A partnership of:

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

Strategic Plan

2012—2015

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Introduction

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. Today, over 54 million—or 1 in 5—people living in the United States have at least one disability."[1]

The 2005 Surgeon General's Call to Action[2] 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-institutionalized population over the age of 5 years) had a disability. According to **2010** Behavioral Risk Factor Surveillance System (BRFSS) 2010 data, there were approximately 53 million adults with disabilities in the United States.

Table 1: 2010 Prevalence of Disability among Adults by Age Group[3]

Ages	National Estimates		Montana Estimates	
	Percent (95% CI)	*Number*	*Percent (95% CI)*	*Number*
All Adults	22.8 (22.6—23.0)	53,117,000	26.0 (24.3—27.17)	196,300
18—44 years	13.9 (13.6—14.3)	15,365,000	16.5 (13.5—19.90)	54,800
45—64 years	27.3 (26.9—27.7)	21,855,000	29.8 (27.7—31.90)	83,100
65+ years	37.8 (37.4—38.2)	15,604,000	40.7 (38.3—43.10)	58,500

[1] The 2005 Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities—what it means to you, CDC's What it Means To You

[2] Ibid.

[3] Montana Behavioral Risk Factor Surveillance System, 2010 national and state disability estimates.

According to a University of New Hampshire, Institute of Disabilities (IOD) report released on August 25, 2011, people with disabilities are generally more likely to experience poorer health. Report findings indicate the following:

- If people with disabilities were a formally recognized minority group, they would be the largest minority group in the United States.
- The highest proportion of people who say their health is fair or poor is found in people with disabilities (40%, compared to 23%t of Hispanics, 22% of American Indian/Alaska Natives, 18% of blacks, and 8% of Asians).
- People with disabilities have the least desirable prevalence rates for 10 of the 14 selected health indicators including cardiovascular disease and diabetes. [4]

"Relatively little research has been conducted comparing the health of people with disabilities to that of people from racial and ethnic minority groups," says Charles Drum, IOD director and report co-author. "However, research has consistently documented that, as a group, people with disabilities experience poorer health than the general population. Specifically, people with a variety of physical and cognitive disabilities are more likely to experience poorer health status, potentially preventable secondary conditions, chronic conditions, and early deaths."[5]

Healthy People 2020 Leading Health Indicators[6]

Healthy People 2020 provides a comprehensive set of 10-year, national goals and objectives for improving the health of all Americans. Healthy People 2020 contains 42 topic areas with nearly 600 objectives (with others still evolving), which encompass 1,200 measures. A smaller set of Healthy People 2020 objectives, called Leading Health Indicators, has been selected to communicate high-priority health issues and actions that can be taken to address them. The leading health indicators in Healthy People 2020 include:

- Access to Health Services (medical insurance, usual primary care provider);
- Clinical Preventive Services (colorectal cancer screening, hypertension and blood pressure under control, diabetes values, children's vaccines);
- Environmental Quality (air quality index, secondhand smoke);
- Injury and Violence (fatal injuries, homicides);
- Maternal, Infant, and Child Health (infant deaths, preterm births);
- Mental Health (suicides, adolescent depression);
- Nutrition, Physical Activity, and Obesity (physical activity, adult obesity, child and youth obesity, vegetable intake);
- Oral Health (oral health care system use);
- Reproductive and Sexual Health (reproductive health services, HIV);
- Social Determinants (high school graduation);
- Substance Abuse (adolescents use, adult binge drinking); and
- Tobacco (adult smoking, adolescent smoking).

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[4] Health Disparities Chart Book on Disability and Racial and Ethnic Status in the United States, University of New Hampshire Institute on Disability, August 24, 2011, Report Finds Health Disparities for People with Disabilities

[5] Ibid.

[6] HealthyPeople.gov, HealthyPeople.gov

Affordable Care Act (ACA)

On March 23, 2010, President Obama signed the Affordable Health Care Act. The law addresses comprehensive health insurance reforms—some of which take effect as early as 2010.

Provisions of the ACA for persons with disabilities*:*

- Under the health care law, job-based and new individual plans are no longer allowed to deny or exclude coverage to any child under age 19 based on a pre-existing condition, including a disability. Starting in 2014, these same plans won't be able to exclude anyone from coverage or charge a higher premium for a pre-existing condition, including a disability.
- Insurance companies can no longer drop a person when s/he is sick just because the person made a mistake on the coverage application.
- Insurance companies can no longer impose lifetime dollar limits on coverage.
- Medicaid covers many people with disabilities now, and in the future it will provide insurance to even more Americans. Starting in 2014, most adults under age 65 with incomes up to about $15,000 per year for a single individual (higher income for couples/families with children) will qualify for Medicaid in every state. State Medicaid programs will also be able to offer additional services to help those who need long-term care at home and in the community.
- According to a February 22, 2012 news release,[7] "States are seeing significant new federal support in their efforts to help move Medicaid beneficiaries out of institutions and into their own homes or other community settings now and in the near future. The Affordable Care Act provides additional funding for two programs supporting that goal, the *Money Follows the Person* (MFP) demonstration program and the *Community First Choice* option program."
- Includes requirements to collect information regarding 1) where patients with disabilities receive care, and 2) the physical and programmatic access of medical providers. In addition, the ACA sets standards for accessible exam and medical diagnostic equipment.[8]
- Several initiatives in the health-care law are designed to support physicians, hospitals and other providers in their lifesaving work. For example, *Partnership for Patients*[9] is a nationwide effort to reduce patient infections and hospital readmissions by replicating the most significant improvements that some of the country's best hospitals have already achieved.

Establishes demonstration programs to develop core competencies, pilot training curricula, and certification programs for personnel and home care aides.[10]

- Establishes grants to eligible entities for training of direct-care workers employed in LTC settings such as nursing homes, assisted living facilities, home care settings, and any other setting determined to be appropriate.

[7] Affordable Care Act Supports States in Strengthening Community Living, HHS, Affordable Care Act Supports States Strengthening Community

[8] Response to the Data Challenges of the Affordable Care Act, Mudrick, Breslin, and Kales

[9] Partnerships for Patients: Better Care, Lower Costs

[10] Direct-Care Workforce and Long-Term Care Provisions,

- Provides grants to Geriatric Education Centers (GEC) for mini-fellowships for faculty; requires that they offer courses on geriatrics, chronic care management, and long-term care; requires activities to include family caregiver training and incorporation of best practices (including mental health); and expands eligibility for Geriatric Academic Career Awards (GACA) to additional disciplines (beyond physicians).
- Includes grants and incentives to enhance training, recruitment, and retention of direct care staff (including career ladders and wage/benefits increases) and improve management practices affecting retention in either long-term care facility or community-based programs or settings.
- Reauthorizes and expands programs to support the development, evaluation, and dissemination of model curricula for cultural competency, prevention, and public health proficiency and aptitude for working with individuals with disabilities training for use in health professions' schools and continuing education programs.
- Provides an option for States to enroll Medicaid beneficiaries with chronic conditions into a health home. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination.[11]
- The ACA includes benefits to make Medicare prescription drug coverage (Part D) more affordable by gradually closing the gap known as the "donut hole." Closing the gap began on January 1, 2011, when individuals who reached the coverage gap automatically received a 50% discount on covered brand-name drugs or a 7% discount on generic drugs while in the donut hole. The gap is scheduled to narrow further each year until the gap is closed in 2020.[12]
- The ACA originally included the *Community Living Assistance Services and Supports (CLASS) Act*, a voluntary long-term care insurance program. In October of 2011, HHS Secretary Kathleen Sebelius wrote a letter to congressional leaders indicating that there was not a "viable path forward" to implement the program while keeping it affordable and financially solvent. The CLASS Act was intended to provide insurance to workers if they become unable to care for themselves because of injury or illness.[13]

[11] Patient-centered Primary Care Collaborative
[12] HealthCare.gov, Medicare Drug Discounts
[13] Obama Administration Ends Reform Law's CLASS Program

Montana's Aging Population

According to a Montana State University study, the percentage of the Montana elderly population doubled between 1940 and 2000 and is projected to double again by 2030.[14]

"The aging of Americans represents one of the most significant concerns facing the United States health system as it is challenged to provide a range of services that meet the diverse needs of the elderly, ranging from community-based options to residential alternatives. Rural areas with a disproportionately large elderly population and lacking necessary resources to provide sufficient long-term care services may face even greater challenges in providing a network of services.

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 a few of the components essential to improving access to LTC services in rural areas."[15]

Access to Health Care in Rural Areas

The summary and conclusions of a recent national study on health care needs of elderly populations indicated the following:

1. The aging of Americans represents one of the most significant concerns facing the United States health system as it is challenged to provide a range of services that meet the diverse needs of the elderly, from community-based options to residential alternatives.
2. Rural areas with a disproportionately large elderly population and lacking necessary resources to provide sufficient long-term care services may face even greater challenges in providing a network of services. Ultimately, improving access to LTC services in rural areas requires addressing a range of factors from system constraints to the unique rural barriers that impact provision of services.
3. 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 a few of the components essential to improving access to LTC services in rural areas. [16]

[14] Project 2030 Montana's Aging Population, Haynes, Watts and Young, Department of Agricultural Economics and Economics, Montana Council on Economic Education

[15] Hutchison, L, Hawes, C., & Williams, L. (2005). Access to Quality Health Services in Rural Areas Long-term Care. In L. Gamm & L. Hutchison (Eds.), Rural Healthy People 2010: A companion document to Healthy People 2010. Volume 3. College Station, TX: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, Rural Health People 2010.

[16] *Access to Quality Health Services in Rural Areas*, Linnae Hutchison, Catherine Hawes, & Lisa Williams

Caregivers

"Unpaid caregivers (family, friends, or neighbors) are the backbone of long-term care provided in people's homes, yet these caregivers may face stress, burden, depression, and negative health effects from their duties. Many caregivers do not adhere to recommendations to follow a healthy diet and exercise program and tend to avoid preventive care for themselves."[17]
In 2009, the Centers for Disease Control and Prevention (CDC) added a 10-question Caregiving Module to BRFSS in order to determine 1) who is a caregiver; 2) the relationship between the caregiver and the care recipient; 3) the average hours of caregiving per week; 4) the most difficult problem facing the caregiver; 5) the age and gender of the care recipient; 6) the types of assistance needed by the care recipient; 7) the major health problem, long-term illness, or disability of the care recipient; 8) the duration of caregiving; and 9) whether the person has had more difficulty with thinking or remembering in the past year.[18]

"The prevalence of caregivers in the American Indian/Alaskan Native population is greater than the general U.S. population (McGuire, 2008). Like many people of all racial/ethnic groups AI/AN families want to care for their elders and the elders want to remain in their homes and have family care for them as long as possible."

"Surveys show AI/AN families would like training on how to take care of an older adult, help to coordinate care and navigate the health system, respite care and adult day care to give the caregiver a break, support groups, and more services for their care recipient."[19]

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.

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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[17] CDC Caregiving Activities, Information for Journalists,
[18] Ibid., Caregiving Module for BRFSS Beginning in 2009
[19] Ibid, American Indian and Alaska Native (AI/AN) Caregiving.

Table 2: Montana Medicaid Eligibility

Category	Income as % of FPL[20]	Allowable Assets	Enrollees
Adults with children	22% to 33%	$3,000	7,770 adults 12,212 children
Aged, blind, disabled	Individual: $674/month Couple: $1,011/month	Individual: $2,000 Couple: $3,000	27,068
Children under 19	133%	Not counted	46,632
Pregnant Women	150%	$3,000	4,077
Children in Foster Care or Subsidized Adoption	Varies	Foster Care: $3,000 Sub. Adoption: Not Counted	3,688
Breast/Cervical Cancer	200%	Not counted	188
Workers with Disabilities	250%	Individuals: $8,000 Couples: $12,000	465

Montana's Economy

According to the ***Montana Poverty Report Card***, published in December of 2011,[21] Montana has had a higher poverty rate than the U.S. since 1995. The highest Montana poverty rate occurred in 1995 (15.8%) and the lowest poverty rate (13.3%) occurred in the year 2000. In 2009, Montana had an estimated 142,000 people living in poverty. In that same year, the median household income for the U.S. was over $50,000, while the median household income for Montana was just over $42,000. Whereas Montana's median household income has been below U.S. median household income, it has followed the same *upward* trend since 1999.

The Report Card study found that poverty is highly correlated with the following:

- Percentage of employed adults,
- Percentage of adults with a low level of education (less than a high school diploma),
- Percentage of households headed by a single female with children, and
- Percentage of American Indians in the county.

The study cited ***five*** Montana counties (Glacier, Big Horn, Mineral, Blaine and Roosevelt) at greatest risk for poverty.

[20] Federal Poverty Level

[21] Study conducted by the Montana Department of Public Health and Human Services in collaboration with Montana State University Extension. Montana Poverty Report Card, December 2011

Table 3: Poverty in Montana and the United States: 2000 and 2010[22]

2000			2010			2000 to 2010
Total Population	Population in Poverty	Percent of Population in Poverty -	Total Population	Population in Poverty	Percent of Population in Poverty	Percent Change
Montana						
878,789	128,355	14.6%	949,414	138,109	14.5%	-0.1%
U.S.						
14,373,439	1,584,805	11.0%	15,814,709	1,872,020	11.8%	0.8%

American Indians experience the highest rate of disability of any group in the United States, yet the Americans with Disabilities Act specifically excludes tribes from coverage. There also are few services for people with disabilities on reservations.[23]

Table 4: Poverty on Montana American Indian Reservations[24]

Reservation	Poverty Rate (2000)	Unemployment Rate (2005)	Free/ Reduced Lunch Eligible Kids (2010)
Blackfeet	34%	69%	82%
Crow	31%	47%	90%
Flathead	20%	24%	56%
Fort Belknap	39%	70%	80%
Fort Peck	35%	54%	83%
Little Shell	37%	Not Available	Not Available
Northern Cheyenne	46%	60%	91%
Rocky Boy's	41%	68%	85%
All Reservations	30%	52%	Not Available
Montana	**Poverty Rate (2000)**	**Unemployment Rate (2005)**	**Free/ Reduced Lunch Eligible Kids (2010)**
	14%	**7%**	**38%**

The Report Card study also indicated that ***employment*** is a critical factor in discussing poverty. Long-term economic changes in Montana have been very similar to those experienced in the U.S. as a whole. Employment has shifted from manufacturing and natural resource-based industries to more knowledge and service-based industries. Many of those with less education who previously held higher paying jobs in manufacturing and natural resource-based employment are now accepting lower paying service industry positions.

[22] Census Data Poverty7 Statistics

[23] Research and Training Center on Disability in Rural Communities, University of Montana Rural Institute

[24] Tribal Borders: Confronting Health Disparities & Accessible Care; Annjeanette Belcourt-Dittloff, Gyda Swaney, Gordon Belcourt; Poverty data adapted from data reported in the Montana Poverty Study 2010 Haynes, G., Haroldson, J., Montana's Poverty Report Card: Reservation Segment: Montana State University, 2009, Montana's Poverty Report Card

Montana has experienced significant ***unemployment rate changes*** from 2001 through 2011, as shown in the following table.

Table 5: Montana Unemployment rates, 2000--2012[25]

Year	Month	Montana Unemployment Rate	National Unemployment Rate
2000	January	5.0%	Not Available
2001	January	4.6%	Not Available
2002	January	4.5%	5.7%
2003	January	4.3%	5.8%
2004	January	4.2%	5.7%
2005	January	3.8%	5.3%
2006	January	3.4%	4.7%
2007	January	3.1%	4.6%
2008	January	3.7%	5.0%
2009	January	5.6%	7.8%
2010	January	7.0%	9.7%
2011	January	7.5%	9.1%
2012	January	6.5%	8.3%
2012	August	6.3%	8.1%

Federal programs including the Social Security (SS) Program, Supplemental Security Income (SSI) Program and Medicare Program provide a range of services to persons who are retired, aged, and/or disabled.

The Social Security Program—Old-Age, Survivors, and Disability Insurance (OASDI)—provides monthly benefits to workers and their families when the worker retires, dies, or becomes disabled. The amount of the worker's retirement insurance (old-age) or disability benefit is based on the worker's level of earnings in employment or self-employment covered by the Social Security program. Monthly benefits are payable to retired workers at age 62 (with reduced benefits) or to disabled workers at ***any*** age. The benefit amount for an auxiliary or survivor beneficiary is based on a percentage of the worker's benefit. Auxiliary and survivor beneficiaries must generally meet age, disability, or child care requirements.

Table 6: Received Social Security Benefits in December of 2005[26]

United States	Montana
• 30,474,930 retired workers • 4,746,780 widows and widowers • 6,510,420 disabled workers • 2,681,460 wives and husbands • 4,032,310 children	• 110,050 retired workers • 16,770 widows and widowers • 19,920 disabled workers • 10,390 wives and husbands • 11,840 children
Total: 48,445,900 persons **15.9%** of the total population **90.3%** of population age 65 or older	**Total: 168,970 persons** **18.1%** of the total population **93.9%** of population age 65 or older

[25] Bureau of Labor Statistics, Washington, D.C., HHS.gov Press Release

[26] Bureau of Labor Statistics, Washington, D.C., data extracted on 01/06/2012, HHS.gov Press Release

Supplemental Security Income (SSI) is a federal cash assistance program that provides monthly payments to low-income aged, blind, and disabled persons in the 50 states, the District of Columbia, and the Northern Mariana Islands. The program is based on nationally uniform eligibility standards and payment levels. The federal SSI payment is determined by the recipient's countable income, living arrangement, and marital status. As of January 2006, the maximum monthly federal SSI payment for an individual living in his or her own household with no other countable income is $603, and for a couple, $904.

Table 7: Received Supplemental Security Income Benefits in December of 2005[27]

United States recipients	Montana recipients
• 1,214,296 were aged • 5,899,583 were disabled or blind	• 1,105 were aged • 13,679 were disabled and blind
Total: 7,113,879 persons • 1,994,511 were 65 or older • 4,082,870 were 18—64 years • 1,036,498 under the age of 18	**Total: 14,784 persons** • 2,417 were 65 or older • 10,421 were 18—64 years • 1,946 were under the age of 18

Table 8:
Worked in employment that was covered under the Social Security (SS) Program in 2004

United States	Montana
• 157,000,000 workers (estimated)	• 544,000 residents
• $4.5 trillion in SS taxable earnings	• $11.99 billion in SS taxable earnings
• $563 billion paid in SS taxes by employees, employers, and self-employed persons	• $1.49 billion paid in SS taxes by employees, employers, and self-employed persons

Table 9:
Persons covered under the Medicare (Hospital Insurance or HI) program in 2004

United States:	Montana:
• 160.7 million workers (estimated)	• 547,000 residents
• $5.6 trillion in Medicare taxable earnings	• $13.02 billion in Medicare taxable earnings
• $161 billion paid in Medicare taxes	• $378 million paid in Medicare taxes

[27] Ibid.

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 the following:

- 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%).[28]
- Students with disabilities (under the IDEA and Section 504 statutes) represent **12%** of students in the sample, but represent nearly **70%** of the students who are physically restrained by adults in their schools.[29]

"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 labour 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 labour 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 underemployed."[30]

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.

[28] Civil Rights Data Collection (CRDC), Department of Education, Office for Civil Rights

[29] Civil Rights Collection, Wide-ranging education access and equity data from a sample of our nation's public schools,

[30] International Labour Office, Achieving Equal Employment Opportunities for People with Disabilities through Legislation Guidelines

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. [31]

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.

Developmental Disabilities

"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."[32]

"The Centers for Disease Control and Prevention's (CDC) National Center on Birth Defects and Developmental Disabilities (NCBDDD), in collaboration with a number of national partners, launched a public awareness campaign called "Learn the Signs. Act Early." The campaign aims to educate parents about childhood development, including early warning signs of autism and other developmental disorders, and encourages developmental screening and intervention.

To access more information about a range of developmental disabilities, go to CDC's ***Learn the Signs, Act Early.***

[31] 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

[32] Child Count Data

Children's Special Health Services

Children's Special Health Services (CSHS),[33] is charged by the Federal Maternal 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:

- 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.
- 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.[34] 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

[33] DPHHS Funding and Goals
[34] Montana's Expanded Newborn Screening

for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."[35]

"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."[36]

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.[37]

Table 10: CSHCN Prevalence for Montana and the Nation, 2005/2006 and 2009/2010

	2005/2006		2009/2010	
CSHCN Prevalence	**Montana %**	**Nation %**	**Montana %**	**Nation %**
• % of children who have special health care needs	**13.6%**	13.9%	**14.0%**	15.1%
CSHCN Prevalence by Age				
• Age 0—5 years	**7.9%**	8.8%	**7.6%**	9.3%
• Age 6—11 years	**13.8%**	16.0%	**15.9%**	17.7%
• Age 12—17 years	**18.1%**	16.8%	**18.2%**	18.4%
CSHCN Prevalence by Sex				
• Male	**15.9%**	16.1%	**16.0%**	17.4%
• Female	**11.3%**	11.6%	**11.9%**	12.7%

Table 11.a.: 2007 Estimated Number of CSHCN in Montana[38]

Estimated Number of CSHCN in 2007:	Estimated Number of non-CSHCN in 2007:
40,975	***186,991***

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

[36] National Survey of Children with Special Health Care Needs

[37] Data Resource Center for Child and Adolescent Health (DRC)

[38] Children with Special Health Care Needs in Context: A Portrait of States and the Nation 2007,

Table 11.b.: Indicators, Montana and the Nation, 2007[39]

Indicator	Explanation (percent of children)	Montana % Non-CSHCN	Montana % CSHCN	National % CSHCN
Physical Activity	• aged 6—17 who exercise 4 or more days per week	71.3	56.6	60.9
Overweight/Obese	• aged 10—17 who are overweight or obese	27.3	32.1	36.3
Inadequate Insurance	• with current insurance that is not adequate to meet health needs	30.3	35.5	29.4
Indicator	**Explanation (percent of children)**	**State % Non-CSHCN**	**State % CSHCN**	**National % CSHCN**
Preventive Medical Care	• with 1 or more preventive medical visits in the past year	79.3	86.2	91.4
Preventive Dental Care	• with 2 or more preventive dental visits in the past year	41.4	44.2	57.1
Specialist Access	• who have problems receiving specialist care when needed	21.8	32.6	27.0
Medical Home	• who receive comprehensive, ongoing and coordinated care within a medical home	63.4	53.2	49.8
Personal Dr. or Nurse	• with at least one personal doctor or nurse	88.9	92.0	94.7
Usual Source of Care	• with a usual source of care when sick	93.6	95.9	94.8
Family Centered Care	• who receive family-centered care	71.1	67.8	65.5
Smoking in the Home	• who live in households where someone smokes inside the home	4.7	8.1	10.1
Television and Media	• aged 1—17 who watch more than 1 hour of TV per weekday	42.2	43.9	54.3
Family Meals	• who share meals with their family on 4 or more days per week	84.6	78.7	76.0
Inadequate Sleep	• aged 6—17 who do not get adequate sleep every night of the week	43.4	46.5	41.1
Maternal Health	• who live with mothers who are in excellent or very good health	63.3	43.6	47.8
Parental Coping	• whose parents feel they are coping very well with demands of parenthood	61.3	38.6	51.9
Parent-Child Relationship	• who share ideas with their parents very well	72.0	56.4	62.6
Parental Stress	• whose parents usually or always feel stress due to parenting	5.2	22.8	20.0
School Engagement	• aged 6—17 who are adequately engaged in school	84.8	69.5	69.5
Missed School Days	• aged 6—17 who missed 11 or more days of school in the past year	5.3	26.5	13.5
Repeating a Grade	• aged 6—17 who have repeated one or more grades since kindergarten	7.6	15.2	18.5

[39] Ibid., Montana Report, Children with Special Health Care Needs in Context

Table 11.b.: Indicators, Montana and the Nation, 2007 (cont.)

Indicator	Explanation (percent of children)	State % Non-CSHCN	State % CSHCN	National % CSHCN
Neighborhood Resources	• who live in neighborhoods with a park, sidewalks, a library, and a community center	41.2	45.1	47.9
Safety of Child in Neighborhood	• who live in neighborhoods that are always safe	58.0	50.7	49.2
Quality of Care	• who meet a minimum quality of care index	35.9	34.0	35.9
Home Environment	• who meet criteria for a home environment summary measure	45.2	27.1	22.7
Neighborhood & School	• who meet criteria for a neighborhood/ school safety and support measure	55.4	45.3	48.6

Table 12: CSHCN Indicators for Montana and the Nation

	2005/2006		2009/2010	
National Chartbook Indicators	**Montana**	**Nation**	**Montana**	**Nation**
Child Health				
CSHCN whose conditions affect their activities usually, always, or a great deal	**28.7%**	24.0%	**30.6%**	27.1%
CSHCN with 11 or more days of school absences due to illness	**18.7%**	14.3%	**22.3%**	15.5%
Health Insurance Coverage				
CSHCN without insurance at some point in past year	**17.4%**	8.8%	**16.1%**	9.3%
CSHCN without insurance at time of survey	**10.3%**	3.5%	**8.4%**	3.5%
Currently insured CSHCN whose insurance is inadequate	**33.5%**	33.1%	**37.4%**	34.3%
Access to Care				
CSHCN with any unmet need for specific health care services	**21.8%**	16.1%	**31.1%**	23.6%
CSHCN with any unmet need for family support services	**7.6%**	4.9%	**10.2%**	7.2%
CSHCN who need a referral and have difficulty getting it	**23.4%**	21.1%	**24.4%**	23.4%
CSHCN without a usual source of care when sick (or who rely on the emergency room)	**7.4%**	5.7%	**10.5%**	9.5%
CSWHCN without any personal doctor or nurse	**9.5%**	6.5%	**13.4%**	6.9%
Family Centered Care				
CSHCN without family-centered care	**37.7%**	34.4%	**35.7%**	35.4%
Impact on Family				
CSHCN whose families pay $1,000 or more out of pocket in medical expenses per year for the child	**26.2%**	20.0%	**31.3%**	22.1%
CSHCN whose conditions cause financial problems for the family	**25.3%**	18.1%	**29.8%**	21.6%
CSHCN whose families spend 11 or more hours per week providing or coordinating child's health care	**12.3%**	9.7%	**13.2%**	13.1%
CSHCN whose conditions cause family members to cut back or stop working	**22.0%**	23.8%	**23.1%**	25.0%

In 2009, several focus groups were held throughout Montana to determine the challenges, concerns, and resources related to maternal and child health issues in the state. Participants included parents of children 0—2 years of age, teenagers, and parents of children with special health care needs. The results were prioritized as follows:

1. Finding resources, services and information
2. Finances
3. Health care specialists in the state
4. Health care providers accepting Medicaid children
5. Coordination of services
6. Health care services for children regardless of age
7. Respect and courtesy from all professionals
8. Medicaid coverage for all disabled children, children who are chronically ill, or have life-threatening illness, regardless of income
9. Family therapy with a therapist who understands how disability affects the whole family
10. Support from the school system

Pre-School and School-Aged Children with Disabilities

The Montana Office of Public Instruction, Division of Special Education, is responsible for assuring that children with disabilities receive a free and appropriate public education in the least restrictive environment. Division staff provide 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.[40]

Table 13: Montana Children Ages 3—5 with Disabilities Receiving Special Education[41]

Disability	Age 3	Age 4	Age 5	Total	Disability Percentage
Autism	8	22	24	54	2.76%
Deaf-blindness	2	0	0	2	0.10%
Developmental delay	186	275	281	742	37.97%
Emotional disturbance	0	0	3	3	0.15%
Hearing impairment	2	8	8	18	0.92%
Mental retardation	1	4	9	14	0.72%
Multiple disabilities	2	1	6	9	0.46%
Orthopedic impairment	1	3	2	6	0.31%
Other health impairment	1	8	8	17	0.87%
Specific learning disability	0	0	13	13	0.67%
Speech or language impairment	146	362	562	1,070	54.76%
Traumatic brain injury	1	1	0	2	0.10%
Visual impairment	2	1	1	4	0.20%
Total	**352**	**685**	**917**	**1,954**	**100.00%**

[40] Montana Office of Public Instruction: School Programs: Special Education

[41] Montana Report of Children Ages 3—5 with Disabilities Receiving Special Education Discrete Age by Disability, Reporting Period 2008—2009

"In 1975, Congress enacted the *Education for All Handicapped Children Act,* which required all public schools that accept federal funds to provide equal access to education for children with physical and mental disabilities. Congress reauthorized the act in 1990, expanded certain programs and renamed it the *Individuals with Disabilities Education Act (IDEA).* In 2004, Congress amended the law and further clarified its intended purpose that states provide a free appropriate public education for all students aged 3 to 21, including children with disabilities.

IDEA defines a 'child with a disability' as any child who has mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities; and who, by reason thereof, needs special education and related services."[42]

Table 14: Disability Status of School-Aged Children United States and Montana: 2010[43]

Area	In metro areas				Outside metro areas			
	All children	MOE*	% with a disability	MOE	All Children	MOE	% with a disability	MOE
United States	45,042,788	24,254	5.0%	0.1	8,454,357	18,392	6.3%	0.2
Montana	53,855	1,141	5.3%	1.6	104,926	1,386	5.3%	1.3

*Margin of Error

Montana was ***one of six states*** with greater than 93.0% of school-aged children with disabilities living in metro areas enrolled in public schools. Other states were Alaska, Kansas, Maine, North Dakota, and Wyoming.

Youth with Disabilities

Table 15: 2011 Montana Youth Risk Behavior Survey High School Student Frequency Distributions for Students with Disabilities[44]

"The following frequency distributions are based upon surveys with 1,672 high school students with disabilities in Montana during February of 2011. Frequency distributions may not total 1,672 due to non-response, and percents may not total 100 percent due to rounding."[45]

Injury and Violence—Percentage of students who:	1999	2001	2003	2005	2007	2009	2011
During the past 30 days:							
• Rode in a car driven by someone who had been drinking alcohol	46.7	45.6	42.9	38.7	41.5	35.6	31.4

[42] American Community Survey Briefs, School-Aged Children With Disabilities in U.S. Metropolitan Statistical Areas: 2010, Issued November 2011,

[43] "School-aged children" are children aged 5 to 17 who have yet to receive a high school diploma or equivalent.

[44] Montana Youth Risk Behavior Survey (YRBS) Montana Office of Public Instruction, Health Enhancement & Safety Division, June 2011,

[45] Ibid.

Table 15: Montana Youth Risk Behavior Survey (cont.)

Injury and Violence—Percentage of students who:	1999	2001	2003	2005	2007	2009	2011
During the past 30 days:							
• Drove a car when they had been drinking alcohol	28.2	26.6	23.8	21.5	20.7	18.1	14.6
• Texted or e-mailed while driving a car							42.8
• Talked on a cell phone while driving a car							45.8
• Carried a weapon such as a gun, knife, or club	30.3	31.5	25.7	31.3	33.3	28.8	32.2
• Did not go to school because they felt unsafe at school or on their way to or from school	5.9	8.1	7.1	9.0	7.9	8.0	10.2
During the past 12 months:							
• Had property such as their car, clothing, or books stolen or deliberately damaged on school property			30.8	32.2	32.6		32.7
• Had been threatened or injured with a weapon on school property	9.7	14.0	11.5	12.2	12.5	10.2	13.5
• Were in a physical fight	41.4	42.5	38.8	42.7	44.8	41.7	36.6
• Were injured in a physical fight that required medical treatment	21.3	20.9	16.4	20.0	20.3	17.1	18.2
• Had been bullied on school property						33.0	38.3
• Had been electronically bullied, such as through e-mail, chat rooms, instant messaging, etc.						21.3	29.1
• Felt so sad or hopeless for two weeks or more in a row that they stopped doing some usual activities	32.9	35.1	35.9	36.3	36.8	37.3	38.2
• Seriously considered attempting suicide	22.4	25.5	24.4	24.8	23.6	23.9	25.6
Tobacco Use—Percentage of students who:	**1999**	**2001**	**2003**	**2005**	**2007**	**2009**	**2011**
In the past thirty days:							
• Smoked a cigarette	44.6	40.7	36.7	37.0	32.2	31.8	27.7
• Smoked cigarettes on 20 or more of the past 30 days "current")	23.8	20.5	17.3	16.7	15.5	13.5	10.3
Alcohol/Other Drug Use—Percentage of students who	**1999**	**2001**	**2003**	**2005**	**2007**	**2009**	**2011**
In the past thirty days:							
• Had at least one drink of alcohol	58.7	59.4	51.7	52.1	48.8	45.1	41.3
• Had five or more drinks of alcohol in a row	46.8	49.0	40.9	39.3	37.9	33.3	30.1
• Used marijuana ("current")	29.8	30.0	29.8	27.8	25.7	25.8	28.8
• Used any form of cocaine	7.8	8.9	6.7	7.4	7.0	5.0	6.9
Have ever:							
• Taken a prescription drug (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription							24.6
Sexual Behaviors—Percentage of students who:	**1999**	**2001**	**2003**	**2005**	**2007**	**2009**	**2011**
• Ever had sexual intercourse	51.8	52.3	52.5	53.6	54.8	54.6	58.1
• Had sexual intercourse before age 13	11.6	12.2	11.3	11.6	12.0	11.5	11.8
• Had sexual intercourse with four or more people during their life	7.4	20.1	20.6	19.9	18.3	21.1	22.3
• Had sexual intercourse during the last 3 months	34.1	32.4	33.7	36.2		34.1	38.7
Weight Management and Dietary Behaviors—Percentage of students who:	**1999**	**2001**	**2003**	**2005**	**2007**	**2009**	**2011**
• Described themselves as slightly or very overweight	29.4	29.7	32.7	30.1	32.9	34.8	34.5

Table 15: Montana Youth Risk Behavior Survey (cont.)

Weight Management and Dietary Behaviors—Percentage of students who:	1999	2001	2003	2005	2007	2009	2011
In the past 30 days:							
• Went without eating for 24 hours or more to lose weight or to keep from gaining weight	15.2	22.2	17.1	20.4	19.9	20.6	19.9
• Took diet pills, powders, or liquids without a doctor's advice to lose weight or to keep from gaining weight	9.1	11.1	12.0	10.3	12.3	9.4	9.6
During the past seven days:							
• Ate fruit	84.7	84.8	83.5	81.8	82.6	85.9	83.8
• Ate green salad	73.9	71.8	70.3	68.4	64.9	67.5	67.4
• Ate potatoes	80.1	76.4	75.7	69.4	69.5	70.6	72.1
• Ate carrots	55.9	55.8	54.2	54.3	51.7	52.0	52.7
• Ate other vegetables	83.6	81.0	82.4	78.0	77.5	80.3	79.2
• Drank a can, bottle, or glass of soda or pop daily					32.4	32.0	27.0
• Drank a can, bottle, or glass of an energy drink, such as Red Bull or Jolt							38.6
• Ate breakfast							35.2
Physical Activity—Percentage of students who:							
• Were physically active for a total of at least 60 minutes per day on five or more of the past seven days					40.3	43.1	49.1
• Watched three or more hours per day of TV on an average school day	31.8	31.2	33.5	32.4	31.0	26.8	29.9
• On an average school day, played 3 or more hours of video or computer games or used a computer for something not school-related					20.6	21.3	25.7
• Attended physical education classes on one or more days in an average week when they were in school	86.9	58.4	61.1	61.5	57.3	61.2	58.6
• Played on one or more sports teams during the past 12 months	62.2	60.5	58.9	55.8	55.3	52.1	53.0
Other—Percentage of students who:	**1999**	**2001**	**2003**	**2005**	**2007**	**2009**	**2011**
• Had ever been told by a doctor or nurse that they had asthma				27.8	28.3	28.0	27.0
• Had received help from a resource teacher, speech therapist or other special education teacher at school during the past 12 months	100	100	100	100	100	100	100

Table 16: Percentage of Total Students Ages 14 through 21 with Disabilities Served Under IDEA, Part B, Who Exited Special Education, by Exit Reason and State, 2008–09[46]

State	Rank	Graduated with diploma	Received a certificate	Dropped out	Reached maximum age
Minnesota	**1**	68%		8%	0%
Montana	**14**	45%	1%	15%	0%
Nevada	**51**	17%	21%	21%	1%

[46] National Council on Disability, Progress Report 2011

Adults with Disabilities

For more than 20 years, the Montana Behavioral Risk Factor Surveillance System (BRFSS) has gathered information (via telephone survey) from adults about a wide range of behaviors affecting health. From 2001 through 2010, Montana BRFSS data has indicated ***significant*** differences in the health of people with disabilities compared to those without disabilities using Healthy People 2010 Objectives as a guide.[47]

The latest data indicate that Montana adults with disabilities compare ***positively*** to those without disability in attaining **four** HP 2010 objectives:

1) Primary health care provider,
2) Regular blood cholesterol screening,
3) Immunizations against influenza and pneumococcal disease, and
4) Lower overall prevalence of binge drinking.

Conversely, Montana adults with disability reported ***significant health gaps and disparities*** in the attainment of **10** other Healthy People 2010 objectives including:

1) Chronic joint symptoms and arthritis,
2) Clinically diagnosed diabetes,
3) High blood pressure,
4) High blood cholesterol,
5) Clinically diagnosed cardiovascular disease,
6) Asthma,
7) Cigarette smoking,
8) No leisure-time physical activity,
9) Moderate physical activity levels below recommendations, and
10) Not seeing a doctor when needed because of cost.

"People with disabilities are often at greater risk for health problems that can be prevented. Some of these other health conditions are also called secondary conditions and might include fatigue, injury, mental health and depression, overweight and obesity, pain, and pressure sores or ulcers. Chronic diseases are among the most common and costly of all health problems, even though many chronic diseases can be prevented. Some chronic diseases can be prevented by living a healthy lifestyle, visiting a health care provider for preventive care and routine screenings, and learning how to manage health issues."[48]

For more information and tools on other health conditions that are important to living healthy with a disability, click on the links that follow the text in each of the next sections.

[47] Montana Disability and Health Update, December, 2011, Issue 4.
[48] Centers for Disease Control and Prevention, Related Conditions

Table 17: Summary of 2010 BRFSS Data for Montana Adults with and without Disability

	Healthy People 2010 Goals[2] and Year 2010 Target	Montana Adults	-with disability	-without disability
1-1a	Increase to 100% the number of adults who have health insurance (18 or older).	81.6% CI: 79.6-83.3	82.9% CI: 79.4-85.9	81.1% CI: 78.8-83.2
1-5	Increase to 85% the number of adults with a usual primary care provider (18 or older).	73.8% CI: 70.9-76.8	87.3% CI: 84.5-89.8	69.0% CI: 66.5-71.3
3-11a	Increase to 97% the number of women 18 and older who have ever received a Pap test.	95.0% CI: 93.1-96.5	95.2% CI: 90.4-97.6	95.0% CI: 92.7-96.6
3-11b	Increase to 90% the number of women 18 and older who received a Pap test in the past 3 years.	78.3% CI: 75.6-80.7	72.2% CI: 66.1-77.5	80.0% CI: 77.0-82.6
3-12a	Increase to 50% the number of people 50 and older who undergone a FOBT in the past two years.	14.6% CI: 13.4-15.9	17.0% CI: 14.9-19.4	13.3% CI: 11.9-14.8
3-12a	Increase to 50% the number of people 50 and older who have ever undergone a sigmoidoscopy.	61.0% CI: 59.2-62.7	66.1% CI: 63.2-69.0	58.1% CI: 55.5-60.4
3-13	Increase to 70% the number of women 40 and older who have received a mammogram in the past two years.	67.4% CI: 65.3-69.4	66.5% CI: 62.8-70.0	68.1% CI: 65.5-70.5
5-3	Reduce overall diagnoses of diabetes to (2.5%) .	7.0% CI: 6.2—7.9	13.2% CI: 11.4-15.3	4.8% CI:4.0-5.7
5-12	Increase to 50% the number of adults with diabetes who have a glycosylated hemoglobin measurement at least once a year.	89.9% CI:86.6-92.5	89.9% CI: 84.9-93.3	89.9% CI: 85.0-93.3
5-14	Increase to 75% the number of adults with diabetes who have at least one annual foot exam.	73.5% CI: 68.5-78.0	72.4% CI:65.4-78.4	74.4% CI: 66.8-80.7
5-17	Increase to 60% the number of adults with diabetes who perform self-blood-glucose-monitoring at least daily.	56.7% CI: 49.7-64.9	56.7% CI: 47.3-69.7	56.4% CI: 46.4-67.5
6-5	Increase to 79% the number of people with disabilities reporting that they have sufficient emotional support (always or usually).	82.0% 78.1-86.0	74.8% 68.0-81.9	84.7% 80.0-89.5
6-6	Increase to 96% the number of people with disabilities reporting satisfaction with life (satisfied or very satisfied).	95.3% CI: 91.2-99.3	89.4% CI: 82.1-96.7	97.3% CI:92.5-102.1
14-29a	Increase to 90% the non-institutionalized adults age 65 older vaccinated annually against influenza.	65.5% CI: 63.1-67.7	71.0% CI: 67.4-74.3	61.9% CI:58.7-64.9
14-29b	Increase to 90% the non-institutionalized adults ever vaccinated against pneumococcal disease.	71.8% CI: 69.5-73.9	80.2% CI: 76.9-83.1	65.9% CI: 62.8-68.9
19-1	Increase to 60% the number of adults at a healthy weight.	38.7% CI: 36.7-40.8	29.5% CI: 26.1-33.2	41.9% CI: 39.4-44.4
19-2	Reduce the number of adults who are obese to 15%.	23.5% CI: 22.0-25.1	32.7% CI: 29.7-36.0	20.3% CI: 18.6-22.2
21-10	Increase to 56% the number of adults that use the oral health care system each year.	61.1% CI: 59.1-63.0	57.4% CI: 53.8-61.0	62.4% CI: 60.0-64.7
22-1	Reduce the number of adults who engage in no leisure-time physical activity to 20%.	21.6% CI: 20.2-23.1	31.8% CI: 28.8-35.0	18.0% CI: 16.4-19.7
26-11c	Reduce to 6% the number of adults reporting binge drinking alcoholic beverages in the past 30 days.	17.0% CI: 15.4—18.6	11.1% CI: 9.0-13.8	19.1% CI: 17.2—21.1
27-1a	Reduce cigarette smoking in adults to 12%.	18.8% CI: 17.1-20.6	25.5% CI: 21.9-29.4	16.5% CI: 14.7-18.5

Table 18: Disability, Montana Adults, 2010

	Require Use of Special Equipment[49]				Self-Reported Disability[50]			
		95% CI				95% CI		
	WT.%	LL	UL	UnWt. N	WT.%	LL	UL	UnWt. N
ALL ADULTS	7.4	6.6	8.2	759	26.0	24.4	27.7	2,264
Sex:								
Male	7.2	6.1	8.6	292	25.9	23.4	28.6	938
Female	7.5	6.6	8.5	467	26.1	24.0	28.2	1,326
Age:								
18—24	2.5	0.7	8.5	6	13.8	7.9	23.1	22
25—34	3.1	1.6	5.9	15	19.1	14.2	25.3	89
35—44	3.7	2.4	5.6	41	15.6	12.6	19.1	151
45—54	5.2	3.9	6.8	77	26.5	23.5	29.8	371
55—64	8.9	7.4	10.7	155	33.5	30.9	36.3	605
65+	18.1	16.3	20.0	462	40.8	38.5	43.2	1,018
Education:								
<High School	11.7	7.6	17.7	86	36.8	29.2	45.0	216
High School	7.0	5.8	8.4	238	24.8	22.1	27.6	729
Some College	7.9	6.7	9.5	242	28.1	24.9	31.6	713
College Degree	6.1	5.0	7.4	191	22.4	19.9	25.0	602
Income:								
<$15,000	16.0	12.1	20.8	191	47.9	41.2	54.6	483
$15,000--$24,999	10.9	8.6	13.7	178	32.9	28.3	37.9	488
$25,000--$49,999	5.9	4.9	7.2	162	24.5	21.8	27.4	583
$50,000--$74,999	4.9	3.6	6.7	63	19.3	15.6	23.6	231
$75,000 +	3.2	2.4	4.3	61	16.0	13.5	18.8	251
Race/Ethnicity								
White, non-Hispanic	7.1	6.3	7.8	643	25.0	23.3	26.7	1,920
American Indian or Alaska Native only	9.1	6.5	12.7	79	27.0	21.7	33.0	212
Other or Hispanic	10.5	5.5	19.2	32	38.2	28.7	48.7	112
Region:								
1—Eastern MT	6.9	5.3	9.0	84	23.3	20.1	26.8	264
2—N Central MT	8.3	6.4	10.8	151	25.8	22.3	29.7	444
3—S Central MT	6.8	5.3	8.6	107	26.6	22.3	31.3	315
4—Southwest MT	6.5	5.3	8.1	157	22.8	19.6	26.3	439
5—Northwest MT	8.0	6.5	9.8	249	28.4	25.6	31.4	777
MMSA—Billings	6.2	4.6	8.4	60	25.9	21.2	31.4	170
MMSA—Helena	7.8	5.5	11.0	77	26.0	21.7	30.8	205
MMSA—Kalispell	5.6	4.2	7.4	65	24.9	21.2	29.0	217

[49] Do you now have any health problems that require you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone? Total Sample Size: 7,300.

[50] Disability is defined as a "Yes" response to one or both of the questions: 1) Are you limited in any way in any activities because of physical, mental, or emotional problems? 2) Do you now have any health problem that requires you to use special equipment? Total Sample Size: 7,278, Weighted Prevalence Estimate: 197,000.

According to Surgeon General Regina M. Benjamin, MD, MBA, "Today's epidemic of overweight and obesity threatens the historic progress we have made in increasing American's quality and years of healthy life. The hard facts:

- Two-thirds of adults and nearly one in three children are overweight or obese. 70% of American Indian/Alaskan Native adults are overweight or obese.
- The prevalence of obesity in the U.S. more than doubled (from 15% to 34%) among adults and more than tripled (from 5% to 17%) among children and adolescents from 1980 to 2008.
- An obese teenager has over a 70% greater risk of becoming an obese adult.

"Change starts with the individual choices Americans make each day for themselves, their families and those around them. To help achieve and maintain a healthy lifestyle, Americans of all ages should: reduce consumption of sodas and juices with added sugars; eat more fruits, vegetables, whole grains, and lean proteins; drink more water and choose low-fat or non-fat dairy products; limit television time to no more than 2 hours per day; and be more physically active."[51]

Table 19: Montana Overweight and Obesity (BMI) Data, 2010

Weight classification by Body Mass Index (BMI)			
	Neither overweight nor obese (bmi < 24.9)	**OVERWEIGHT (bmi 225.0—29.9)**	**OBESE (bmi 30.0—99.8)**
% CI n	**38.7 (36.6—40.8) 2562**	**37.8 (35.9—39.7) 2721**	**23.5 (21.9—25.1) 1825**

Healthy People Program

The national Healthy People (HP) initiative was launched in 1979 with the publication of *Healthy People: the Surgeon General's Report on Health Promotion and Disease Prevention*, a document presenting quantitative goals to reduce preventable death and injury by 1990. The U.S. Public Health Service released a companion document in 1980, setting out specific, quantifiable objectives to attain these broad goals by 1990. Since then, the U.S. Department of Health and Human Services has issued updated national health promotion and disease prevention goals and objectives each decade—Healthy People 2000 (issued in 1990), Healthy People 2010 (issued in 2000) and Healthy People 2020, issued in 2010. Throughout the decades, the Healthy People initiative has expanded in size. The number of objectives has increased with each update, as have the number of categories for organizing those objectives.[52]

The HP2020 focus on Improving access to comprehensive, quality health care services is a major step in achieving health equity and for increasing the quality of a healthy life for everyone. There are four major components of access to care:

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[51] The Surgeon General's Vision for a Healthy and Fit Nation Fact Sheet

[52] U.S. Department of Health & Human Services, Healthy People 2020 Topics & Objectives

1. Coverage: adequate health insurance coverage helps patients enter and stay in the health care system.
2. Services: having a primary care provider (PCP) as the usual source of care is especially important for better health outcomes and fewer disparities and costs.
3. Timeliness: the health care system's ability to provide health care quickly after a need is recognized.
4. Workforce: PCPs play an important role in the general health of the communities they serve. However, there has been a decrease in the number of medical students interested in working in primary care. To improve the Nation's heath, it is important to increase and track the number of practicing PCPs.

Specific issues that will be monitored over the next decade include 1) increasing and measuring access to appropriate, safe, and effective care, including clinical preventive services; 2) decreasing disparities and measuring access to care for diverse populations, including racial and ethnic minorities and older adults; and 3) increasing and measuring access to safe long-term and palliative care services and access to quality emergency care.

Table 20: Healthy People 2020 Disability and Health (DH) Objectives

DH-1	Include in the core of Healthy People 2020 population data systems a standardized set of questions that identify "people with disabilities."	
DH-2	Increase the number of Tribes, States, and the District of Columbia that have public health surveillance and health promotion programs for people with disabilities and caregivers.	
	DH-2.1	Increase the number of State and District of Columbia (DC) health departments that have at least one health promotion program aimed at improving the health and well-being of people with disabilities.
	DH-2.2	Increase the number of State and DC health departments that conduct health surveillance for caregivers of people with disabilities.
	DH-2.3	Increase the number of State and DC health departments that have at least one health promotion program aimed at improving the health and well-being of caregivers of people with disabilities.
	DH-2.4	Increase the number of Tribes that conduct health surveillance for people with disabilities.
	DH-2.5	Increase the number of Tribes that have at least one health promotion program aimed at improving the health and well-being of people with disabilities.
	DH-2.6	Increase the number of Tribes that conduct health surveillance of caregivers of people with disabilities.
	DH-2.7	Increase the number of Tribes that have at least one health promotion program aimed at improving the health and well-being of caregivers of people with disabilities.

Table 20: Healthy People 2020 Disability and Health (DH) Objectives (cont.)

DH-3	Increase the proportion of US master of public health (MPH) programs that offer graduate-level courses in disability and health.
DH-4	Reduce the proportion of people with disabilities who report delays in receiving primary and periodic preventive care due to specific barriers.
DH-5	Increase the proportion of youth with special health care needs whose health care provider has discussed transition planning from pediatric to adult health care.
DH-6	Increase the proportion of people with epilepsy and uncontrolled seizures who receive appropriate medical care.
DH-7	Reduce the proportion of older adults with disabilities who use inappropriate medications.
DH-8	Reduce the proportion of people with disabilities who report physical or program barriers to local health and wellness programs.
DH-9	Reduce the proportion of people with disabilities who encounter barriers to participating in home, school, work, or community activities.
DH-10	Reduce the proportion of people with disabilities who report barriers to obtaining the assistive devices, service animals, technology services, and accessible technologies that they need.
DH-11	Increase the proportion of newly constructed and retrofitted US homes and residential buildings that have visitable features.
DH-12	Reduce the number of people with disabilities living in congregate care residences.
	DH-12.1 Reduce the number of adults with disabilities (aged 22 years and older) living in congregate care residences that serve 16 or more persons.
	DH-12.2 Reduce the number of children and youth with disabilities (aged 21 years and under) living in congregate care facilities.
DH-13	Increase the proportion of people with disabilities who participate in social, spiritual, recreational, community, and civic activities to the degree that they wish.
DH-14	Increase the proportion of children and youth with disabilities who spend at least 80% of their time in regular education programs.
DH-15	Reduce unemployment among people with disabilities.
DH-16	Increase employment among people with disabilities.
DH-17	Increase the proportion of adults with disabilities who report sufficient social and emotional support.
DH-18	Reduce the proportion of people with disabilities who report serious psychological distress.
DH-19	Reduce the proportion of people with disabilities who experience nonfatal unintentional injuries that require medical care.
DH-20	Increase the proportion of children with disabilities, birth through age 2 years, who receive early intervention services in home or community-based settings.

People with disabilities can find it more difficult to eat healthy, control their weight, and be physically active. This might be due to the following:

- A lack of healthy food choices
- Difficulty with chewing or swallowing food, or its taste or texture
- Medications that can contribute to weight gain, weight loss, and changes in appetite
- Physical limitations that can reduce a person's ability to exercise
- Pain
- A lack of energy
- A lack of accessible environments (for example, sidewalks, parks, and exercise equipment) that can enable exercise
- A lack of resources (for example, money, transportation, and social support from family, friends, neighbors, and community members)

However, all people can eat more fruits and vegetables and fewer foods high in fat and sugar, drink more water instead of sugary drinks, watch less television, be more physically active, and promote policies and programs at school, at work, and in the community that make the healthy choice the easy choice.[53]

Table 21:

Weight and Physical Activity Data, Persons with and without Disability, 2001—2010[54]

Healthy People 2010 goals[2] & year 2010 target		2001	2003	2004	2005	2006	2007	2008	2009	2010
Increase to 60% the number of adults at a healthy weight										
19-1	all adults	43%	43%	43%	43%	41%	38%	38%	37%	39%
	with disability	34%	34%*	33%*	34%*	35%*	32%*	31%*	28%*	30%*
	without disability	46%	46%	45%	45%	42%	40%	41%	40%	42%
Reduce to 15% the number of adults who are obese										
19-2	all adults	19%	19%	20%	21%	21%	23%	24%	24%	24%
	with disability	30%	28%*	32%*	29%*	30%*	30%*	38%*	1%*	33%*
	without disability	16%	16%	17%	19%	19%	20%	21%	22%	20%

[53] The Surgeon General's Vision for a Healthy and Fit Nation Fact Sheet

[54] Sources: [1]Behavioral Risk Factor Surveillance System. Public Health Service, Healthy People 2010: National Health Promotion and Disease Prevention Objectives—full report with commentary. Washington, DC: US Dept. of HHS, 2000, Montana BRFSS Data, 2001 and 2003—2010; * indicates a significant difference between adults **with** and **without** a disability

Table 21: Weight and Physical Activity Data, Persons with and without Disability, 2001—2010 (cont.)

Healthy People 2010 goals[2] & year 2010 target		2001	2003	2004	2005	2006	2007	2008	2009	2010
Reduce to 20% the number of adults who engage in no leisure-time physical activity										
22-1	all adults	22%	20%	19%	22%	19%	20%	23%	22%	22%
	with disability	35%	34%*	33%*	39%*	32%*	33%*	34%*	34%*	32%*
	without disability	19%	17%	15%	18%	16%	16%	20%	19%	18%
Increase to 30% the number of adults who engage in regular, moderate physical activity										
22-2	all adults	51%	59%	---	57%	---	58%	---	48%	---
	with disability	37%	49%*	---	41%*	---	48%*	---	39%*	---
	without disability	55%	61%	---	61%	---	61%	---	50%	---
Increase to 30% the number of adults who engage in regular vigorous activity										
22-3	all adults	---	33%	---	33%	---	33%	---	36%	---
	with disability	---	22%*	---	21%*	---	21%*	---	23%*	---
	without disability	---	36%	---	37%	---	36%	---	40%	---

Table 22: Montana and the U.S. Indicator Report on Physical Activity, 2010[55]

	Adults			Students in grades 9--12	
	Physically Active	Highly Active	No leisure-time physical activity	Physically Active	Daily physical education
U.S.	**64.5**	**43.5**	**25.4**	**17.1**	**30.3**
Montana	**72.4**	**52.2**	**22.8**	**21.2**	**32.8**

[55] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, PA State Indicator Report 2010

Table 23:

Montana and the U.S. Physical Activity Policy and Environmental Indicators 2010[56]

Strategies				
	Create/enhance access to places for physical activity			
	% of middle and high schools that allow youth use of PA facilities	% of youth with parks, community centers and sidewalks in neighborhood	% of census blocks with park within ½ mile of boundary	% of census blocks with fitness center within ½ mile of boundary
U.S.	**89.4**	**50.0**	**20.3**	**16.6**
MT	**93.9**	**43.7**	**3.1**	**7.1**

	Enhance PE and PA in schools and PA in child care settings			
	Require or recommend elem. schools provide scheduled recess	Require elementary, middle & high schools to teach PE	% of middle & high schools that support walking or biking to & from school	Child care centers specify MVPA
U.S.	**20**	**37**	**46.1**	**8**
MT	**No**	**Yes**	**58.5**	**Yes**

	Support urban design, land use and transportation policies		
	Community scale urban design/ land use policy	Street-scale urban design/land use policy	Transportation and travel policy
U.S.	**27**	**23**	**36**
MT	**No**	**Yes**	**No**

	Develop Physical Activity Public Health Workforce
	Number of state physical activity full-time equivalent personnel
U.S.	1
MT	1.0

[56] Ibid.

State and National Progress

Since 2005, several national and statewide initiatives have been initiated or improved.

In 2005:

- The Surgeon General issued a *Call to Action to Improve the Health and Wellness of Persons with Disabilities.*[57]
- The American Association of Retired Persons (AARP) Public Policy Institute, in collaboration with the Arizona State University Herberger Center for Design Excellence, updated their 2000 publication of *Living Communities: An Evaluation Guide* and defined a livable community as "one that has affordable and appropriate housing, supportive community features and services, and adequate mobility options, which together facilitate personal independence and the engagement of residents in civic and social life."
- The Montana legislature passed the Clean Indoor Air Act (CIAA), requiring all enclosed public places and workplaces to be smoke free and requiring businesses to prominently place smoke free signs on all public entrances.

In 2006:

- The United Nations adopted the Convention on the Rights of Persons with Disabilities and its Optional Protocol. The latter was opened for signature on March 30, 2007.[58]

In 2007:

- The Centers for Disease Control and Prevention (CDC) developed the "Breast Cancer Screening: The Right to Know" campaign to increase awareness of breast cancer among women with physical disabilities and to encourage these women to be screened.

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 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).

In 2009:

- The U.S. signed the UN Convention on the Rights of Persons with Disabilities.
- Vice President Joe Biden announced Kareem Dale as the first *Assistant to the President for Disability Policy*.
- On February 17, President Obama signed the *American Recovery and Reinvestment Act* to provide:

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[57] Surgeon General's Call to Action

[58] Convention on the Rights of Persons with Disabilities

    - Financial assistance to states as well as an extension of unemployment benefits and COBRA health insurance subsidies;
    - Financial assistance for new infrastructure, manufacturing, transit, and green energy technology; and
    - The largest middle class tax cut in American history.
- On March 9, President Obama signed an executive order lifting the restrictions on federal funding for stem cell research.
- On March 30, President Obama signed the Christopher and Dana Reeve Paralysis Act that improves the quality of life for people living with paralysis and mobility impairments (from stroke, ALS, spinal cord injuries, and other causes).
- On June 9, the Surgeon General's *Call to Action to Promote Healthy Homes* was issued. This *Call to Action* looks at the ways housing can affect health and initiates a national dialogue about the importance of healthy homes.
- On June 22, the 10th anniversary of the Olmstead decision, President Barack Obama launched *The Year of Community Living* to reaffirm the Administration's commitment to "vigorous enforcement of the civil rights for Americans with Disabilities and to ensuring the fullest inclusion of all people in the life of our nation."[59]
- On October 1, the *Montana Clean Indoor Air Act* for smoke-free environments was applied to bars, taverns and casinos throughout the state.

In 2010:

- On March 23, President Obama signed the Patient Protection and Affordable Health Care Act into law.[60]
- 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.[61] 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.[62]
- 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.[63]
- 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

[59] HHS.gov Serving People with Disabilities
[60] The Patient Protection and Affordable Health Care Act Section by Section Analysis, Association of University Centers on Disabilities
[61] Providing Individuals with Disabilities the Tools to Live Independently
[62] National Center on Physical Activity and Disability
[63] Intellectual Disability: Definition, Classification, and Systems of Support, 11th Edition

went through several rounds of cognitive testing and has been adopted in most major federal data collection systems.[64]

- 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.[65]
- 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 outcomes are tracked across the ADRC network. Through the grant, states will also design, implement and test draft standards for Options Counseling.[66]
- 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[67] 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. [68]

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.[69]
- 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.[70]
- In April, the NCBDDD celebrated its 10th anniversary with notable achievements, including autism and sickle cell awareness.[71]
- 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

[64] For more information on improving data collection to reduce health disparities, click on: Improving Data Collection to Reduce Health Disabarities

[65] For more information, click on: National Transportation Library, Livable Communities Initiative

[66] Administration on Aging, Draft National Options Counseling Standards,

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

[68] The Arc, Still in the Shadows with Their Future Uncertain, a Report on Family and Individual Needs for Disability Supports (FINDS, June 2011

[69] MMWR, Supplement/Vol.60, January 14, 2011

[70] National Center on Birth Defects and Developmental Disabilities (NCBDDD) Strategic Plan

[71] Bright Futures: Family Matters, Volume 12, Issue 2, Summer 2011

health surveys in ways that will help researchers better understand health disparities and zero in on effective strategies for eliminating them.[72]

- 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.[73]

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*.[74]
- On February 8, 2012, 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.[75]
- In March, the Aging and Disability Resource Center (ADRC), an initiative of the U.S. 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
    - Consumer population partnerships and stakeholder involvement
    - Quality assurance and continuous improvement

- On March 21, the Association of University Centers on Disabilities (AUCD) expressed strong disappointment in the proposed federal budget that lowers the overall discretionary spending cap. Medicaid, the sole lifeline for many individuals with developmental disabilities, would be severely cut over the next ten years and converted to block grants to states.[76]

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[72] HHS press release, June 29, 2011
[73] HHS Press Office
[74] To read the entire article, click on: Women's Issue Brief
[75] Alaska Health Policy Review
[76] AUCD Press Statement, March 21, 2012

Vision, Mission and Goals

Vision

The Montana Disability and Health (MTDH) Program Advisory Board envisions a state where *all* people with disabilities are healthy in body, mind and spirit and have equal opportunities to participate in their communities —a place where people with disabilities go where they want to go, do what they want to do, have their individual needs met, and are treated with respect.[77] 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.

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[77] 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. Accessibility: A guiding principle of the Convention

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.
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).
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
  - 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 25: Outcome Goals

Long-term Outcome Goal

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

Intermediate Outcome Goal

↑	↑	↑	↑	↑
• Build capacity of the MTDH program & partnerships	• Support direct health promotion services and programs that meet the specific health promotion needs of PWD	• Increase access to generic health promotion services, ensuring civil rights of PWD	• Improve access to community environments, ensuring civil rights of PWD • Improve comm. Planning to optimize resilience of PWP (EP)	• Integrate disability and health agenda into public policies that influence the health of PWD

Short Term Outcome Goals

↑	↑	↑	↑	↑
• Increase availability of disability and health data ▪ Educate partners about disability and health issues ▪ Additional funding	• Train partners to implement programs and provide services (such as *Living Well with a Disability*) ▪ Support peer mentoring programs (such as *Have Healthy Teeth*)	▪ Increase awareness of public health partners about barriers experienced by PWP. ▪ Increase awareness of PWD regarding the benefits of generic services. ▪ Support removal of barriers	• Increase community awareness of barriers experienced by PWD. ▪ Support removal of barriers	• Educate policy professionals ▪ Partner with other agencies and programs ▪ Integrate disability and health into long-range plans

Outputs, Products Activities

↑	↑	↑	↑	↑
▪ Surveillance ▪ Disability Advisors ▪ Epidemiology studies ▪ New partnerships	▪ Nutrition ▪ Oral health ▪ Funding ▪ LWD Program	▪ Assessment tool ▪ Curriculum ▪ Information and materials ▪ Technical assistance ▪ Disability advisors ▪ Awareness	▪ Surveys ▪ Training ▪ Accessibility Ambassador program ▪ Architectural design Resources & tools (EP planning)	▪ Establish partnerships & collaborative arrangements

Outcome Goal One: Enhance Program Infrastructure and Capacity

The *United Nations Development Programme* (UNDP) defines capacity building as a long-term continual process of development that involves *all* stakeholders (including ministries, local authorities, non-governmental organizations, professionals, community members, academics and more). Capacity building uses a country's human, scientific, technological, organizational, institutional and resource capabilities. The goal of capacity building is to tackle problems related to policy and methods of development, while considering the potential, limits and needs of the people of the area concerned. The UNDP outlines capacity building as taking place on an individual level, an institutional level and the societal level.[78]

SMART Objective 1A

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

Rationale

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

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

Activities

Core Management Team

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

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

MTDH Staff:

- 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 Psychology Department graduate students collecting original data that could be used to draft analytical reports for the MDPHHS.
- Act as liaison between MDPHHS staff and UM staff.

Public Health & Safety Division Staff:

- 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 Staff:

- 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.

SMART Objective 1B

By January of 2013, the UMRI will develop training materials for public health professionals and 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 staff:

- 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.

SMART 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 Staff:

- Continuously identify and pursue opportunities for collaboration.
- Identify and apply for relevant competitive grants.
- Seek support from private foundations, corporations and community partners.

SMART 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 Staff:

- 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*[79]
- By September 1, 2014, submit grant application for *Healthy Habits: Timing for Developing Sustainable Healthy Behaviors I Children and Adolescents (R03)*[80]

[79] U.S. Department of Health and Human Services, National Institutes of Health, Modification 1

[80] Ibid., U.S. DPHHS, National Institutes of Health, Modification 2

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*.[81] These programs are effective in improving participant health and well being and are slated for expansion over the next five years.

Smart 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 for 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 Staff

- 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.
- Integrate the MENU-AIDDs program evaluation into the statewide data monitoring systems, such as Therap.

[81] **M**aterials Supporting **E**ducation and **NU**trition for **A**dults with **I**ntellectual and **D**evelopmental **D**isabilities

- Integrate adults with IDD into existing nutrition health promotion efforts, such as the Diabetes Prevention Program, and an understanding of the nutritional needs of persons with IDD into the professional practice of nutrition agencies, such as County Extension and WIC.
- Continue to create evidence for the MENU-AIDDs program through research funded external to the MTDH.

SMART 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 shows that people with disabilities can manage and even prevent the negative effects of secondary conditions through health promotion activities" (Ravesloot et. al., 2007).[82]

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.[83]

Activities

MTDH Staff

- 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.

[82] Living Well with a Disability
[83] Findings from a Study of the Working Well with a Disability Program, Research Report 2010

- 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 as a self-management component in new student orientation,
  - Including all students, not just students with disabilities, and
  - Partnering with CILs to provide facilitators.
- Explore the possibility of LWD being incorporated into continuing education classes on college campuses while assuring the integrity of the program.
- Partner with County Extension Offices to make referrals to LWD and WWD Programs.
- Collect outcome data from specific sentinel sites and collect process evaluation data from other sites in the state to address need for both effectiveness data and impact data.
- Identify other evidence-based peer support programs.
- Develop and execute a survey to determine existing peer support groups for persons with disabilities living in Montana.
- Assess the need for peer support networks throughout Montana.
- Offer Peer Training, Peer Support Training and Peer Specialist Training through the LWD Program.
- Contact the VA hospital in Helena to identify viable peer support programs for amputees in Montana.
- Determine best practices for peer support networks.

Outcome Goal Three: Improve Access to Generic Services

"Today, about 50 million Americans, or 1 in 5 people, 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."[84]

"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."[85]

SMART 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 and 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.

Rationale

"Education in disability should range from clinical information about specific conditions, practical issues about medical procedures, through to exploration of the human rights approach to disability. It is important for professionals to understand not just disease, but also the experience of living with disability. Improved survival rates, the shift from acute to chronic disease, and the ageing of the population mean that the number of disabled people in the population is likely to increase; thus, the need for effective education about their health-care needs is even more pressing. Disabled people have great insight into their own condition and this can ideally make their relationships with health professionals more of a partnership, where each can learn from the other and where disabled people and their health-care choices are respected."[86]

[84] People with Disabilities: Living Healthy
[85] Ibid.
[86] Disability and the Training of Health Professionals, The Lancet, Volume 374, Issue 9704, pages 1815—1816,29 November 2009,

Activities

MTDH Staff

- Continue to provide training and technical assistance to the 46 Montana Community Health Centers (CHCs) and Rural Health Clinics (RHCs), as well as the 40 Montana mammography centers that were previously assessed for accessibility.
- Continue to Increase CHCs and RHCs 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 by:
    - Collaborating with the *Montana Geriatric Resource Center of the University of Montana* to develop online courses targeted toward health professionals who work with PWD.[87]
    - Collaborating with the *Kansas University Research & Training Center on Independent Living* to adopt training modules pertinent to the online or in-person training of health professionals.[88]
- In collaboration with local and national partners, identify resources and materials that have been useful to health care facilities and providers for addressing accessibility barriers to receiving health care services.

SMART 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.

Rationale

Removing Barriers to Health Care, a Guide for Health Professionals strongly encourages disability and health programs to create a team that will help determine and meet accessibility standards and include people with a variety of disabilities on the team."[89] In 2003, the MTDH Accessibility Ambassadors program was initiated. Since that time, Ambassadors have demonstrated methods for assessing program and facility accessibility of community health and fitness programs, health departments, and mammography centers.

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[87] Montana Geriatric Resource Center of the University of Montana

[88] KU Research & Training Center on Independent Living

[89] Ibid.

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).

Accessibility Ambassadors

- Provide input regarding:
  - Accessibility issues and ways to address those issues; and
  - Customer-based services for persons with disabilities.

SMART 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.

Rationale

MTDH staff has been successful in educating students of other disciplines about MTDH by:

- Supporting MSU Nursing students in fulfilling requirements of their senior public health nursing program, *Population-Based Nursing in the Community,* through Right to Know activities.
- Training Master of Public Health (MPH) Program students and Montana State University nursing students on the Montana BRFSS prevalence interactive data system.
- Introducing the *I Can Do It* (ICDI) mentoring opportunity to UM health-related courses, engaging 102 interested students in further ICDI orientation, and matching 22 students as mentors with 20 middle school students to start the ICDI program in late March of 2010.
- Supervising two Health and Human Performance department students to evaluate the current use (including barriers and facilitators) of MENU-AIDDs through telephone interviews of group home managers who have taken MENU-AIDDs training. Results were used to improve training and materials and propose new electronic supports for MENU-AIDDs users.

Activities

MTDH Staff

- Work with the MPH Program to institute certificates of disability and public health.
- Provide opportunities for MPH Program students to collect, interpret and disseminate data.
- Continue to support MSU nursing students.

SMART 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.

Rationale

University Centers for Excellence in Developmental Disabilities Education, Research and Services (UCEDD) positively affect the lives of individuals with developmental disabilities as well as their families by increasing their independence, productivity, and integration into communities. University Centers have four broad tasks:

- Conduct interdisciplinary training,
- Promote community service programs,
- Provide technical assistance at all levels (from local service delivery to community and state government), and
- Conduct research and dissemination activities.

As a UCEDD, the UMRI is positioned to work with disability data across the lifespan. The use of such data can be a significant aide in leveraging resources.

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.

SMART 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.

Rationale

Health promotion programs for people with disabilities are in the early stages of development at the Rehabilitation Research and Training Center on Health and Wellness/Center on Community Accessibility, Oregon Health and Science University in Portland, Oregon. This critical review utilizes a credentialed expert panel (including Dr. Tom Seekins of the University of Montana Rural Institute) to develop a set of guidelines for community-based health promotion programs for individuals with disabilities. The procedures include a review of background material, systematic literature review with drafted guidelines consisting of operational, participation and accessibility recommendations. The role that those with disabilities can play is addressed and includes program planning, implementation and evaluation, physical and programmatic accessibility of programs, and importance of evidence-based practices.[90]

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.

[90] Rehabilitation Research and Training Center on Health and Wellness/Center on Community Accessibility, Oregon Health & Science University, Portland, OR 97207-0574, USA

SMART 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.

Rationale

The American Psychological Association's (APAs) Task Force on Guidelines for Assessment recently developed *Guidelines for Assessment and Treatment of Persons with Disabilities* to increase discussion, training, and awareness about disability across the profession.

The task force based the guidelines on core values that include "respect for human dignity, recognition that individuals with disabilities have the right to self-determination, participation in society, equitable access to the benefits of psychological services, recognition that people with disabilities are divers and have unique individual characteristics, and recognition that disability is not solely a biological characteristic but is also a result of the individual's interaction with the environment."[91]

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.

[91] American Psychological Association, Guidelines for Assessment of and Intervention with Persons with Disabilities

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.[92] 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* is 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."[93]

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.

SMART Objective 4A

Through June 30, 2015, support the Emergency Preparedness program of the MDPHHS and its partners (Montana Disaster and Emergency Service and Hospital Preparedness Program) to assure that Montanans with disabilities are adequately represented in state and county Emergency Preparedness (EP) plans.

Rationale

A National Preparedness Goal was adopted in September 2011 and establishes the 35 core capabilities required across the whole community to prevent, protect against, mitigate, respond to, and recover from the threats and hazards that pose the greatest risk. Threats to human health and national health security in Montana include: avalanches, chemical/biological warfare, dam failure, drought and extreme heat, earthquakes, floods, hazardous materials, landslides, nuclear attacks, tornadoes, vector-borne diseases, violence and terrorism, volcanic fall out, and wildfires.[94]

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[92] Revised ADA Regulations Implementing Title II and Title III

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

[94] Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness

MTDH will 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[95] while attending to the needs of At-Risk/Special Populations (ARSP), defined as "those with critical functional health needs that are beyond their capability to maintain during an emergency."[96]

Activities

MTDH Staff

- Partner with existing networks to assist persons with disabilities to:
    - 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
    - Create a personal emergency preparedness plan.

MDPHHS Staff

- Develop tools and materials to assist local administrators in accomplishing deliverable goals.
- Identify and commit public health personnel for ARSP emergency preparedness/ awareness training.
- Provide EP information to special, vulnerable, and at-risk populations that have disabilities or are vulnerable due to age.
- Collect information that:
    - Identifies strengths, weaknesses, and gaps in EP efforts in local communities; and
    - Demonstrates work already done at the local level for ARSP.
- Assure that a description of how Local/Tribal Health Departments will serve ARSP in the event of an emergency is included in all emergency response plans.
- Assure that all Local/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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[95] Public Health Preparedness Capabilities, National Standards for State and Local Planning

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

Local / Tribal Health Departments ARSP Deliverables

ARSP-1: Training

- Identify / commit public health personnel for ARSP EP and awareness training.
- Select and attend a communications-related training.

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.
  - 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.
  - Integrate citizen participation in the planning process at all levels.
  - Develop and provide community preparedness public education programs and materials for ARSP.
  - Determine locations of ARSP who need assistance with evacuation from an affected area.
  - Support community infrastructure to achieve appropriate levels of preparedness.

As of November 8, 2011, 51 of 58 jurisdictions have completed all ARSP deliverables.

SMART 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.[97]

Activities

- 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.

SMART 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.

Rationale

"The Montana League of Cities and Towns is an incorporated, nonpartisan, nonprofit association of 129 Montana municipalities. Organized under a constitution originally adopted in 1931, the League has as its sole purpose the cooperative improvement of municipal government in Montana. It acts as a clearinghouse through which the municipalities cooperate for their mutual benefit.

Major policies are determined by vote of the delegates at the annual conference, implemented by an 18 member governing body elected and appointed from among the city and town delegates. The League serves as an advisory body in contracts between municipal officials and state and federal governments. By cooperating through the League, the municipalities provide for themselves a research program and a legislative voice which would be impossible for any of them individually."

Activities

MTDH Staff

- 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.

[97] 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.

SMART 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).

Rationale

Visitability first surfaced in the U.S. in 1986 with the founding of the grassroots group Concrete Change, based in Atlanta. The term refers to single-family housing designed in such a way that it can be lived in or visited by people with disabilities. A house is visitable when it meets three basic requirements:

- At least one no-step entrance,
- Doors and hallways wide enough to navigate through, and
- A bathroom on the first floor large enough to accommodate a wheelchair, and close the door.[98]

These design features provide safety and accessibility to people with disabilities whether they live in or are visiting the building.

Activities

MTDH staff:

- 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.

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[98] The Center for an Accessible Society, "Visitability" bill introduced in Congress

- 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 has 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."[99]

SMART Objective 5A

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.

Rationale

Montana was one of 10 states awarded a federal *Community Transformation Grant (CTG)* in 2011 to serve the entire state. The MDPHHS is responsible for carrying out the grant requirements that address the following priority areas: 1) tobacco-free living; 2) active living and healthy eating; and 3) evidence-based clinical and other preventive services, specifically prevention and control of high blood pressure and high cholesterol.

The MTDH Program, in partnership with the Primary Care Office of Epidemiology and Scientific Support (OESS), has played an active role in monitoring these priority areas for *all* adults in the state, including break-out reporting for people with disabilities. MTDH staff has also implemented evidence-based and practice-based programs including Living Well with a Disability and MENU-AIDDS.

[99] Ibid. Conclusion, page 9.

Activities

MTDH Staff

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

MDPHHS Staff

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

SMART Objective 5B

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.**

Rationale

Montana BRFSS Data from **2003** and **2007** indicate that Montana adults with disabilities reported significant health gaps and disparities in attaining Healthy People 2010 objectives including:

1. Chronic joint symptoms and arthritis,
2. Clinically diagnosed diabetes,
3. High blood pressure,
4. High blood cholesterol,
5. Clinically diagnosed cardiovascular disease,
6. Asthma,
7. Cigarette smoking,
8. No leisure-time physical activity,
9. Moderate physical activity levels below recommendations, and
10. Not seeing a doctor when needed because of cost.

Activities

MTDH Staff

- 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.

Short-term Outcome Goal 5C

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.**

Rationale

The winter 2009 issue of the Montana BRFSS focused on depression and anxiety among Montana adults. The estimated prevalence of current depression among adults in Montana was **6.7%** in 2006. Almost one in five **(17%)** adults in 2006 had ever been told by a doctor or other healthcare provider that they had a *depressive disorder* at some time in their lives. Anxiety disorders are the most common of all mental disorders. In Montana, slightly more than one in 10 **(10.9%)** of Montana adults in 2006 had been told by a doctor or other health care provider at sometime in their lives they had an *anxiety disorder*.

Montana adults who had been diagnosed with depression or anxiety were more likely to be female, previously married, and unable to work or unemployed. Adults with some college were more likely to have been diagnosed with anxiety in their lives than adults with college degrees.

Activities

MTDH Staff:

- 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.
- Encourage adults with these disorders to seek treatment in order to prevent increased severity or progression of the illnesses.

SMART Objective 5D

The MTDH 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.

Rationale

The MTDH Program has partnered with a variety of programs to promote model policies and assure that resources are available. In the future, promotion will include all people with disabilities across the life course.

There is a need to educate caretakers, family members, and people who are in short- and long-term care about prevention strategies and health resources. According to the latest available data, there are 533 facilities in Montana that serve seniors and adults with disabilities, including the following:

- 65 Adult Day Care facilities
- 106 Adult Foster Care facilities
- 38 Home Health agencies
- 34 Hospice Care agencies
- 85 Long-term Care facilities
- 205 Personal Care Homes for Assisted Living[100]

[100] Montana Senior Housing and Care, Senior And Long Term Care Division, MDPHHS

Activities

MTDH Staff

- 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.

SMART Objective 5E

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 that have at least one Disability Advisor as a member.

Rationale

Disability Advisors have served on:

- Eight State of Montana coalitions, workgroups, or councils;
- A Missoula city advisory council; and
- The University of Montana Masters of Public Health program advisory board.

Placing Disability Advisors on additional task forces and advisory boards assures that disability and health issues are considered in developing policies, regulations, and plans.

Activities

MTDH Staff and current Disability Advisors:

- Work with additional state agencies, private non-profit groups and University programs to identify at 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.