>40</sup>

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<sup>40</sup> 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](http://www.ilo.org/global/publications/ilo-bookstore/order-online/books/WCMS_091340/lang--en/index.htm)

## 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.<sup>41</sup>
- 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.<sup>42</sup> 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.<sup>43</sup>
- 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.<sup>44</sup>
- 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.<sup>45</sup>
- 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.<sup>46</sup>
- 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, and how

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<sup>41</sup> The Patient Protection and Affordable Health Care Act Section by Section Analysis, Association of University Centers on Disabilities, <http://www.aucd.org/docs/Section-by-Section%20full.pdf>

<sup>42</sup> Providing Individuals with Disabilities the Tools to Live Independently  
[http://harkin.senate.gov/issue/equalrights/Live\\_Independently.cfm](http://harkin.senate.gov/issue/equalrights/Live_Independently.cfm)

<sup>43</sup> National Center on Physical Activity and Disability, <http://www.ncpad.org/>

<sup>44</sup> Intellectual Disability: Definition, Classification, and Systems of Support, 11<sup>th</sup> Edition  
<http://www.aaid.org/intellectualdisabilitybook/>

<sup>45</sup> For more information on improving data collection to reduce health disparities, click on:  
<http://www.healthcare.gov/news/factsheets/disparities06292011a.html>

<sup>46</sup> For more information, click on: <http://ntl.bts.gov/DOCS/livbro.html>

outcomes are tracked across the ADRC network. Through the grant, states will also design, implement and test draft standards for Options Counseling.<sup>47</sup>

- 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 Arc<sup>48</sup> 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.<sup>49</sup>

## 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.<sup>50</sup>
- 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.<sup>51</sup>
- In April, the NCBDDD celebrated its 10<sup>th</sup> anniversary with notable achievements, including autism and sickle cell awareness.<sup>52</sup>
- 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.<sup>53</sup>
- 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.<sup>54</sup>

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<sup>47</sup> Administration on Aging, Draft National Options Counseling Standards, [www.adrc-tae.org/tiki-wnload\\_file.php?fileId=29256](http://www.adrc-tae.org/tiki-wnload_file.php?fileId=29256)

<sup>48</sup> The Arc is a national organization devoted to the needs of people with intellectual and/or developmental disabilities.

<sup>49</sup> 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>)

<sup>50</sup> MMWR, Supplement/Vol.60, January 14, 2011, <http://www.cdc.gov/mmwr/pdf/other/su6001.pdf>

<sup>51</sup> National Center on Birth Defects and Developmental Disabilities (NCBDDD) Strategic Plan, <http://www.cdc.gov/NCBDDD/AboutUs/birthdefects.html>

<sup>52</sup> Bright Futures: Family Matters, Volume 12, Issue 2, Summer 2011 <http://www.brightfuturesforfamilies.org/pdf/BFFM-NCBDDDSummer2011.pdf>

<sup>53</sup> HHS press release, June 29, 2011, <http://www.hhs.gov/news/press/2011pres/06/20110629a.html>

<sup>54</sup> HHS Press Office, <http://www.hhs.gov/news/press/2011pres/09/20110908a.html>

## In 2012:

- 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*.<sup>55</sup>
- 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.<sup>56</sup>
- 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.<sup>57</sup>

## 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<sup>SM</sup> (DEI<sup>SM</sup>). Created by leaders in the business and disability communities, the DEI is an online benchmarking tool that offers businesses the

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<sup>55</sup> To read the entire article, click on: <http://www.kff.org/womenshealth/upload/7213-03.pdf>

<sup>56</sup> <http://akhealthpolicy.org/2012/02/08/new-study-finds-profound-income-divide-in-health-care-reform-law-will-help/>

<sup>57</sup> <http://www.aapd.com/resources/press-room/aapd-releases-the-2013.html>

opportunity to receive an objective score, on a scale of zero to 100, on their disability inclusion policies and practices.<sup>58</sup>

- The 7<sup>th</sup> 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.<sup>59</sup>
- 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.<sup>60</sup>

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<sup>58</sup> <http://www.aapd.com/resources/press-room/press-releases/disability-equality-index-1.html>

<sup>60</sup> [disability.gov@service.govdelivery.com](mailto:disability.gov@service.govdelivery.com)

## Vision, Mission, Goal, and Strategies

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.<sup>61</sup> 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,
2. Support direct health promotion services and programs that meet the specific health promotion needs of people with disabilities,

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<sup>61</sup> 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>

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 **MTDH Program** is the result of a cooperative agreement between:

1. The Centers for Disease Control and Prevention (CDC); and
2. 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.

Four major divisions of MDPHHS have partnered with the MTDH Program to attain the long term outcome goals for this strategic plan.

### **A. Public Health and Safety Division**

- The Financial Operations and Support Services Bureau houses budget functions, operations support, public health informatics, and vital statistics.
- The Chronic Disease Prevention and Health Promotion Bureau includes:
  - The Cardiovascular Health, Diabetes, and Nutrition and Physical Activity (NAPA) Section
  - The Cancer Control Section,
  - The Emergency Medical Services and Trauma Systems Section, and
  - The Tobacco Use Prevention Section.
- The Family and Community Health Bureau includes:
  - Children's Special Health Services Section
  - Maternal, Infant and Child Health Section
  - WIC (Women, Infants and Children) Section
  - Women's and Men's Health, including Family Planning Section
  - Primary Care Office
- The Laboratory Services Bureau includes:
  - The Clinical Public Health Laboratory
  - The Environmental Laboratory
  - Environmental Health Section
  - Laboratory System Improvement Section
- The Communicable Disease Control and Prevention Bureau includes:
  - Communicable Disease Epidemiology Section
  - Food and Consumer Safety Section
  - Immunization Section
  - STD/HIV Section
  - Public Health Emergency Preparation and Training Section

### **B. Developmental Services Division**

The Development Disabilities Program contracts with private, non-profit corporations to provide services across the lifespan for individuals who have developmental disabilities and their families. The focus of the program is to tailor care to the individual and provide it in as natural an environment as possible.

**C. *Senior and Long-Term Care Division***

This division administers aging services, adult protective services, and the state's two veterans' homes. It also helps to fund care for elderly and disabled Montanans who are eligible for Medicaid and Supplemental Security Income (SSI).

**D. *Disability Transitions Services Division***

This division contracts with private, non-profit corporations to provide services across the lifespan for individuals who have developmental disabilities and their families. The focus of the program is to tailor care to the individual and provide it in an environment as natural as possible.

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.

***The Rural Institute: Center for Excellence in Disability Education, Research, and Service***, 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. Since 1979, the Institute has designed, implemented, and evaluated specific programs and services to prevent secondary conditions and promote the health of Montanans with disabilities.

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.

## Logic Model

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 6: Outcome Goals**

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

## 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.<sup>62</sup>

### Objective 1A

By June 30, 2015, the MTDH Core Management Team<sup>63</sup> 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: **Todd Harwell, Chair**

- 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.

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

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<sup>62</sup> 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](#)

<sup>63</sup> See Appendix A, page 64

- 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: **Todd Harwell, Chief**

- 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: **Jeff Sturm, Administrator**

- 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 January of 2013, the UMRI will: 1) develop training materials for public health professionals; and 2) provide technical assistance to Life Style Coaches at 15 diabetes prevention statewide program sites.**

#### Rationale

The Rural Institute has developed an impressive history of recruiting and training undergraduate students, graduate students, and professionals who are interested in working with PWD and offering quality assistance for their individual needs.

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

- Develop a clear and concise position description for potential Life Style Coaches.
- Publish the position description on relevant websites and within pertinent UM departments.
- Develop criteria for successful candidates.

- Identify potential interviewers and determine if they are interested and available.
- Develop interview questions that cover the fundamental principles and duties of Life Style Coaches.
- Hire and train successful candidates.
- Provide a tour of MonTech to inform Life Style Coaches about available communications technology.
- Develop a brochure to assist Life Style Coaches in understanding the special equipment needs of persons with disabilities (e.g. mammography).
- Include Life Style Coaches in *Disability Cultural Sensitivity* webinar training.
- Include Life Style Coaches in the problem-solving section of *Living Well with a Disability* facilitator training.
- Assure that Life Style Coaches are well-versed in current referral processes for mental health problems.
- Identify possible teaching supports for persons with intellectual or developmental disabilities.
- Host a fitness workshop for Life Style Coaches, incorporating elements of the ACSM/ NCPAD.
- Provide technical assistance as needed.

### ***Objective 1C***

**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.

### **Objective 1D**

**By September 1, 2014, develop two grant proposals focused on early intervention strategies targeted toward children with disabilities and submit the proposals to the *National Institutes of Health (NIH)* as well as other funders who may be interested in this work.**

#### Rationale

The UMRI and the MTDH have developed an impressive record of designing programs that work well for adults with disabilities. NIH funding would provide an opportunity to partner with Montana organizations and state agencies that target youth with disabilities.

#### Activities

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

- Determine NIH funding priorities and deadlines for application.
- Identify appropriate statewide partners.
- By September 1, 2014, submit grant application for *Health Promotion for Children with Physical Disabilities through Physical Activity and Diet: Developing an Evidence Base*<sup>64</sup>
- By September 1, 2014, submit grant application for *Healthy Habits: Timing for Developing Sustainable Healthy Behaviors I Children and Adolescents (R03)*<sup>65</sup>

### **Objective 1E**

**By September 1, 2013, prepare a list of Montana coalitions that specifically include people with disabilities in their areas of focus.**

#### Rationale

In 2008, the Americans with Disabilities Amendments Act (ADAAA) reinterpreted the definition of “disability” to include protection for many individuals with impairments that were not previously included in the Americans with Disabilities Act (such as cancer, diabetes or epilepsy). The

<sup>64</sup> [U.S. Department of Health and Human Services, National Institutes of Health, Modification 1](#)

<sup>65</sup> [Ibid., U.S. DPHHS, National Institutes of Health, Modification 2](#)

regulations were designed to simplify the determination of who has a “disability” and make it easier for people to establish that they are protected by the (ADA).

### ***Objective 1F***

**By July 31, 2013, the MTDH will collaborate with the MTDPHHS, Public Health and Safety Division to develop a Sustainability Plan.**

#### Rationale

Because of several successful initiatives in the past several years, Montana is well positioned to initiate and sustain collaborative efforts across the state.

1. In 2009, the Montana Legislature passed and the Governor signed into law House Bill 173. This legislation charged the MTDPHHS with implementing a **pilot project** that provided local public health agencies with funding and technical assistance to assess their readiness and prepare for national voluntary public health accreditation. This effort was aimed at creating a **sustainable public health system in Montana**, with the capacity to make measurable improvements in the health status of Montana citizens.<sup>66</sup>
2. As a result of the aforementioned legislation, seven Montana County Health Departments were chosen to participate in the pilot project and charged with producing: 1) a **Community Needs Assessment**, 2) a **Community Health Improvement Plan**, and 3) a **Strategic Plan** that articulates agency priorities and plans to accomplish strategic goals.<sup>67</sup>
3. In September of 2011, Montana received federal funding to strengthen state and community childhood services and systems, including developing and supporting local early childhood coalitions. Montana’s early childhood (Best Beginnings) coalitions are collaborative efforts between the DPHHS Family and Community Health Division and the Early Childhood Services Bureau. Twenty-five communities (including one region) received funding for coalitions to conduct early childhood needs assessments and develop plans and priorities for an early childhood system. In addition, these coalitions provide professional development opportunities for early childhood providers. Best Beginnings coalitions are located in 20 counties and five tribal jurisdictions.<sup>68</sup>
4. The Montana State Department of Public Health and Human Services received \$1 million in FY11 and FY12 as part of the National Public Health Improvement Initiative (NPHII). Montana is using this funding to conduct a statewide assessment of health status and health services, and to work with stakeholders to develop a state health improvement plan and encourage collaboration between hospitals, local health departments, and other

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<sup>66</sup> <http://www.dphhs.mt.gov/publichealth/accreditation/hb173pilot.shtml>

<sup>67</sup> Public Health Accreditation Board (PHAB) [www.phaboard.org](http://www.phaboard.org)

<sup>68</sup> <http://www.dphhs.mt.gov/biennialreports/PHSDPresentation2013.pdf>

community providers. The NPHII grant is helping to accelerate the agency's readiness to apply for and achieve National Public Health Accreditation.<sup>69</sup>

5. On June 21, 2013, Montana Governor Steve Bullock announced the publication of the state's ambitious public health improvement plan entitled ***Big Sky. New Horizons. A Healthier Montana: A Plan to Improve the Health of Montanans.*** The focus is on:

- Preventing, identifying and managing chronic conditions,
- Promoting the health of mothers, infants and children,
- Preventing, identifying and controlling communicable disease,
- Preventing injuries and reducing exposure to environmental health hazards, and
- Improving mental health and reducing substance abuse.<sup>70</sup>

For each of these health improvement priorities, strategies for improvement are included in four key action areas:

- Public health policies,
- Prevention and health promotion efforts,
- Access to health care, particularly clinical preventive services, and
- Strengthening Montana's public health and health care system<sup>71</sup>

In addition to specific strategies within each section of the plan that focus on Montana's public health and health care system, this plan includes 10 goals to emphasize the need to strengthen and better integrate Montana's public health and health care system and support the work outlined in these health improvement priorities.<sup>72</sup>

The health improvement planning process was initiated by the Public Health and Safety Division (PHSD) of the Montana Department of Public Health and Human Services (MTDPHHS) in 2012. The Montana Public Health System Improvement Task Force served as the Steering Committee for this effort. The PHSD compiled information on the health status and health needs of Montanans and presented it to key stakeholder groups and the public. Information from focus groups, on-site meetings, surveys, and a series of webinars informed this plan. More than 300 individuals representing more than 130 organizations participated in its development, including the ***Montana Disability and Health Program*** as well as the ***Montana Disability and Health Advisory Group.***<sup>73</sup>

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<sup>69</sup> <http://healthyamericans.org/health-issues/wp-content/uploads/2013/04/MT-Fund-at-Work.pdf>

<sup>70</sup> <http://www.dphhs.mt.gov/ship/documents/StateHealthImprovementPlan.pdf> Big Sky. New Horizons. A Healthier

Montana: A Plan to Improve the Health of Montanans. Page 4

<sup>71</sup> Ibid

<sup>72</sup> Ibid

<sup>73</sup> Ibid, page 20

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

Assure a common state-wide agenda:

- Maintaining public health surveillance systems that produce reliable data;
- Engaging public, private, non-profit, and community partners;
- Employing best practices;
- Clarifying priorities, goals, targets, indicators, and strategies;
  - Informing and engaging the general public;
  - Promoting healthy behaviors through programs, events, and activities;
  - Supporting community and/or statewide coalitions with similar interests and goals; and
- Assuring adequate funding.

### ***Objective 1G***

**By June 30, 2013, the MTDH will compile a listing of statewide and local coalitions that meet the Healthy Communities criteria.**

Montana has a rich history of statewide and community coalitions dedicated to improving health and wellness of all citizens. Statewide coalitions include the following:

#### **Statewide Coalitions**

Best Beginnings Advisory Council:

<http://www.dphhs.mt.gov/hcsd/childcare/advisorycouncil.shtml>

Hypertension Coalition: <http://www.dphhs.mt.gov/publichealth/cardiovascular/index.shtml>

Montana Cancer Control Coalition:

<http://www.dphhs.mt.gov/publichealth/cancer/comprehensivecancercontrolplan.shtml>

Montana Coalition for the Homeless: <http://www.mtcoh.org/>

Montana Diabetes Project Advisory Coalition:

<http://www.dphhs.mt.gov/publichealth/diabetes/advisorycoalition.shtml>

Montana Fall Prevention Coalition: <http://www.ncoa.org/improve-health/center-for-healthy-aging/falls-prevention/state-coalitions-map/montana.html>

Montana Health Coalition:

<http://www.dphhs.mt.gov/boardscouncils/montanahealthcoalition.shtml>

Montana Injury Prevention Coalition:

<http://www.dphhs.mt.gov/ems/prevention/documents/StatePreventionPlan.pdf>

Montana Lifetime Respite Care Coalitions: <http://archrespice.org/lifespan-programs>

Montana Prevention Coalition: <http://www.boydandrew.com/services/mpc/>

Montana Worksite Health Promotion Coalition:

<http://www.dphhs.mt.gov/newsevents/newsreleases2012/may/worksitehealthconference.shtml>

Youth Connection Coalition: <http://prevention.mt.gov/resource/coalitions/view.php?id=2371>

### **Community Coalitions**

The Prevention Resource Center, located within the MTDPHHS, has a listing of community coalitions at:

<http://prevention.mt.gov/resource/coalitions/index.php>

### **Activities**

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

- Review the MTDPHHS website to identify all coalitions sponsored by divisions/ programs within the Department.
- Work with agency personnel to determine whether agency listings are current.
- Communicate with coalition staff to assure that people with disabilities are adequately represented within the coalition.
- Increase the number of Disability Advisors who can be involved within the coalitions.

## 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*.<sup>74</sup> 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

##### MTDH:

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

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<sup>74</sup> **M**aterials Supporting **E**ducation and **N**utrition for **A**ddults with **I**ntellectual and **D**evelopmental **D**isabilities

- 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).<sup>75</sup>

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.<sup>76</sup>

### Activities

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

- 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.

<sup>75</sup> [Living Well with a Disability](#)

<sup>76</sup> [Findings from a Study of the Working Well with a Disability Program, Research Report 2010](#)

- 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.

## 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.”<sup>77</sup>

“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.”<sup>78</sup>

### *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).
- 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.

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<sup>77</sup> [People with Disabilities: Living Healthy](#)

<sup>78</sup> Ibid.

- 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.

### ***Objective 3C***

By June 30, 2015, educate 150 college and graduate students in a variety of disciplines (such as public health, architecture, biology, and psychology) about the MTDH Program in general and accessibility issues for persons with disabilities in particular.

#### ***Activities***

- Provide opportunities for MPH Program students to collect, interpret and disseminate data.
- Continue to support MSU nursing students.

### ***Objective 3D***

By June 30, 2015, develop a data-based decision-making training for at least five state agencies and private non-profits and provide at least 15 trainings in various locations in the state.

#### ***Activities***

##### **MTDH Staff**

- Educate state agency and private nonprofit personnel about data system elements that identify people with disabilities.
- Explore the possibilities of:
  - Recruiting UM Psychology Department students to analyze available data from state governmental agencies and report their findings; and
  - Providing small stipends for this work.
- Identify ways to:
  - Recruit and train health care providers for the state; and
  - Promote model policy practices that assure disability cultural competency among providers.
- Support state agency and private nonprofit agencies in:
  - Providing a healthy work place;
  - Promoting the health of the people they serve, and
  - Addressing health equity.

## ***Objective 3E***

**By June 30, 2015, develop and facilitate 15 health promotion programs for people with disabilities as well as their families and/or caregivers , using the Guidelines for Community-based Health Promotion Programs.**

### ***Activities***

#### **MTDH Staff**

- Develop an underlying conceptual or theoretical framework for community-based health promotion programs for people with disabilities.
- Implement process evaluation.
- Collect outcomes data using disability-appropriate measures.
- Involve people with disabilities and their families or caregivers in the development and implementation of health promotion programs for people with disabilities.
- Consider the beliefs, practices, and values of the target groups, including support for personal choice.
- Assure that programs are socially, behaviorally, programmatically, and environmentally accessible.
- Assure that health promotion programs are affordable to PWD and their families/caregivers.

## ***Objective 3F***

**By June 30, 2015, adapt the *American Psychological Association Guidelines for Assessment of and Intervention with Persons with Disabilities* for public health professionals.**

### ***Activities***

#### **MTDH Staff**

- Become familiar with the:
  - 12 guidelines related to disability, awareness, training, accessibility, and diversity,
  - 5 guidelines related to testing and assessment, and
  - 5 guidelines related to interventions.
- Determine how these guidelines could be adapted to public health professionals.

## 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.<sup>79</sup> 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.”<sup>80</sup>

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 needs<sup>81</sup> are adequately represented in state and county Emergency Preparedness plans.

#### Rationale

“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

<sup>79</sup> [Revised ADA Regulations Implementing Title II and Title III](#)

<sup>80</sup> [Center for Universal Design, an initiative of the College of Design at North Carolina State University \(NCSU\)](#),

<sup>81</sup> A function-based definition reflects the capabilities of the individual, not the condition, label or medical diagnosis.

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.”<sup>82</sup>

#### 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 transportation<sup>83</sup>
  - 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.<sup>84</sup>
- 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.
- Partner with Montanan’s Area Agencies on Aging to address the needs and concerns of older Montanans at the local level.

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<sup>82</sup> Montana Emergency Response Framework (MERF), 2012; [http://montanadma.org/sites/default/files/MERF\\_2012\\_v1.2\\_0.pdf](http://montanadma.org/sites/default/files/MERF_2012_v1.2_0.pdf)

<sup>83</sup> DPHHS Emergency Operations Plan, <http://www.dphhs.mt.gov/publichealth/phep/documents/dphseop.pdf>

<sup>84</sup> Public Health Emergency Preparedness, Dec., 2010, <http://www.dphhs.mt.gov/publichealth/phep/index.shtml>

- 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 threats<sup>85</sup> 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.”<sup>86</sup>
- Periodically update the MTDH website on Emergency Preparedness<sup>87</sup> and encourage people with disabilities and/or functional needs to access information on the website.
- Identify approaches for developing and disseminating tools to create an emergency preparedness plan to care providers of PWD.

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<sup>85</sup> [Public Health Preparedness Capabilities, National Standards for State and Local Planning](#)

<sup>86</sup> Montana Emergency Preparedness Plan for At-Risk/Special Populations, Version 2.3, Aug. 29,2008, [Preparedness for Functional Needs](#)

<sup>87</sup> [http://mtdh.ruralinstitute.umt.edu/?page\\_id=123](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.
- 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, and
  - Assist PWD to create a personal emergency preparedness plan and/or kit that addresses the following needs: transportation and communication; specific resources (e.g. medical, nutritional, service animals); personal hygiene; and mental health.
- 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.<sup>88</sup>

### 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.

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<sup>88</sup> 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.

## ***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;
2. Setting priorities among disparities to be addressed at the federal, state, tribal, and local levels;
3. Articulating valid reasons to expend resources to reduce and ultimately eliminate priority disparities;
4. 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
5. 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.”<sup>89</sup>

### **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.

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<sup>89</sup> Ibid. Conclusion, page 9.

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 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).