

**PUBLIC HEALTH AND HUMAN SERVICES**Public Health and Safety Division  
V-2**DIVISION CONTACTS**

The division administrator and chief financial officer for the division and their contact information are:

Title	Name	Phone Number	E-mail address
Administrator	Jane Smilie, MPH	444-4141	<a href="mailto:jsmilie@mt.gov">jsmilie@mt.gov</a>
Financial Officer	Dale McBride	444-3635	<a href="mailto:dmcbride@mt.gov">dmcbride@mt.gov</a>
Chief Medical Officer	Steven Helgerson, MD, MPH	444-1286	<a href="mailto:shelgerson@mt.gov">shelgerson@mt.gov</a>

**WHAT THE DIVISION DOES**

The mission of the Public Health and Safety Division is to improve the health status of Montanans to the highest possible level. The Division provides a wide range of services aimed at understanding the health status of our citizens, promoting healthy lifestyles, preventing and controlling communicable and chronic diseases, improving the public health system and assuring it is prepared to address all types of public health events and emergencies. The division operates two laboratories, one focusing on environmental health and the other on public health, including testing of newborn children.

**SPENDING AND FUNDING INFORMATION**

The following figures show funding and expenditure information for FY 2006 for all sources of funding of the Public Health and Safety Division. Because the figures include all sources of funding there are no direct relationships between these figures and appropriation levels presented in the Budget Analysis for the 2007 Biennium.

**STATUTORY AUTHORITY FOR DIVISION**

Title 50, MCA, including local public health activities. Rules concerning public health programs are in Title 37 of Administrative Rules of Montana. Specific citations include: Maternal and Child Health Title 50, Chapter 1 and Chapter 19, MCA, and Title V of the Social Security Act; Family Planning Title X of the federal Public Health Service Act and 42 CFR, Subpart A, Part 59; WIC P.L. 95-627, Child Nutrition Act of 1966, and 7CFR part 246.

**HOW SERVICES ARE PROVIDED**

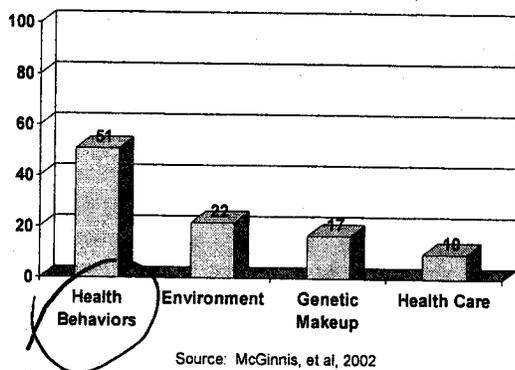
Services are delivered primarily through local and tribal public health agencies, as well as private providers, clinics, hospitals and other community organizations.

The division is organized into 5 bureaus and one office with the following functions:

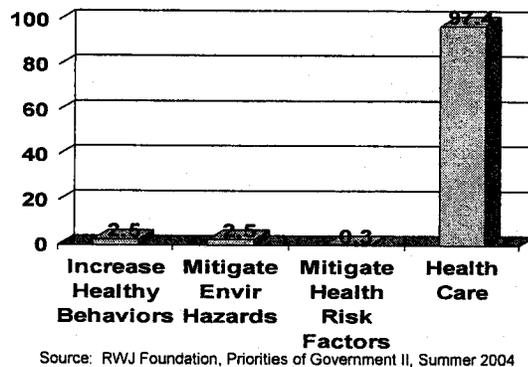
- 1) **Financial Services and Operations Bureau** provides budget analysis, contract procurement, financial management, information technology and records, and equipment management services.
- 2) **Communicable Disease Control and Prevention Bureau** works closely with local and tribal public health agencies and health care providers to detect, monitor, control and prevent communicable and infectious diseases including tuberculosis, hepatitis, HIV, and sexually transmitted diseases. The bureau operates a program to assure children and others at risk for certain diseases receive the appropriate immunizations. It also works with local public health agencies to inspect and license pools, trailer courts, public housing and accommodations, institutions and daycares. Kathleen McCarthy, MS, Bureau Chief, 444-4735, [kmccarthy@mt.gov](mailto:kmccarthy@mt.gov)
- 3) **Family and Community Health Bureau** provides services to assure the health of women, children and families. These include maternal and child health services, family planning, services for children with special health care needs, Special Supplement Nutrition Program for Woman, Infants, and Children (WIC), public health home visiting for high risk pregnant women, youth suicide prevention and other child and adolescent health programs. JoAnn Dotson, RN, MSN, Bureau Chief, 444-4743, [jdotson@mt.gov](mailto:jdotson@mt.gov)

- 4) **Laboratory Services Bureau** operates the environmental and clinical public health laboratories. The environmental laboratory does water and soil analysis and completes EPA certification of private laboratories for drinking water testing. The clinical laboratory completes biotechnology and microbiology tests to determine the presence of disease antibodies such as Hantavirus and Tuberculosis. The Bureau also administers an environmental health and biomonitoring program and oversees the Montana Asbestos Screening and Surveillance Activity in Libby. Anne Weber, MS, Bureau Chief, 444-5559, [aweber@mt.gov](mailto:aweber@mt.gov)
- 5) **Chronic Disease Prevention and Health Promotion Bureau** manages the tobacco prevention and cessation programs, cancer control programs including breast and cervical health and the tumor registry, diabetes prevention, cardiovascular health and emergency medical services and trauma systems. Todd Harwell, MPH, Bureau Chief, 444-1437, [tharwell@mt.gov](mailto:tharwell@mt.gov)
- 6) **Office of Public Health Preparedness and Training** oversees the public health, hospital and pandemic influenza preparedness grants and works with local health departments and hospitals in preparedness planning and response, as well as workforce development and training. Jim Murphy, Supervisor, 444-4016, [jmurphy@mt.gov](mailto:jmurphy@mt.gov)

### What Influences Our Health

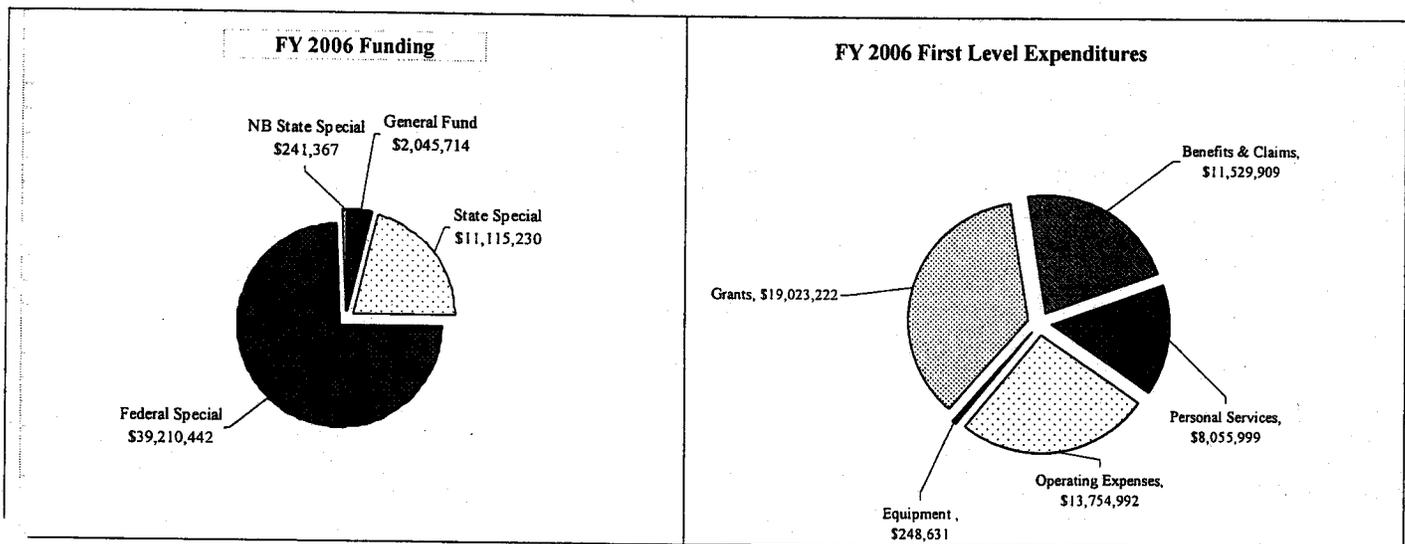


### How We Spend Money



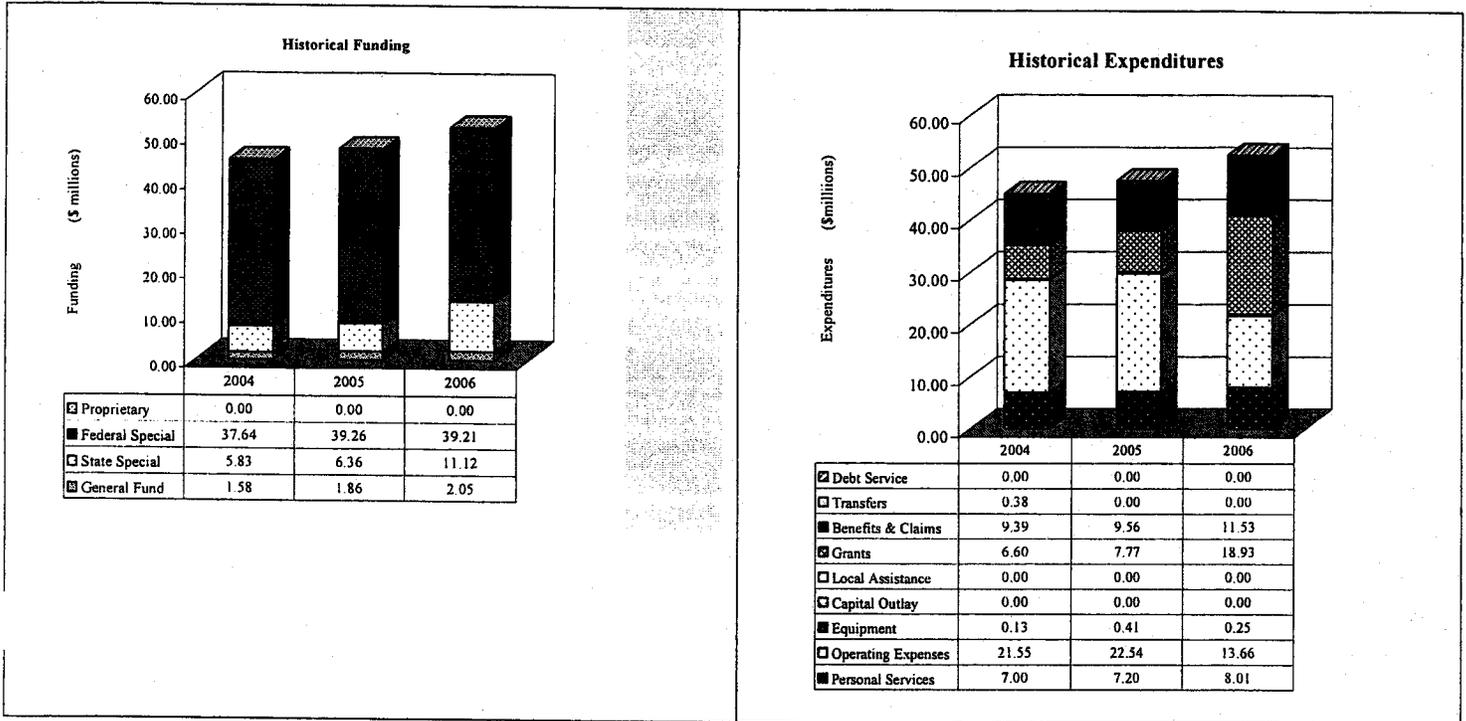
### Spending and Funding Information

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The above information does not include administrative appropriations. The division had \$9,788 in administrative appropriations in fiscal year 2006. Departmental indirect charges are not included as expenditures or revenues in the above tables.

The following figures show funding and expenditures from FY 2004 through FY 2006, for HB 2 funding. Funding and expenditure information is not provided here for 2001-2003 since the division was not created until 2004. At that time the Health Policy and Services Division was split into two new divisions, the Public Health and Safety Division and the Health Resources Division.



## 2007 BIENNIUM NEW PROGRAM IMPLEMENTATION AND PROGRAM EXPANSION

### Program Expansion

Per the recommendation of our Legislative Fiscal Division liaison, we are highlighting the new and expanded issues that were outlined in the October 11, 2006 LFD report to the Legislative Finance Committee meeting.

The most significant program expansions during the 2007 biennium were:

- DP 3111 that expanded the Montana Tobacco Use Prevention Program with Master Settlement Agreement allocated to the Program through Initiative 146 (see page 28), and
- DP 124 expanding the Public Health Emergency Preparedness Program (see page 46).

DP 160 implemented an Early Childhood Comprehensive System (ECCS) grant of \$200,000 per year in federal funds. The intent of the ECCS grant is to link various federal and state efforts to act together as a coordinated system of care for young children, ages 0-5 and their families. Areas of focus in this planning grant include: medical homes; mental health and social/emotional development; early care and education; parent education; and family support. Due to the variety of federal and state agencies involved in ECCS, the federal government recognized the need to empower states to organize

and link existing activities into a coordinated effort. The ECCS grant is not intended to create new programs, but to link existing activities and programs that will improve the way services for young children and their families are coordinated and delivered.

Montana has shared the responsibility of the ECCS project between several divisions and agencies, including the Head Start Collaboration Office and the Early Childhood Services Bureau in the Human and Community Services Division, and the Family and Community Health Bureau in the Public Health and Safety Division. The Montana Early Childhood Advisory Council has advised and overseen the activities of the grant, and through their members, facilitated input from local childcare providers and early childhood experts.

Outcomes achieved include:

- Development of a strategic plan to address priority areas
- Conducted community forums to facilitate local input into the vision for early childhood systems
- Linkage of the early childhood efforts in multiple agencies to coalesce on the topic of school readiness
- Conducted a statewide school readiness summit in June
- Development of mental and physiologic health services for child care settings in the form of consultant training
- Application for and receipt of the federal implementation grant, which was contingent upon successful completion of the planning phase

DP 3137 and SB 137 implemented inspection and licensing of body piercing and tattooing. The Department has developed a process for inspecting and licensing these establishments. Administrative rules were drafted, a hearing was held on October 25, 2006 and the rules will be published and in effect in February 2007. Establishments have had on-site inspections and this will allow us to license them very quickly upon publication of the rules.

## FTE

The legislature approved appropriations for an additional 14 FTE in the 2007 Biennium. The following figure shows the positions and hire dates for the new FTE.

2007 Biennium FTE Hire Dates	FTE	Date
Libby Asbestos Staff	69107729	12/10/2005
Libby Asbestos Staff	69107706	08/06/2005
Montana Tobacco Use Program	69107722	08/20/2005
Montana Tobacco Use Program	69107727	02/13/2006
Montana Tobacco Use Program	69107723	09/03/2005
Montana Tobacco Use Program	69107732	08/14/2006
Statewide Emergency Preparedness	69107724	08/06/2005
Statewide Emergency Preparedness	69107725	08/06/2005
Statewide Emergency Preparedness	69107728	08/06/2005
Clinical Lab Specialist	69107726	08/06/2006
Environmental Public Health Tracking	69107730	08/06/2006
Communicable Disease Monitoring	69107731	08/06/2005
Public Health Planner	69107733	Vacant
Environmental Lab Chemist	69107701	05/15/2006

## CORRECTIVE ACTION PLANS

The WIC Program had two legislative audits and a Federal Management Evaluation (ME) with recommendations and associated corrective action plans in place during the 2005 biennium.

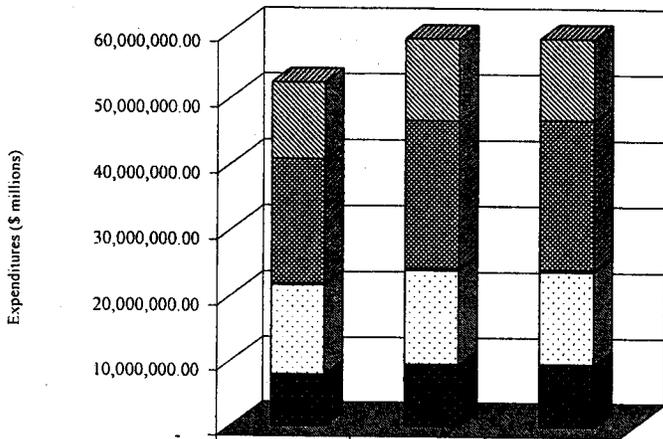
In the 2005 Legislative Audit there were seven findings of non-compliance. At that time the program put in place a corrective action plan. A follow up audit in September 2006 showed procedures are in place to complete all seven of the findings. There is a legislative audit scheduled for February 2007.

A Federal ME was conducted in May 2005. There were 38 findings and five observations. The Montana WIC Office has submitted four corrective action plans in response to the ME, with the last submitted in September 2006. Five findings continue to remain open. Those findings are related to memorandums of understanding with neighboring states to prevent dual participation and written procedures for check review. Staff and attorneys are currently working to close these findings.

# 2009 BIENNIUM BUDGET

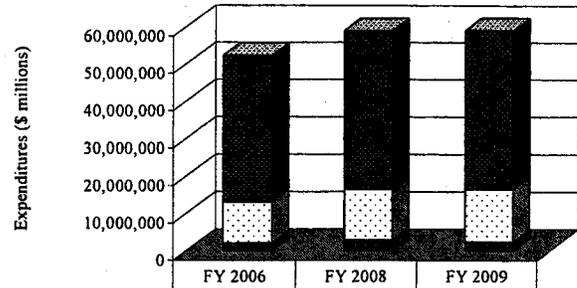
following figures show the proposed HB 2 budget for the 2009 biennium.

Public Health and Human Services  
2009 Biennium HB2 Budget



	FY 2006	FY 2008	FY 2009
Debt Service	0	0	0
Transfers	0	0	0
Benefits & Claims	11,529,909.00	12,486,158	12,368,158
Grants	18,929,942.00	22,305,304	22,640,304
Local Assistance	-	0	0
Capital Outlay	-	0	0
Equipment	248,631.00	393,562	393,562
Operating Expenses	13,658,203.00	14,296,528	14,064,453
Personal Services	8,004,701.00	9,609,295	9,704,836

Public Health and Human Services  
2009 Biennium HB2 Budget



	FY 2006	FY 2008	FY 2009
Proprietary	0	0	0
Federal Special	39,210,442	42,548,617	42,590,267
State/Other Special	11,115,230	13,626,064	14,143,396
General Fund	2,045,714	2,916,166	2,437,650

## Goals and Measurable Objectives

The following figure shows the department base year and budgeted biennium goals and performance measures that are associated with the proposed 2009 biennium HB 2 budget.

Public Health and Human Services Public Health and Safety Division		
Measurable Objectives for the 2009 Biennium		
Goal	Measurable Objectives	Current status of Measures
<b>Family and Child Health:</b> Provide programs and services to improve the health of Montana's women, children, and families.	<ul style="list-style-type: none"> <li>By June 30, 2009, reduce the rate of birth for teenagers aged 15 through 17 years to 9.3 per 1,000.</li> <li>By June 30, 2009, increase the percentage of mothers who breastfeed their infants at hospital discharge to 77.1%. <b>DP 70003</b></li> <li>By June 30, 2009, increase the percent of potential WIC eligibles served by 10%. <b>DP 70003</b></li> <li>By June 30, 2009, decrease the frequency of WIC computer helpdesk calls for assistance due to program inadequacies. <b>DP 70003</b></li> <li>By June 30, 2009, decrease the number of WIC audit findings due to computer system operations. <b>DP 70003</b></li> </ul>	9.7 (2005)  73% (2005)  65% (2005)  114 calls per month (Dec and Nov 2006)  Two internal and four external audit findings (2005)

	<ul style="list-style-type: none"> <li>• By June 30, 2009, increase the percentage of newborns who have been screened for hearing before hospital discharge to 92%. <b>DP 70005</b></li> <li>• By June 30, 2009, 100% of newborns will receive timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their state-sponsored newborn screening programs. <b>DP 70005</b></li> <li>• By June 30, 2009 increase accessibility to specialty services for children with special health care needs through specialty clinics by 10%. <b>DP 70005</b></li> <li>• By June 30, 2009, increase the percentage of infants born to pregnant women receiving prenatal care beginning in the first trimester to 87.4%. <b>DP 70103</b></li> <li>• By June 30, 2009, 100% of Montana's counties will have been reviewed as potential Health Professional Shortage Area designations for primary care, mental health, and dental services in an effort to improve the health-care access of medically underserved and vulnerable populations of Montanans.</li> <li>• By June 30, 2009, decrease the rate per 100,000 of suicide deaths among youth ages 15 through 19 to 9/100,000. <b>DP 70014</b></li> </ul>	<p>87.9% (2005)</p> <p>100% (2005)</p> <p>2,510 (2005)</p> <p>83.5% (2005)</p> <p>In progress</p> <p>25.1/100,000 (2005)</p>
<p><b>Communicable Disease Control and Prevention:</b> To reduce the incidence of communicable disease in Montana through efforts in prevention, treatment, surveillance, and epidemiology.</p>	<ul style="list-style-type: none"> <li>• By June 30, 2009, achieve and maintain a 90% immunization coverage rate for children 19-35 months of age in accordance with the recommended immunization schedule.</li> <li>• By June 30, 2009, continue to maintain at 100%, the proportion of tuberculosis cases completing curative therapy within 12 months.</li> <li>• Increase the rate of compliance with food and pool safety regulations by licensed establishments by 5% annually through June 30, 2009. <b>DP 70013 DP 70016</b></li> <li>• By June 30, 2009, reduce the incidence of chlamydia to 150 cases per 100,000 in Montana.</li> <li>• Control the incidence of HIV/AIDS in Montana so as not to exceed 1.4 cases per 100,000 persons, through June 30, 2009. <b>DP 70007</b></li> </ul>	<p>91% (2005)</p> <p>100% (2005)</p> <p>Baseline to be established in 2007</p> <p>258/100,000 (2005)</p> <p>1.6/100,000 (2005)</p>
<p><b>Chronic Disease Prevention and Control:</b> Reduce the burden of chronic disease, injury, and trauma in Montana.</p>	<ul style="list-style-type: none"> <li>• By June 30, 2009, decrease the proportion of high school students who report smoking cigarettes in the past 30 days to the Healthy People National Objective of 16%. <b>DP 70106</b></li> <li>• By June 30, 2009, decrease the proportion of high school students who report spit tobacco use in the past 30 days to the Healthy People 2010 National Objective of &lt;1%. <b>DP 70106</b></li> <li>• By June 2009, decrease the proportion of adults who report smoking to the Healthy People 2010 National Objective of 12%. <b>DP 70106</b></li> <li>• By June 2009, decrease the proportion of pregnant women who report smoking to the Healthy People 2010 National</li> </ul>	<p>20% (2005)</p> <p>15% (2005)</p> <p>19% (2005)</p> <p>18% (2005)</p>

	<p>Objective of 12%. <b>DP 70106</b></p> <ul style="list-style-type: none"> <li>• By June 30, 2006, increase community awareness of the warning signs of acute stroke. <b>DP 70108</b></li> <li>• By June 30, 2006, establish a baseline measure of the proportion of eligible persons with an acute ischemic stroke who receive thrombolytic therapy. <b>DP 70108</b></li> <li>• By June 30, 2009, increase the proportion of persons aged 50 years and older who have ever had a colorectal cancer screening examination. <b>DP 70108</b></li> <li>• By June 30, 2009, establish a baseline measure of the proportion of adults at high risk for diabetes and heart disease who have lost 7% of their body weight. <b>DP 70108</b></li> <li>• By June 30, 2009, increase the proportion of people with diabetes in Montana who receive the recommended preventive care services to the Healthy People 2010 National Objectives.</li> </ul>	<p>79% (2005)</p> <p>Baseline to be established</p> <p>53% (2005)</p> <p>Baseline to be established</p> <p>60% (Pneumococcal vaccination, 2004) 77% (Annual foot exam, 2004) 69% (Annual A1c test, 2004)</p>
<p><b>Laboratory Services:</b> Reduce communicable disease in Montana through a surveillance system based upon public health laboratory disease diagnosis and assessment.</p>	<ul style="list-style-type: none"> <li>• Through June 30, 2009, maintain full access of local health departments and other public clinics to accurate, reliable, population-based laboratory services. <b>DP 70002, DP 70011, DP 70013</b></li> <li>• Through June 30, 2009, maintain the state's capacity to provide technically advanced laboratory testing for conditions that affect the health of Montanans, including unusual and emerging diseases. <b>DP 70002, DP 70011, DP 70013</b></li> <li>• Through June 30, 2009, maintain a communication system through faxes and e-mail with Montana hospitals, clinics, and infectious disease physicians for the purpose of providing updated information related to infectious diseases. <b>DP 70002, DP 70011, DP 70013</b></li> <li>• Through June 30, 2009, continue to provide testing capable of monitoring public drinking water according to current EPA standards and to ensure that private drinking water laboratories throughout the state are capable of meeting the same EPA standards of testing. <b>DP 70002, DP 70011</b></li> <li>• Through June 30, 2009, maintain laboratory preparedness for testing agents of bioterrorism, and continue to develop methods of meeting expectations regarding testing for agents capable of being used for chemical terrorism. <b>DP 70002, DP 70011, DP 70013</b></li> </ul>	<p>In place</p> <p>On-going</p> <p>In place</p> <p>In place</p> <p>In place</p>
<p><b>Office of Public Health Preparedness and Training:</b> A strong and prepared public health system that provides the foundation for to respond to emergencies with a well-trained workforce.</p>	<ul style="list-style-type: none"> <li>• By June 30, 2009, 75% of Montana's local and tribal jurisdictions, in collaboration with hospitals/clinic, will have participated in <u>multi-jurisdictional</u> pandemic influenza exercises that are evaluated, and result in improved response plans. <b>DP 70105, DP 70015</b></li> <li>• By June 30, 2009, the Public Health &amp; Safety Division will make public health training and continuing education opportunities available that are accessible to 85% of Montana's public health workforce on an on-going basis. <b>DP 70105</b></li> </ul>	<p>In-Progress, app. 25-30% participated in a multi-jurisdictional exercise in 2006.</p> <p>In progress</p>

<p><b>Division Administration:</b> A strong public health system that provides the foundation for Montanans' safe and healthy lives.</p>	<ul style="list-style-type: none"> <li>• By 2010, develop and/or implement information technology applications that integrate major public health programs and comply with the Centers for Disease Control and Prevention's (CDC) Public Health Information Network (PHIN) standards. <b>DP 70015</b></li> <li>• By 2010, continue to update Montana's public health statutes and administrative rules to more accurately reflect current public health threats and practices. <b>DP 70105</b></li> <li>• By 2010, surveillance data such as, Behavioral Risk Factor Surveillance System data, Montana County Health Profiles, and related health information will continue to be presented in useable forms and as readily accessible web-based resources for state, local, and tribal public health agencies. <b>DP 70023, DP 70018</b></li> </ul>	<p>In progress – recently implemented CDC's PHIN compliant web-based communicable disease registry</p> <p>Two bills with updates in 2007</p> <p>In progress</p>
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## BUDGET AND POLICY ISSUES

Legislation from the Public Health & Safety Division:

1. **SB 95: An act removing the requirement for a physician director of an automated external defibrillator (AED) program** - This legislation would remove the requirement for a physician to provide oversight to organizations that have AED(s) on their premises. It would allow other health care professionals to provide oversight to these organizations in matters related to the AED(s).
2. **SB 94: An act removing the requirement that wholesale and retail nonprescription drug manufacturers be licensed and regulated entities through the Department of Public Health and Human Services (DPHHS)** - This is a housekeeping bill that would remove the requirement that DPHHS license and regulate wholesale and retail nonprescription drug manufacturers, since this function is performed by the Federal Food and Drug Administration.
3. **HB 148: An act to increase fees for licensure of public pools; authorizing promulgation of rules to establish fees for plan reviews for public pools** - This legislation would increase the fees for licensing and inspecting public swimming pools and other water attractions. These fees have not been increased since 1991 and the cost of performing these services has far outpaced the fee structure. In addition, the fees for review of plans to develop new pools and water attractions would be set in administrative rule and would be commensurate with the complexity of the plans.
3. **HB 118: An act to allow dispensing of non-oral and oral prepackaged contraceptives by a registered nurse employed by a family planning clinic under contract with the Department of Public Health and Human Services** - This legislation would remove the word "oral" from the existing statute to allow registered nurses in family planning clinics under contract with DPHHS to dispense both non-oral and oral prepackaged contraceptives.
5. **HB 117: An act requiring provision of and reporting regarding newborn hearing screenings and education** - This legislation would require that a hearing screening test be performed for all newborn infants before discharge from a hospital or no later than 1 month after birth, so that the DPHHS can plan, establish and evaluate a comprehensive system of services for infants and children who are deaf or hard of hearing.
6. **SB 162: An act expanding the genetic and metabolic conditions required to be screened in newborns and allowing the state to contract with one or more providers of follow-up services for newborns suffering from such conditions** - This legislation would mandate the full panel of genetic and metabolic conditions recommended by the American College of Medical Genetics and endorsed by the American Academy of Pediatrics and the

March of Dimes. In addition, it would establish a program of comprehensive follow-up services, including education and counseling, for newborns and parents of newborns identified with disorders.

7. **HB 92: An act to modernize Montana's public health statutes by amending the powers and duties of the Department of Public Health and Human Services, local boards of health, and local health officers; and encouraging greater collaboration among and between constituents in the public health system** - This act would amend the powers and duties of the DPHHS, local boards of health, and local health officers to reflect current public health issues and practices. It would also create a basic purpose statement for the public health system and encourage collaboration among federal, state, local and tribal partners.
8. **SB 142: An act requiring a public health emergency plan and establishing powers and duties in public health emergencies** - This act would assure the necessary role of public health agencies as part of the Disaster and Emergency Services response system. The legislation would define and allow the Governor to declare a public health emergency and provide the Governor with powers and authorities that could be used in one; require a public health emergency plan; provide powers and authorities for which the DPHHS would be the lead agency during a declared public health emergency, in collaboration with local public health agencies, Disaster and Emergency Services, and other relevant agencies; and allow for recognition of interstate licensure for volunteer health care and public health professionals and immunity for volunteer health care providers.

The following are requests for state funding for public health activities. Some of the requests are for general funds and some are for various sources of state special revenues as noted below.

1. **LFD Page B-102, DP 70002 - Laboratory Equipment Replacement and Maintenance** - This is a one-time-only request is for \$145,000 in general funds for each year of the biennium for laboratory equipment and instrument replacement and maintenance along with supplies and training for specialized testing. A list of the equipment to be purchased is on page B-102 of the Legislative Budget Analysis 2009 Biennium, Volume 4. The laboratory cannot purchase this equipment with laboratory fees due to the high cost of the equipment and the need to keep fees at a reasonable level to support public health programs.
2. **LFD Page B-93, DP 70003 - WIC Information Technology System Maintenance** - This one-time-only request is for \$290,000 for the biennium in general funds to sustain our current system until a USDA system is available. Please see the "significant issues expanded" page 11 for a detailed description. In addition, we have completed a full template for this program (see page 21).
3. **LFD Page B-99, DP 70007 HIV - Treatment** - This is a request for an increase of \$150,000 in general funds for each year of the biennium for HIV Treatment. As of October 2006, there were 22 individuals waiting to be enrolled into the Montana AIDS Drug Assistance Program (ADAP) so they can receive medications at a discount. General fund is used to cover federal funding gaps and to meet a 1:4 state/federal match. The current average cost of HIV medication through ADAP is \$8,811 per person per year. The requested amount would cover 16 additional clients each year.
4. **LFD Page B-97, DP 70103 - Public Health Home Visits** - This request is for \$200,000 in Tobacco Trust Fund Interest (SSR) for each year of the biennium to support expansion of Public Health Home Visits (PHHV), a part of the Montana Initiative for the Abatement of Mortality in Infants (MIAMI). Please see the "significant issues expanded" page 12 for a detailed description of this request.
5. **LFD Page B-87, DP 70105 - Rural Public Health Development Project** - This request is for a \$75,000 biennial appropriation of general fund to develop locally driven solutions for creating public health infrastructure in rural and frontier Montana. The appropriation is intended to address public health surge capacity in a large-scale event or emergency and develop basic orientations for boards of health and health officers. The division would contract for services with a newly-created association of local public health officials.

6. **LFD Page B-89, DP 70106 - Tobacco Use Prevention** - This budget request is for 1.00 FTE and \$1,700,000 in state special revenue from the Master Settlement Agreement with the tobacco companies for each year of the biennium for expansion of activities of Montana Tobacco Use Prevention. Please see the "significant issues expanded" page 12 for a detailed description. In addition, we have completed a full template for this program (see page 26).
7. **LFD Page B-106, DP 70107 Purchase of Tamiflu** - This request has been withdrawn. This product arrived ahead of schedule and is included in a request for supplemental funding for the 2007 biennium.
8. **LFD Page B-91, DP 70108 - Chronic Disease Prevention and Control** - This budget request is for 2.00 FTE and \$500,000 from the Tobacco Trust Fund Interest (SSR) for FY 2009 for chronic disease prevention and control activities. Please see the "significant issues expanded" section page 14 for a detailed description of this request.
9. **LFD Page B-94, DP 70005 - Newborn Screening Follow-Up Program** - This request is for \$290,000 in Tobacco Trust Fund Interest (SSR) for each year of the biennium to support a comprehensive newborn screening follow-up program to assure the availability of appropriate clinical diagnostic and support services for families and primary care providers of those babies identified with an abnormal condition from the expanded panel of newborn screening tests. This is **contingent upon passage of legislation**. Please see the "significant issues expanded" page 15 for a detailed description. In addition, we have completed a full template for this program (see page 35).

**Requests for authority to expend federal and state special revenue funds**

The following are requests for authority to expend funds received from federal grants or generated by fees collected.

1. **LFD Page B-102, DP 70011 - Laboratory Services**- This request is for \$130,000 in spending authority for each year of biennium to spend SSR generated by fees for laboratory tests. The laboratory needs to expend these fees to meet projected increases in the testing and supply expenses. The number of tests performed by the Laboratory Services Bureau is expected to increase from 135,460 tests in FY05 to an estimated 145,000 tests in FY06.
2. **LFD Page B-105, DP 70015 - Public Health Emergency Preparedness** - This request is for \$1,800,000 per year of the biennium for federal spending authority to allow the PHSD to expend federal grants to prepare and respond to a pandemic of influenza. Please see the "significant issues expanded" page 16 for a detailed description. In addition, we have completed a full template for this program (see page 43).
3. **LFD Page B-106, DP 70018 and LFD Page B-106, DP 70023 - Behavior Risk Factor Survey** - This request for additional federal authority of \$40,000 for each year of biennium to expend the Behavioral Risk Factor Surveillance System (BRFSS) grant. The increase will be used for increased costs for administering the survey; increased sample size (6,000); and over-sampling of the American Indian population. State and local health departments use the data to identify priority health issues and subpopulations, monitor trends over time, and monitor effectiveness of programs. In addition, the PHSD is requesting \$65,000 in state special revenue for each year of the biennium for the BRFSS fee account. When a program requests the addition of new items to the survey, fees are collected to help support the survey and deposited into this account.
4. **LFD Page B-89, DP 70021 - Montana Comprehensive Cancer Control Program Grant** - This request is for federal authority of \$112,000 for each year of biennium so the PHSD can expend an anticipated increase in the Montana Comprehensive Cancer Control Program (MCCCP) grant. A five-year MCCCP Plan was published in April 2006 and these funds are for implementation of the plan. The total grant is \$260,000 per year.
5. **LFD Page B-103, DP 70013 - Food Emergency Response Network Grant** - The PHSD is requesting an increase in federal spending authority of \$50,000 for the Food Emergency Response Network (FERN) grant to allow it to expend the full amount of the expected grant award. The funding is for laboratory equipment and supplies related to testing foods for bacterial pathogens.

6. **LFD Page B-96, DP 70014 - Youth Suicide Prevention Program Grant** - This request is for \$400,000 for federal spending authority for each year of biennium to expend a federal youth suicide prevention grant. Please see the "significant issues expanded" section page 17 for a detailed description of this request.
7. **LFD Page B-89, DP 70017 - Health Educator Position for Montana Breast & Cervical Health Program** - This request is for 1 FTE and federal spending authority to make permanent the position of Montana Breast and Cervical Health Program (MBCHP) Health Educator. This position provides direction, technical assistance and training for local MBCHP contractors, programs serving Montana's American Indians and the network of MBCHP medical service providers.
4. **LFD Page B-100, DP 70016 - Food and Consumer Safety Pool Inspections** - This request is for \$60,000 in SSR for each year of the biennium to allow Food and Consumer Safety to expend fees from pool inspections and plan reviews performed by DPHHS employees. This is **pending legislation** to increase pool inspection and plan review fees. The fees for licensing and inspecting public swimming pools and other water attractions have not been increased since 1991 and the cost of performing these services has far outpaced the fee structure. In addition, with passage of HB 148, the fees for review of plans to develop new pools and water attractions would be set in administrative rule and would be commensurate with the complexity of the plans. Local public health agencies have delegated pool inspections to the state, since the payment is not adequate to cover the cost of the services and we believe this would engage more of them in providing this service. The bill has industry support.
9. **LFD Page B-106, DP 70101 - Environmental Public Health Tracking Reduction** - This request will remove the **federal** Environmental Public Health Tracking Grant (\$430,563) from the state budget since Montana was not granted federal funds to continue the program.
10. **LFD Page B-93, DP 70104 - Genetics Program Reduction** - During the last biennium the Montana Genetics Program was granted a fee increase only for the current biennium. The fees on insurance premiums to support the Montana Genetics Program will revert from \$1.00 for the biennium back to \$.70 effective July 1, 2007. This request is to remove \$242,559 in SSR from the state budget to reflect the sunset of this fee increase.

## SIGNIFICANT ISSUES EXPANDED

1. **LFD Page B-93, DP 70003 - WIC IT System Maintenance** - \$290,000 one time only biennial appropriation. These funds will be used to sustain our current system until a USDA system is available. The system may be available as early as summer 2008; however, roll out to states may not be until 2010. No FTE are requested.

This computerized system is used to maintain documentation on eligibility, certification, reporting requirements, and to issue food instruments, which serve as currency for participants to obtain supplemental foods. The WIC program provides nutrition education and supplementary food to approximately 22,000 low-income pregnant and nursing women, infants and children up to age 5 statewide. Requested funding will support a programmer, IT and WIC staff travel to support local agencies, and consultant time to develop and monitor the mandated Planning Advance Planning Document (PAPD). The current system is 12 years old and needs modification in order to document compliance with some federal requirements. Due to the age of the system, it is very difficult for state and local staff to operate it. The extraction of information outside of the preset definitions is cumbersome and requires the time and expertise of the programmers. The federal funds to modify and maintain the existing system are not available, as the current federal priority is development of new State Agency Model Systems (SAM). Maximus Consulting reviewed Montana's existing WIC system as part of the DPHHS Business Process Re-engineering in May 2005. It was recommended that the existing system could not be upgraded, but required complete replacement. The present request is to maintain the existing system until the SAM product is available and rolled out.

2. **LFD Page B-97, DP 70103 – Public Health Home Visits** - \$200,000 per year in Tobacco Trust Fund Interest. These funds would support Public Health Home Visits (PHHV), a part of the Montana Initiative for the Abatement of Mortality in Infants (MIAMI). DPHHS will use new PHHV funding for additional PHHV sites and/or to increase funding to existing sites in order to expand home visiting services by providing intensive case management to pregnant women who are at risk for using substances while pregnant.

PHHV is part of the Montana Initiative for the Abatement of Mortality in Infants (MIAMI). MIAMI was authorized in MCA 50-19-301 – 323 in 1989, creating a multi-faceted approach to improving pregnancy outcomes and decreasing infant mortality in Montana. The four main approaches were:

1. infant mortality and morbidity review (now known as Fetal Infant and Child Mortality Review or FICMR);
2. low birthweight prevention, using contractors to provide home visiting services;
3. assistance to low-income women and infants in gaining access to prenatal care, delivery, and postpartum care and referral of low-income women and children to other programs to protect the health of women and children, and
4. public education and community outreach to inform the public on the importance of receiving early and comprehensive prenatal care. Beginning in 1989, funding to support local program efforts or home visiting was authorized by the legislature. In 2003, the Montana Legislature designated \$550,000 to support these home visiting services for high-risk pregnant women and infants. The funding was provided to local contractors in 2004 through an RFP process to continue the services by providing home visiting services to high-risk pregnant women and infants, establish common program expectations, and apply a single funding methodology. The objectives are to:
  - a) Improve pregnancy outcomes in service areas.
  - b) Improve family functioning in target populations served.
  - c) Monitor and improve the home environment of pregnant women and infants in the target population, considering environmental, economic, psychosocial, and medical risks.
  - d) Decrease the incidence and impact of drug and alcohol use and abuse in the target populations.

Based on the above RFP process, DPHHS contracts with 14 counties and 2 tribal nations to provide home visiting/community based services for high-risk pregnant women and infants.

3. **LFD Page B-89, DP 70106 – Tobacco Use Prevention Increase** - This request is for 1.00 FTE and \$1,700,000 in state special revenue (Master Settlement Agreement Funds) for each year of the biennium for expansion of current prevention activities. These funds will support a) new community-based programs, b) program to prevent spit tobacco use, c) programs to reduce smoking during pregnancy, d) new college campus prevention programs, e) youth public education campaigns, targeted promotion of the Montana tobacco quit line, f) and enhanced surveillance.

**A. Fund Remaining Montana Counties for Community-based Tobacco Prevention Activities -**

This proposal would provide funding for the fifteen remaining Montana counties that currently do not have tobacco prevention funding for community-based efforts. These counties include Glacier, Granite, Jefferson, Broadwater, Meagher, Madison, Sweetgrass, Big Horn, Valley, Garfield, McCone, Prairie, Wibaux, Fallon, Carter, all of which are rural counties. Funding all 56 Montana Counties will ensure comprehensive tobacco use prevention for all Montana citizens. Funding for these community-based programs will be used to implement and enforce the Montana Clean Indoor Air Act, and to implement community-level activities to prevent youth initiation, and promote tobacco use cessation. The community-based programs will be evaluated based on the quarterly and annual progress reports they submit to MTUPP. These activities address the first four objectives listed under chronic disease prevention and control.

\$458,100 per year ongoing to support and fund additional counties:

- \$300,000.00 to fund twelve unfunded counties with small populations
- \$ 98,100.00 to fund three counties with larger populations
- \$ 60,000.00 for salary and benefits for 1.00 FTE to manage, train and offer technical assistance to the additional county programs

**B. Prevent Spit Tobacco Use in Montana** - This proposal would utilize funding to implement the action plan recommended by the Spit Tobacco Strategic Initiative Committee to prevent and reduce spit tobacco use in Montana. The FY08 action plan will include the following activities.

\$200,000 per year

- \$155,000 Develop and implement a statewide public education campaigns focusing on spit tobacco use prevention.
- \$15,000 Create support materials to assist in the adoption of tobacco-free policies for hospitals, colleges and other targeted institutions.
- \$10,000 Create and distribute spit tobacco cessation materials through the Montana Tobacco Quit Line to promote spit tobacco cessation.
- \$20,000 Expand surveillance, evaluation and the publishing of reports on spit tobacco use in Montana to help direct effective intervention strategies.

Data from the Youth Risk Behavior Survey and the Prevention Needs Assessment survey will be used to assess changes in youth attitudes toward spit tobacco, prevalence of spit tobacco use, and the age of initiation of use prior to and after initiation of the interventions. Data from the Adult Tobacco Survey will be used to assess changes in the prevalence of spit tobacco use in adults prior to and after initiation of the interventions. These activities address the second objective under chronic disease prevention and control.

**C. Reduce Smoking During Pregnancy in Montana** - This proposal would focus on reducing the prevalence of smoking during pregnancy among Montana mothers.

\$240,000 per year

- \$150,000 to develop and implement a public education and awareness campaign focusing on the benefits of smoking cessation during pregnancy and where to go for help (e.g., provider and the Quit Line).
- \$80,000 to conduct outreach to primary care providers regarding:
  - state-of-the-art counseling and pharmacologic techniques to assist their patients to quit using tobacco
  - free counseling services and cessation aids provided by the Montana Tobacco Quit Line, and information on how to refer women to the quit line
- \$10,000 to develop and disseminate pregnancy specific cessation materials for patients and primary care providers.

This pilot program will be evaluated using the Montana birth records and intake data collected through the Montana Tobacco Use Quit Line. The overall goals will be to increase utilization of Montana Tobacco Use Quit Line, and to reduce the prevalence of smoking during pregnancy among women. These activities address the fourth objective listed under chronic disease prevention and control.

**D. Establish New College Campus Tobacco Prevention Programs** - The 18-24 age group is the only population segment in Montana that shows an increase in tobacco use. As described under our progress report, MTUPP is collaborating with the BACCHUS Network to coordinate and provide tobacco prevention at Montana colleges and universities. This program has been implemented at the University of Montana, Montana State University (Bozeman), Salish Kootenai College, and Montana State University Billings. This proposal requests \$200,000 per year to expand this program to additional colleges in Montana. These activities address the third objective listed under chronic disease prevention and control.

**E. Statewide Youth Public Education for Tobacco Prevention** - This proposal would utilize \$381,900 of funding to develop and implement ongoing statewide public education campaigns targeting youth to increase awareness of the health impact of tobacco use (both smoking and spit tobacco), and to promote effective messages that prevent youth initiation of tobacco use. These funds will be used to develop and place television, radio, newsprint advertisements. These activities would be coordinated with the youth empowerment initiative described in the progress report to

ensure that the local youth activities and the statewide campaigns work together and address the second objective under chronic disease prevention and control.

**F. Targeted Quit Line Promotion** – This proposal would utilize \$120,000 per year to develop and implement targeted tobacco quit line outreach to subpopulations at high risk for tobacco use including Montanans with low-incomes, native Americans, and rural Montanans. These funds would be used to develop and disseminate mass and small media messages promoting tobacco cessation and the Montana tobacco quit line. These activities address the first and second objectives under chronic disease prevention and control. Additional objectives and baseline measures address youth attitudes toward tobacco use and perceived risk of harm for tobacco use will be developed.

**G. Enhanced surveillance Activities** – This proposal would utilize \$100,000 per year to enhance surveillance for tobacco prevention including expanding the sample size for our Adult Tobacco Survey, enhanced surveillance for the Montana Central Tumor registry, and to conduct additional surveillance and program evaluation that is not currently funded.

**4. LFD Page B-91, DP 70108 – Chronic Disease Prevention and Control - \$500,000 FY 2009 Tobacco Trust Fund Interest and 2.00 FTE.** This proposal would fund three specific program areas including cancer control, improving acute stroke treatment, and diabetes and heart disease prevention. Each of these programs is described below.

**A. Cancer Control** - This proposal would provide funding to implement the States Comprehensive Cancer Control Plan. The Five-Year Montana Comprehensive Cancer Control Plan was published in April 2006. The Comprehensive Cancer Coalition has prioritized the strategies and goals and objectives for the next 5 years. The Montana Cancer Control Program would utilize these funds to implement the following activities. These activities address the seventh objective listed under chronic disease prevention and control.

\$150,000 per year

- \$50,000 to develop public awareness campaign on screening and early cancer detection for breast, cervical, and colorectal cancer.
- \$40,000 to support a position that will be funded through the University of Washington and the National Cancer Institute. This will not be a state FTE but will be an individual assigned and hired by the National Cancer Institute who will work in Montana to provide outreach and education about cancer control to American Indian communities in Montana.
- \$60,000 for 1.00 FTE health educator for the comprehensive cancer program for program implementation activities.

**B. Improve Acute Stroke Care in Rural Montana** - The Cardiovascular Health (CVH) Program proposes conducting pilot projects with the Stroke-Doc telemedicine system. The pilot projects would include four rural hospitals and four primary stroke centers. The system provides two-way audio/video communication allowing neurologist consultation with the local hospital; transmission of the patient's CT to the neurologist, and flexibility to do consults outside of the hospital. Existing telemedicine systems in Montana cannot meet these requirements. This pilot will help address the disparities in care that stroke patients face in rural Montana. For sustainability of the project, the CVH Program will work with the sites to identify potential funding sources once the pilot is completed.

The CVH Program also proposes to expand its public education campaigns to increase community awareness of the warning signs and risk factors for stroke and to increase community awareness of the need to call 911 when experiencing these warning signs. This funding would allow the CVH Program to implement the public education campaigns in additional communities throughout Montana. These activities address the fifth and sixth objectives listed under chronic disease prevention and control.

\$150,000 per year

- \$120,000 for Stroke-Doc telemedicine hardware and software for each remote site plus the software for

consulting neurologists x 4 sites, technical support fees for licenses, and training costs.

- \$30,000 for the stroke warning signs and need to use 911 EMS public education campaigns.

These activities will be evaluated by assessing the number of patients with an ischemic stroke who are evaluated for and treated with thrombolytic therapy prior to and after the initiation of the intervention. To evaluate the public education campaigns the Program will conduct pre- and post- telephone surveys to assess changes in community awareness of the warning signs for stroke and the need to call 911. Not implementing these activities will lead to continued high rates of death and disability from acute ischemic stroke in Montana.

**C. Diabetes and Heart Disease Prevention** - The Diabetes Program would establish and implement diabetes primary prevention activities in two pilot programs within local health departments, community health centers, diabetes education programs, or other appropriate health care facilities to promote increased physical activity, improved nutrition, and tobacco use cessation among persons at high risk for developing diabetes, and the development of supportive health education materials for these pilot programs using \$200,000 of new funding. These activities will be evaluated by assessing weight loss, physical activity, and reduction in tobacco use by persons at high risk for diabetes, who are referred for these services on a pre-determined recruitment target.

Diabetes is a leading cause of morbidity and mortality in Montana. The prevalence of overweight and obesity in Montana has continued to increase, resulting in increasing number of Montanans with pre-diabetes, diabetes, metabolic syndrome and gestational diabetes. The Diabetes Prevention Program, a national study, has shown that with lifestyle intervention (healthy eating and increased physical activity), adults (including women with a history of gestational diabetes) can reduce their risk of developing diabetes by 58% and their future risk of developing heart disease and stroke.

The overall goal of this program will be to prevent diabetes, and cardiovascular disease among person at high risk for diabetes. This approach will allow us to: a) develop and implement diabetes primary prevention programs; and b) assess the feasibility of this approach and assess the clinical outcomes of persons enrolling in this program. Not implementing these activities will lead to a continued increase in the number of Montanans with diagnosed diabetes, heart disease and stroke. These activities address the eighth objective under chronic disease prevention and control.

5. **LFD Page B-94, DP 70005 – Newborn Screening Follow-up** - \$290,000 per year in Tobacco Trust Fund Interest. These funds would be used to support a comprehensive newborn screening follow-up program. This program will assure the availability of appropriate clinical diagnostic and support services for families and primary care providers of those babies identified with an abnormal condition from the expanded panel of newborn screening tests. Screening of newborns for metabolic and other disorders through a blood test has become a standard of care over the last three decades. Technological advances have made available screening for multiple metabolic conditions that had previously been difficult to determine in a timely manner. This proposal provides funding to assure that:
1. Every Montana-born baby will receive the panel of newborn screening tests which are currently recommended by the American Academy of Pediatrics. In March 2006, the Academy is recommending 29 tests; a hearing screening and 28 metabolic and other disorders detected through testing of blood.
  2. Every person in Montana with positive newborn screening test results will receive an appropriate continuum of follow-up care.

The funding provided will assure availability of clinical diagnostic and support services which include:

- a) Metabolic specialists services
- b) Nurse consultation and regional clinical services
- c) Nutritionists services
- d) Family Support
- e) Training and education of the public and providers re NBS

Item	Tests	Costs
Metabolic specialist (MD)	Clinic consultation	\$100,000
Nutritionist 0.5 FTE @ \$75,000/FTE)	Clinic and family consultation	\$37,500
Nurse Coordinator (0.5 FTE at \$70,000/FTE)	Clinic and family consultation	\$35,000
Family Support	Clinic and family consultation	\$30,000
Genetic Counseling (0.5 FTE)	Clinic and family consultation	\$37,500
Resources and training		\$50,000
<b>TOTAL</b>		<b>\$290,000</b>

In 2005, the Maternal and Child Health Bureau of the federal Department of Health and Human Services published a report entitled "Newborn Screening: Toward a Uniform Screening Panel and System" (<http://www.mchb.hrsa.gov/screening/summary/htm>). This report calls for national adoption of a mandatory panel of 29 tests (hearing screening and 28 tests for metabolic and other disorders detected by testing of blood samples) in order to ensure that all babies born in the United States have equal access to the same screenings.

This recommendation was adopted by the Montana Newborn Screening/Genetics Task Force in July 2006. Implementation of these national standards in Montana would require the addition of 24 tests currently available on an optional basis and mandatory hearing screening for all babies born in Montana. This expansion will require expansion of newborn services available to the families and physicians of the babies who are screened and diagnosed as positive for the conditions tested.

The goal of this program will be to assure the availability of appropriate clinical diagnostic and support services for babies identified with an abnormal condition from the expanded panel of newborn screening tests, for their families, and primary care providers. Beginning in the first year of the 2009 biennium, we will expand the newborn screening mandatory panel to 28 tests and a hearing screening, and we will contract for appropriate clinic consultation and family consultation for conditions identified from expanded panel of tests. By June 30, 2008, we will ensure that all babies born in Montana receive the full panel of mandatory tests for inborn errors of metabolism and other conditions detected by blood sample testing and ensure that all babies born in Montana with conditions identified through the mandatory expanded panel of tests have access to appropriate clinical and family consultation services.

Failure to implement the national standard for newborn screening for inborn errors of metabolism and other recommended conditions detected by blood sample testing will result in babies born with conditions not currently screened remaining undetected unless the specific optional test is ordered by the baby's physician.

6. **LFD Page B-105, DP 70015 – Public Health Emergency Preparedness** - \$1.8M per year in federal grant funds to prepare for and respond to a pandemic of influenza. All states receive a portion of \$250,000,000 for this purpose. The U.S. Centers for Disease Control and Prevention (CDC) provides funding to assist state and local agencies to prepare for public health emergencies, specifically targeted for an influenza pandemic. Funding is allocated to each state on a population based formula and requires state and local jurisdictions to perform a variety of public health related tasks. Activities include completing assessments intended to measure local response capabilities as well as developing and exercising a variety of response plans to ensure a coordinated response to an influenza pandemic.

The Montana Department of Public Health and Human Services (DPHHS) receives and distributes funding to support a variety of emergency preparedness efforts by state, county and tribal jurisdictions throughout the state. This request is for \$1.8 million in federal authority. To ensure a coordinated effort among state and local response agencies, DPHHS provides funding to local agencies via contracts and requires specific tasks to be performed. DPHHS develops detailed guidance and assists each jurisdiction with preparedness efforts to ensure that systems are in place to protect the public health.

During the first year of what will be a three year project to prepare for an influenza pandemic, each local jurisdiction receiving funding will have:

- 1) Developed a working group consisting of key partners representing public health, the medical community, preparedness agencies and other relevant partners within the community to address:
  - a) Medical Surge Capacity
  - b) Isolation and Quarantine of Ill or Exposed Individuals
  - c) Delivery of Antiviral Treatments to Local Populations
  - d) Interoperability of Communications and Data Systems
  - e) Planning issues
- 2) Developed and submitted a work plan to DPHHS outlining immediate and long term plans to address gaps identified through community assessments in each of the above areas and all contractors (local and tribal jurisdictions) will have public health emergency preparedness plans that have been tested via drills and exercises.
- 3) Depending on the maturity of existing plans, local jurisdictions will have reviewed, refined, existing plans to ensure a coordinated response during a pandemic.

During the contract period DPHHS will have received and evaluated progress reports and work plans from 62 local jurisdictions (55 local and 7 tribal) health agencies receiving funding for pandemic influenza planning efforts. State and local contractors will conduct drills and exercises to ensure that information is available for prescribed performance measures by CDC. Contractors will plan drills and exercises that stress their routine and urgent response systems to ensure that they are building capacity for larger events.

Each year of the biennium the Department will provide specific guidance for pandemic influenza preparedness to local and tribal agencies. Agencies will submit work plans and, in some cases, refined response plans. The State of Montana has data systems in place to accurately capture required information and report requested information to the CDC.

Failure to develop and exercise plans supported through this funding would increase the likelihood of illnesses and deaths in the event of an influenza pandemic. These funds are necessary and provide additional incentive and means to develop adequate emergency response plans to ensure rapid identification and response to events of public health significance.

7. **LFD Page B-96, DP 70014 - Youth Suicide Prevention Program** - \$400,000 per year in federal grant funds. This program provides resources to communities to support and promote youth suicide prevention efforts. On October 1, 2005, the Montana Department of Public Health and Human Services (DPHHS) received this \$400,000 federal grant from Substance Abuse and Mental Health Services Administration (SAMHSA) to support suicide prevention efforts in Montana with potential continued funding over the next three years. This funding will be used to lower the rate of suicide among youth and young adults in Montana, ages 10-24. Montana Department of Public Health and Human Services (DPHHS) issued a request for proposals and has funded the following organizations:

- Flathead City-County Health Department, Kalispell
- Lewis and Clark City-County Health Department, Helena
- Missoula City-County Health Department
- University of Montana on behalf of Fort Peck
- University of Montana on behalf of Rocky Boy Reservation
- Yellowstone City-County Health Department, Billings
- Cascade City-County Health Department, Great Falls
- District II Alcohol and Drug Program, Sidney
- Confederated Salish and Kootenai Tribes, Ronan
- Voices of Hope, Great Falls
- Indian Development and Education Alliance, Miles City

- Western Montana Mental Health Center, Ravalli County

One of the SAMHSA requirements is that 85% the funding be contracted to communities and institutions of higher learning. In Montana, \$342,460 of the \$400,000 is contracted to communities and institutions of higher learning, including funding for the project evaluator through MSU, a public awareness campaign and training of medical providers.

Suicide is a major statewide public health problem in Montana. Montana has ranked in the top five states with the highest rates of suicide for the past 20 years, along with other mountain states. For a number of years, Montana has ranked second only to Nevada. From 1999 – 2002, the suicide rate in Montana among 15 to 24 year olds was 17.68 per 100,000 compared to 10.01 per 100,000 nationally, and the rate of suicide for American Indians ages 15 – 19 was 15.18 per 100,000 and for ages 20 – 24 was 36.91 per 100,000 (Centers for Disease Control and Prevention, 2003). Suicide profoundly effects individuals, families, workplaces, neighborhoods and societies. For each completed suicide, the lives of at least six other people are deeply impacted. The economic costs alone associated with suicide and self inflicted injuries in Montana are estimated at over 103 million dollars (Children's Safety Network 2005). The emotional and social cost of these losses is immeasurable. Each suicide in Montana represents a lost life, lost talents, lost creativity, and lost contributions to society.

Montana seeks to prevent both fatal and non-fatal suicidal behaviors among youth and young adults 10-24 years of age. The proposed approach builds on the foundation of prior statewide youth suicide prevention efforts to develop and implement youth suicide prevention and early intervention strategies, grounded in public and private collaboration. This project will aim to:

- Improve access to and availability of appropriate prevention services for vulnerable youth in funded communities, tribes and/or institutions of higher learning projects;
- Increase access to and community linkages with mental health and substance abuse service systems serving youth and young adults;
- Implement activities for an ongoing public information and awareness campaign to promote awareness that suicide is a public health problem and it is preventable; and
- Establish a process that promotes effective clinical and professional practices, and oversees and supports suicide prevention activities at local and state levels.

The suicide rate among youth in Montana will continue to be one of the highest in the nation without coordinated prevention efforts in Montana communities. The individuals and agencies that are currently addressing suicide often do so from their own unique perspective and to meet their own special needs. Montana needs a statewide, strategic effort to link these many assets together and to build a stronger network of resources to address suicide as a public health priority with this funding.

#### **PERSONAL SERVICES STATEWIDE PRESENT LAW ADJUSTMENTS:**

**1. (a) Has the agency implemented a broad band pay plan, agency-wide or for selected jobs?**

The Department began with selected positions depending on the needs of the program (e.g. to ensure good customer service and maintain qualified, experienced staff; for recruitment issues; reduce turnover; to be competitive with other state agencies and the private sector).

**(b) If so, when was it implemented and what were the estimated cost increases in the year of implementation?**

In 2002, due to our inability to compete with the private sector in recruiting and retaining clinical laboratory specialists, the Public Health and Safety moved 31 public health lab employees to pay plan 20. Nine received no increase in pay and 22 received an average of \$2,472 per year.

**(c) How were these costs funded (by holding vacant positions open, appropriations for other purposes that were unexpended, etc)?**

Depending on the program, the agency used a variety of means such as holding positions open (non-critical--those that did not affect the quality of service or client health and safety), reducing operating costs for a period of time or tapping into authorized federal funding for those programs funded 100 percent with federal funds.

**2. (a) At what percentage of market are new employees paid?**

Employees can progress to the market rate by: statutory pay increases, successful completion of a training assignment, retention pay exception (in pay plan 60), market adjustment (in pay plan 20), competence or performance pay adjustment (in pay plan 20).

**(b) How do employees progress to the market rate for their position?**

The agency would like to see all employees move eventually to 100% of market to provide us with a greater opportunity to retain staff. When employees are moved to pay plan 20, our practice has been to ensure all employees are paid at least at entry.

**(c) What is the agency's target percent of market?**

The department has not established a target percentage other than its initial effort suggesting 85 percent of market as existing staff positions move into PP20.

The department has three categories of employees; union, non-union and supervisory staff. MEA MFT has not yet reached an agreement to move to PP20. MEA MFT agreements require renewal every two years; however, the section involving pay negotiations can be opened at any time there is a request to do so, such as moving to PP20, or negotiating a component of PP20 such as results-based pay.

**(d) What is the agency average percent of market in FY 2006?**

Generally, the percent of market is between 80 and 85 percent

**(a) Did the agency have vacant positions for a significant portion (6 months or more) of FY 2006? Yes**

**(b) If yes, how many and why were these vacant?**

As of June 2006, the Public Health and Safety Division 11 position vacant for longer than six month. Often positions were advertised two or three times, and even as many as six times. For some, offers were made and were declined because of the pay offered, or there was no pool of qualified applicants generated. The division also held positions vacant for mandatory vacancy saving and other cost savings needed to help mitigate a shortfall in general fund in other divisions.

**(c) How did the vacancies impact agency operations?**

Current staff took on additional duties and responsibilities. Work was prioritized and things that were not deemed as critical were delayed.

**4. Did the agency have authorized pay exceptions for pay plan 60 positions? If yes, why?**

Yes. The Public Health and Safety Division has a total of 20 pay exceptions. Most were for retaining current staff with expertise in their field. Others were necessary to hire qualified candidates with unique knowledge, skills, and abilities that were essential to the operations of vital agency services and could not be attracted without pay exceptions.

**5. Did the agency have authorized position upgrades or downgrades for pay plan 60 positions? If yes, why?**

According to MOM policy #3-0401, the Department of Administration may delegate authority to classify new positions and reclassify existing positions to an agency that meets specific requirements. The exercise of this authority is final, subject to review by the Department of Administration under Rule 1722, Classification Reviews of the above referenced policy.

Delegation of classification authority is provided to an agency when staff, assigned to review and classify positions, has been trained according to the standards provided by classification specialists in the State Personnel Division of the Department of Administration. The above referenced policy also states that, "An agency may not hire a person to fill a position until that position has been properly classified. Job selection procedures must be based on a job analysis, which

requires, at minimum, a description of current job duties. Agencies should review vacant positions before filling them to ensure that they are correctly classified.”

In addition to review of vacant positions prior to recruitment, reviews are also initiated when filled positions experience substantial changes in predominant duties or when supervision has been added or deleted from the position.

In addition, the Human Resources Department received one multiple position reclassification request that affected 125 positions at Montana State Hospital. This review resulted in a one grade upgrade for these positions. Although DPHHS has been delegated the authority to review and classify positions by the State Personnel Division in the Department of Administration, any multiple position classification requires review and concurrence of State Personnel Division classification staff prior to finalization of the review.

During FY05/06, the Human Resources Office reviewed 11 positions for the Public Health and Safety Division. Eight resulted in upgrades and three resulted in down grades.

**6. What challenges does the agency face in recruiting and retaining staff? What actions has the agency taken to address recruitment and retention issues? Is the agency competing with other state agencies or the public sector for staff?**

The Public Health and Safety Division faces many challenges in trying to recruit and retain staff. Many of the program positions are advertised for recruitment two to three times, and even as many as six times before we are successful in hiring. A number of factors contribute to this challenge. Many of our positions require health-related education and experience. We must compete with the private medical sector and our pay scales are not competitive. Some positions require very specialized public health expertise, for example, epidemiology. In most cases, persons with this background must be recruited from outside Montana, and again, we find our pay scale is not competitive. Even in-state, we are finding that larger local public health agencies are now compensating more competitively than the state. Finally, for positions that do not require a health-related background, we find that competing with other state agencies is becoming an issue. We have had a number of employees move to other agencies that are paying at 95% to 100% of the market rate.

**7. (a) Are agency staff members represented by collective bargaining units?**

Yes. MEA-MFT and MPEA

**(b) How many of the agency staff are impacted by collective bargaining unit agreements?**

Currently, 120 FTE are impacted by a collective bargaining agreement.

**(c) What provisions are included in bargaining unit agreements?**

Typically, these provisions are included: union and management rights, non-discrimination, labor-management committees, pay and hours, insurance, overtime and compensatory time, the various leaves, workers compensation, grievances and arbitration, employee rights, job posting, health and safety, use of private automobiles, retirement, payroll deductions, not strike/no lockout, term of the agreement, and pay schedules.

**(d) How often are these agreements negotiated?**

These agreements are negotiated for a two-year period. Occasionally, agreements are “rolled over” without any negotiation being conducted. Usually the agreements are opened and the parties negotiate a new contract every two years.

# PUBLIC HEALTH AND HUMAN SERVICES

## Public Health and Safety Division

Woman, Infant, and Children (WIC)

### DIVISION CONTACTS

The department, division, program director and chief financial officer for the department, division, program and their contact information are:

Title	Name	Phone Number	E-mail address
Administrator	Jane Smilie	444-4141	<a href="mailto:jsmilie@mt.gov">jsmilie@mt.gov</a>
Financial Officer	Dale McBride	444-3635	<a href="mailto:dmcbride@mt.gov">dmcbride@mt.gov</a>
Bureau Chief	JoAnn Dotson	444-4743	<a href="mailto:jdotson@mt.gov">jdotson@mt.gov</a>
Section Supervisor	Joan Bowsher	444-4747	<a href="mailto:jbowsher@mt.gov">jbowsher@mt.gov</a>

### WHAT THE PROGRAM DOES

The Special Supplemental Nutrition Program provides low income, pregnant, breastfeeding and postpartum women, infants, and children up to age five, at nutrition risk, with:

- Nutrition screening, education and counseling to improve eating behaviors and reduce or eliminate nutrition problems.
- Access to preventive health programs and referral to private and public health providers.
- Selected foods to supplement diets lacking in nutrients needed during this critical time of growth and development.

### SPENDING AND FUNDING INFORMATION

The following figures show funding and expenditure information for FY 2001 - 2006 for all sources of funding of the WIC program. Because the figures include all sources of funding there are no direct relationships between these figures and appropriation levels presented in the Budget Analysis for the 2007 Biennium.

### STATUTORY AUTHORITY FOR THE PROGRAM

Federal Regulations are contained in CFR Part 246 Special Supplemental Nutrition Program for Women, Infants and Children. State Regulations are contained in the Montana State Plan which is submitted annually to the Mountain Plains Regional office for approval. The State Plan is available at <http://www.dphhs.mt.gov/PHSD/family-health/nutrition-wic/nutrition-wic-state-plan.shtml>. Administrative rules of Montana for WIC are available in Chapter 59 subchapter 1 37.59.101-203.

### HOW SERVICES ARE PROVIDED

The WIC program is part of the Family and Community Health Bureau in the Public Health and Safety Division. The Bureau mission is to "promote and improve the health and safety of Montana's women, men, children, and families. The target population is infants, children, youth to age 21, women of childbearing age, including those who are pregnant, and their families.

The Montana State WIC Program contracts with 27 local agencies, including all seven of Montana's American Indian Reservations. Across the state local agencies provide WIC services in about 100 local clinics. WIC services are provided for women who are financially eligible, pregnant, breastfeeding, postpartum women and infants, and children up to the age of five who are at nutritional risk.

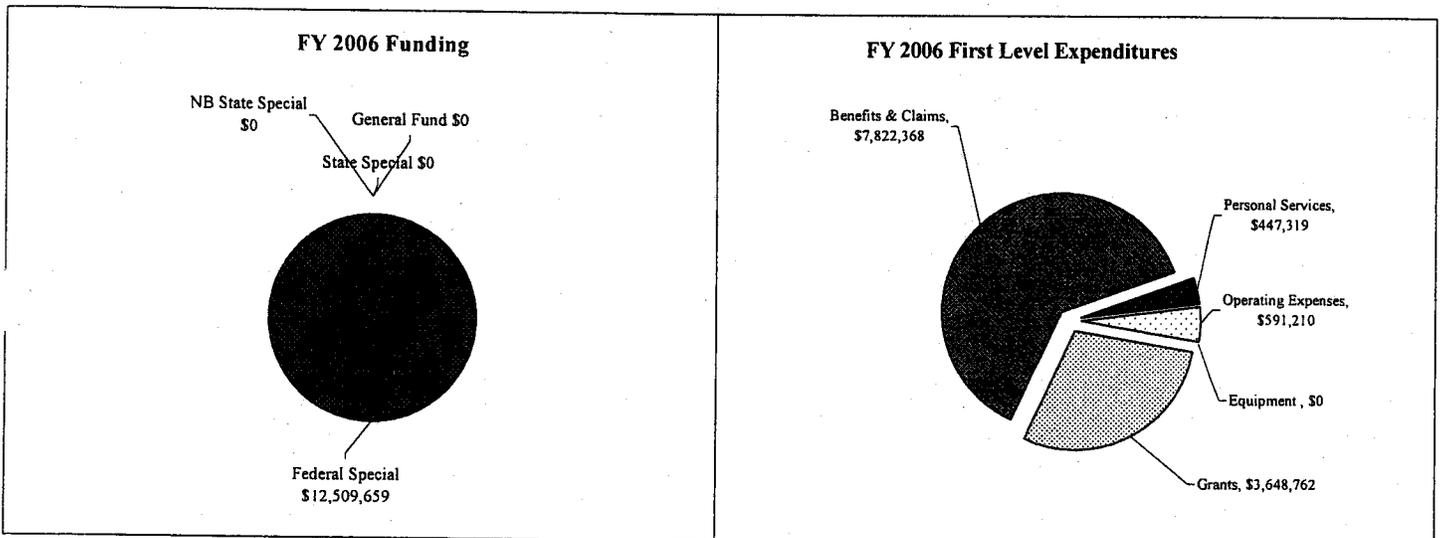
WIC participants receive nutrition assessments, counseling and education to improve health outcomes, eating behaviors, and reduce nutritional problems in a professional and confidential setting. WIC provides access to preventive health programs and referral to private and public health providers.

Participants also receive checks for a supplemental food package that can be redeemed at local grocers. The foods that can be purchased with the checks have nutrients needed during critical times for growth and development. Foods provided are milk, eggs, cheese, cereal, dried peas or beans, peanut butter, juice, tuna, carrots and infant formula. Changes to the food packages are currently being considered by USDA.

Automation of the WIC services delivery system was initiated in the early 1990s. Improvements to the system are long overdue. New technologies are available to improve customer service, efficiency of program administration, benefit accuracy and reduction in fraud.

## SPENDING AND FUNDING INFORMATION

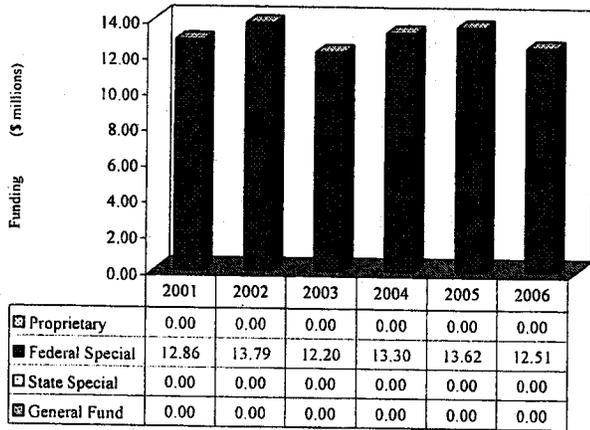
The following figures show funding and expenditure information for FY 2006 for all sources of funding of the Public Health and Safety Division. Because the figures include all sources of funding there are no direct relationships between these figures and appropriation levels presented in the Budget Analysis for the 2007 Biennium.



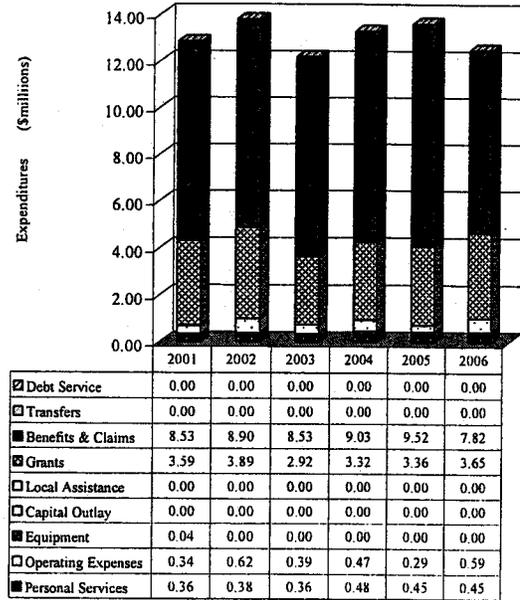
The above information does not include administrative appropriations. The department, division, program had \$0 in administrative appropriations in fiscal year 2006. Departmental indirect charges are included as expenditures or revenues in the above tables.

The following figures show funding and expenditures from FY 2001 through FY 2006, for HB 2 funding.

**Historical Funding**



**Historical Expenditures**



The change in revenues and expenditures between fiscal years 2001 and 2006 resulted from increases and decreases in WIC participation.

The value of food instruments cashed also has an impact on WIC funding. The State WIC Program has consistently asked for more food dollars each Federal Fiscal Year to support an estimated value of food instruments issued. In FY 2006 we were penalized by USDA for not spending 97% of the previous year food dollars and we voluntarily returned \$500,000 of designated food dollars to avoid another penalty in FY 2007.

## 2007 BIENNIUM NEW PROGRAM IMPLEMENTATION AND PROGRAM EXPANSION

### PROGRAM EXPANSION

During the 2007 biennium, WIC clinics were regionalized, decreasing the number of administrative contractors from 41 to 29. The total number of clinic sites and clients served through the program was maintained. Programming to correct the inability of sites to monitor "dual eligibles" and food instruments that were voided and reissued was completed and rolled out to contractors. A successful outreach program developed by a Montana WIC contractor was replicated and rolled out to all clinic sites. Evaluation at the original site demonstrated that the program increased WIC enrollment in the target communities.

### FTE

No additional FTEs are requested for the 2007 Biennium.

2007 Biennium FTE Hire Dates	FTE	Date

## CORRECTIVE ACTION PLANS

The WIC Program had two legislative audits and a Federal Management Evaluation (ME) with recommendations and associated corrective action plans in place during the 2005 biennium.

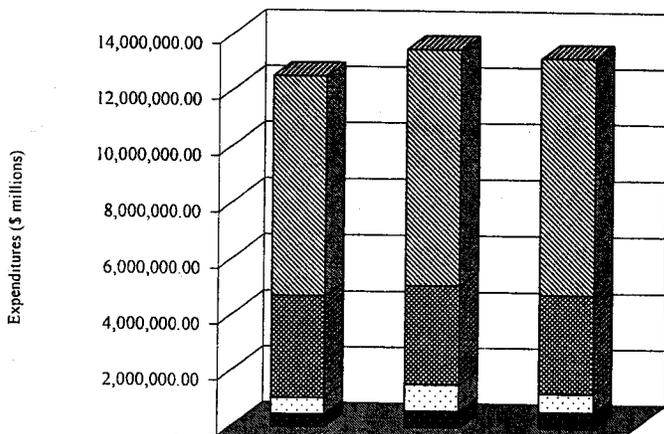
In the 2005 Legislative Audit there were seven findings of non-compliance. At that time the program put in place a corrective action plan. A follow up audit in September 2006 showed procedures are in place to complete all seven of the findings. There is a legislative audit scheduled for February 2007.

A Federal ME was conducted in May 2005. There were 38 findings and five observations. The Montana WIC Office has submitted four corrective action plans in response to the ME, with the last submitted in September 2006. Five findings continue to remain open. Those findings are related to memorandums of understanding with neighboring states to prevent dual participation and written procedures for check review. Staff and attorneys are currently working to close these findings.

## 2009 BIENNIUM BUDGET

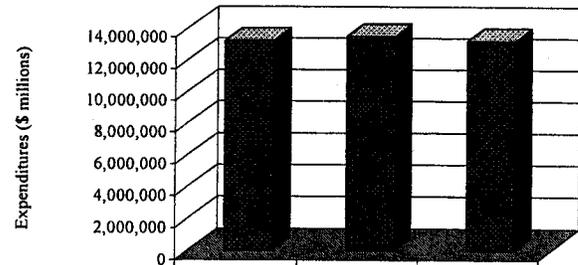
The following figures show the proposed HB 2 budget for the 2009 biennium.

Public Health and Human Services  
2009 Biennium HB2 Budget



	FY 2006	FY 2008	FY 2009
Debt Service	0	0	0
Transfers	0	0	0
Benefits & Claims	7,822,369.00	8,417,852	8,417,852
Grants	3,648,762.00	3,541,917	3,541,889
Local Assistance	-	0	0
Capital Outlay	-	0	0
Equipment	-	0	0
Operating Expenses	591,210.00	948,715	659,306
Personal Services	447,318.00	585,268	587,503

Public Health and Human Services  
2009 Biennium HB2 Budget



	FY 2006	FY 2008	FY 2009
Proprietary	0	0	0
Federal Special	13,217,204	13,203,752	13,206,550
State/Other Special	0	0	0
General Fund	0	290,000	0

## GOALS AND MEASURABLE OBJECTIVES

The following figure shows the department base year and budgeted biennium goals and performance measures that are associated with the proposed 2009 biennium HB 2 budget.

Public Health and Human Service Public Health and Safety Division		
Measurable Objectives for the 2009 Biennium		
Goal	Measurable Objectives	Current status of Measures
Goal: To safeguard the health of low-income women, infants, and children up to age 5 who are at nutrition risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care. (Federal USDA WIC Mission).	By June 30, 2009, increase the percent of women who breastfeed their infants at hospital discharge to 77.1%.	73% (2005)
	By June 30, 2009, increase the percent of potential WIC eligibles served by 10%.	65% (2005)
	By June 30, 2009, decrease the frequency of WIC computer helpdesk calls for assistance due to program inadequacies.	114 calls per month due to program inadequacies (Dec and Nov 2006)
	By June 30, 2009, decrease the number of WIC audit findings due to computer system operations.	Two internal and four external audit findings were attributable to the computer system (2005)
The above objectives are related to DP 70003		

## BUDGET AND POLICY ISSUES

The following budget or policy issues are included in the (department, division, program) budget submission to the Governor's Office.

**LFD Page B-93, DP 70003 – WIC Information Technology System Maintenance** – This one time only request is for \$290,000 for the biennium in general funds to sustain our current system until a USDA system is available.

## SIGNIFICANT ISSUES EXPANDED

**LFD Page B-93, DP 70003 – WIC Information Technology System Maintenance** - Montana WIC's information system is approximately 12 years old, and numerous patches over the years have made the system fragile and challenging to maintain. In July of 2005, the State performed a Business Process Review (BPR) project of the WIC environment. A common denominator with all of the stakeholders throughout the BPR project was the deficiencies of the WIC Information System (IS). While it has been recognized and appreciated that improvements have been made with the existing WIC IS, especially from an operational standpoint, the stakeholders have said that additional enhancements are required, especially if the business processes are to be improved. Many of the business processes within Client Services, vendor management, and financial management are impacted by the inadequacies of the system. This is especially prevalent in the vendor management area, where three disparate databases are used to automate and assist with the business functions of vendor management. The end result is that state staff spends more time to support the system through manual processes and data entry than in performing the business functions required for vendor management. The existing WIC IS does not effectively automate the operational needs of the WIC program, and will not be compliant with future federal mandated requirements.

This funding will support modifications to the system required until the "New State Agency Models (SAM)" are released for use in 2009-2010. These general funds are anticipated in addition to the resources presently budgeted for and allowed by USDA for maintenance of the IT system.

## DIVISION CONTACTS

Title	Name	Phone Number	E-mail address
Administrator	Jane Smilie	444-4141	<a href="mailto:jsmilie@mt.gov">jsmilie@mt.gov</a>
Financial Officer	Dale McBride	444-3635	<a href="mailto:dmcbride@mt.gov">dmcbride@mt.gov</a>

# PUBLIC HEALTH AND HUMAN SERVICES

## Public Health and Safety Division Tobacco Use Prevention Program

### DIVISION CONTACTS

The department, division, program director and chief financial officer for the department, division, program and their contact information are:

Title	Name	Phone Number	E-mail address
Administrator	Jane Smilie	444-4141	<a href="mailto:jsmilie@mt.gov">jsmilie@mt.gov</a>
Financial Officer	Dale McBride	444-3635	<a href="mailto:dmcbride@mt.gov">dmcbride@mt.gov</a>
Bureau Chief	Todd Harwell	444-1437	<a href="mailto:tharwell@mt.gov">tharwell@mt.gov</a>
Section Supervisor	Linda Lee	444-9617	<a href="mailto:llee@mt.gov">llee@mt.gov</a>

### WHAT THE PROGRAM DOES

The Montana Tobacco Use Prevention Program (MTUPP) implements evidence-based interventions to reduce tobacco use, and tobacco-related morbidity and mortality among Montanans. The Program also conducts surveillance and evaluation to monitor trends and assess program effectiveness. The comprehensive program goals of the program include:

- prevent youth from beginning a lifetime of addiction to tobacco products
- providing population-based cessation services to Montanans
- eliminating exposure to the hazardous effects of secondhand smoke, and
- supporting the elimination of disparities related to tobacco use

### SPENDING AND FUNDING INFORMATION

The following figures show funding and expenditure information for FY 2006 for all sources of funding of the MTUPP. Because the figures include all sources of funding there are no direct relationships between these figures and appropriation levels presented in the Budget Analysis for the 2007 Biennium.

### Statutory Authority For The Program

Federal Regulations for the cooperative agreement with the Centers for Disease Control and Prevention are contained in CFR 93-283. The statutory citation related to funding for tobacco prevention is included in MCA 17-6-606. The Montana Tobacco Use Prevention Plan, which is current through 2010, is available at <http://tobaccofree.mt.gov/mttobaccouseventionplan.pdf>.

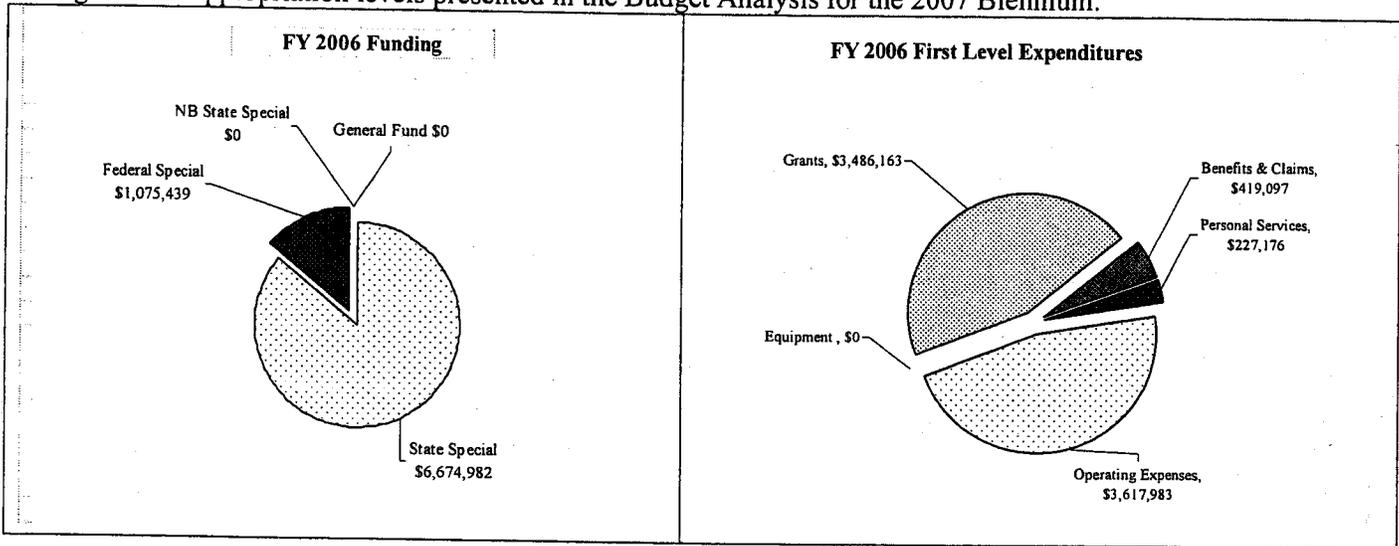
### How Services Are Provided

Tobacco prevention services conducted by the Department and through contracts and memorandums of understanding with the following organizations:

- County, Tribal and Urban Indian community-based programs
- Montana DPHHS, Addictive and Mental Disorders Division
- Office of Public Instruction
- Big Brothers and Big Sisters
- BACCHUS Network (programs targeting college and university campuses)
- National Jewish Medical and Research Center (Montana Tobacco Quit Line)
- University of Montana (training and technical assistance)
- Communications contractor (public education and awareness)
- Department's of Justice and Revenue (Enforcement)

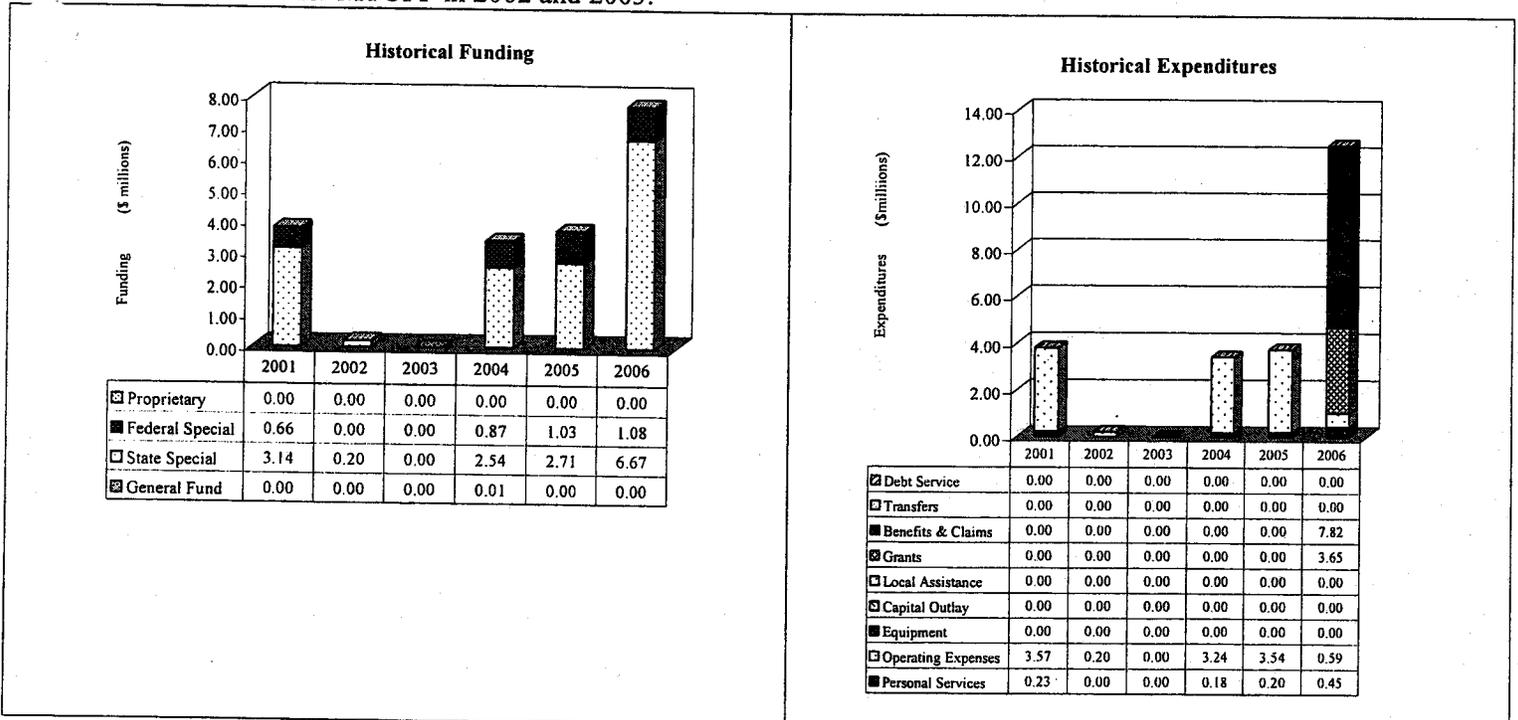
## Spending and Funding Information

The following figures show funding and expenditure information for FY 2006 for all sources of funding of the Public Health and Safety Division. Because the figures include all sources of funding there are no direct relationships between these figures and appropriation levels presented in the Budget Analysis for the 2007 Biennium.



The above information does not include administrative appropriations. The program had \$0 in administrative appropriations in fiscal year 2006. Departmental indirect charges are included as expenditures or revenues in the above tables.

The following figures show funding and expenditures from FY 2001 through FY 2006, for HB 2 funding. State Special revenue was reduced for MTUPP in 2002 and 2003.



# 2007 BIENNIUM NEW PROGRAM IMPLEMENTATION AND PROGRAM EXPANSION

## Program Expansion

### FTE

The legislature approved appropriations for an additional 4 FTE in the 2007 Biennium. The following figure shows the positions and hire dates for the new FTE.

2007 Biennium FTE Hire Dates	FTE	Date
Montana Tobacco Use Program	69107722	08/20/2005
Montana Tobacco Use Program	69107727	02/13/2006
Montana Tobacco Use Program	69107723	09/03/2005
Montana Tobacco Use Program	69107732	08/14/2006

## Community-Based Programs

### County, Tribal, and Urban Indian Community-Based Programs

MTUPP contracted with 41 counties, 8 tribes, and 4 urban Indian centers to provide tobacco use prevention services at the community level. This funding supported the work of 54 tobacco prevention specialists in 41 counties, on seven reservations (and among the Little Shell Tribe) and four Urban Indian Centers. The prevention specialists worked in a variety of ways to educate their communities about the hazards of commercial tobacco use and secondhand smoke exposure; promote tobacco use cessation; implement and enforce statewide policies such as the Montana Clean Indoor Air Act and the Tobacco Free Schools portion of that law; and to specifically focus on reducing smoking and spit tobacco use among youth.

### Community Work Through DPHHS Addictive and Mental Disorders Division (AMDD)

MTUPP has partnered with and provided funding to Addictive and Mental Disorders Division (AMDD) to support its community prevention work. AMDD provided evidenced-based community and youth-based programs in 17 counties using interventions including media literacy and counter advertising. Their efforts focused not only on providing services, but helping build local infrastructure and capacity using a "train-the-trainer" model. The target audience for the train-the-trainer programs are local health departments, community-based organizations, and other public health related groups.

### Community Work Through Big Brothers and Sisters (BBBS)

MTUPP has also partnered with and funded BBBS to help increase the availability of adult big brothers and sisters to Montana youth. As they engage Montana youth in their program, BBBS offers educational and training opportunities for staff, volunteers and youth about tobacco prevention.

## School-Based Programs

### Office of Public Instruction (OPI) Tobacco Prevention and Education Program

Through a Memorandum of Understanding MTUPP funded OPI to implement a Tobacco Use Prevention and Education Program. They hired one FTE to oversee the program and provided funding to 25 school district grantees to implement tobacco prevention, education and/or cessation activities during the 2006-2007 school year.

### Tobacco Use Prevention at Colleges and Universities

The 18-24 age group is the only population segment in Montana that shows an increase in tobacco use. To address this, MTUPP contracted with the BACCHUS Network, based out of Denver, Colorado to coordinate and provide tobacco prevention at colleges and universities. Pilot projects were started at the University of Montana (Missoula), and Montana State University (Bozeman). Baseline data on student tobacco use, attitudes and campus tobacco control policies was collected, and student-based Campus Tobacco Task Forces were developed to implement prevention activities. This program has been expanded to include Salish Kootenai College and Montana State University, Billings.

## **Statewide Programs**

### Tobacco Cessation Services Through the Montana Tobacco Quit Line

Since May 2004 MTUPP has contracted with National Jewish Medical Center from Colorado to implement the Montana Tobacco Quit Line. The Quit Line offers free cessation services for anyone in Montana who wants to quit using tobacco. The service is extensive and involves free nicotine replacement therapy, materials and guidance from quit specialists who help the caller plan their quit attempt. The quit specialists also provide support for as many as five calls as the client moves through the extremely difficult process of quitting. The Quit Line has received over 10,000 calls from Montanans between May 2004 and May 2006.

### Public Education and Awareness

MTUPP contracted with the Helena-based media firm Flying Horse Communication to implement public education and awareness campaigns about the MT Clean Indoor Air Act and the tobacco cessation services provided through the MT Quit Line. The Clean Indoor Air campaign included creation and distribution of signs, and educational, implementation, and enforcement materials for businesses and local health departments. Paid media placement for television, radio, newspapers and billboards was a large component of both campaigns. The funding was also used to conduct outreach at conferences and expositions, develop "quit kits" to promote the quit line, and to support the community programs through the development of sample press releases, and fact sheets.

### Technical Assistance and Training for Community-Based Programs

To ensure that Montana's tobacco use prevention workforce is skilled in the work they do, MTUPP contracted with the University of Montana (UM) Technical Assistance and Training Center to provide technical assistance and training for the community-based tobacco prevention specialists located across the state. Using a small cadre of experts UM provided services at regional and statewide meetings, through site visits, conference calls and ad hoc meetings. UM also developed training modules for new prevention specialists and specific materials on such topics as secondhand tobacco smoke, youth tobacco use, spit tobacco, and cessation.

### Statewide Youth Empowerment Movement

Youth Empowerment: *ReACT! Against Corporate Tobacco* is Montana's teen-led movement against the tobacco industry's efforts to target youth to smoke or use spit tobacco. Managed directly by MTUPP staff and VISTA volunteers, *ReACT* joins statewide youth movements across the U.S. in recognizing the power of young people to effectively take on the problem of tobacco use. *ReACT* involves media literacy, peer education, and grassroots advocacy. In June 2006, 140 teens attended the *ReACT* Teen Summit in Bozeman where they received training and skills to take to their communities. These youth will develop and implement tobacco prevention activities in their communities in FY 2007.

## **Chronic Disease Prevention**

MTUPP contracted with Greg Holzman, MD, MPH to offer Continuing Education Units to health care providers across Montana for attending tobacco intervention training. Dr. Holzman traveled the state teaching at clinics, hospitals and doctor's offices to improve practitioner skills in intervening with patients addicted to tobacco, prescribing nicotine replacement therapy, and promoting the referral of patients to the Montana Quit Line. Thirty-nine primary care practices in Montana have participated in FY 2006.

## **Policy Enforcement**

The Montana Legislature revised and enacted the Montana Clean Indoor Air Act (CIAA) during the 2005 session. The law prohibits smoking in all indoor public places, except for bars and casinos that meet specific criteria. In October 2009, all indoor public places including bars and casinos will be covered by the law. The Department established rules for the law in October 2005. Additionally, MTUPP, local health departments, and the community-based programs are providing ongoing technical assistance to businesses and schools regarding compliance (e.g., hot line, educational materials, signage). MTUPP is also conducting an ongoing public education campaign to increase community awareness regarding the law.

In July 2005, the Departments of Revenue, Justice (DOJ) and Public Health and Human Services (DPHHS) entered into a Memorandum of Understanding for cooperative administration and enforcement of tobacco related laws and taxes. As a result, the DOJ seized a large quantity of untaxed loose tobacco in the state, and the Gambling Control Division (GCD) was able to close over 1600 cases related to tobacco tax enforcement. Additionally, they are now focusing on the addressing the illegal sale of un-taxed tobacco products through the internet and out of state purchasing of tobacco products. The GCD has supported the implementation of Montana's new Clean Indoor Air Act, by conducting compliance inspections in bars and casinos. Between March and December of 2006, 670 inspections have been completed.

### **Program Surveillance and Evaluation**

Comprehensive program surveillance, assessment and evaluation are accomplished by MTUPP's epidemiologist. The program is using a number of data sources for surveillance in FY 2006. The Adult Tobacco Survey and the Behavioral Risk Factor Surveillance Survey provide data regarding the prevalence of smoking and spit tobacco use, cessation practices, and exposure to secondhand smoke in adults. The Youth Risk Behavior Survey and the Prevention Needs Assessment provide data regarding the knowledge, attitudes and the prevalence of tobacco use, and exposure to secondhand smoke among Montana youth. Data from the Montana Central Tumor Registry has been used to assess the incidence of tobacco-related cancers (e.g., lung and oral cancer), and data from the Montana birth and death records have been used to assess the prevalence of smoking in pregnancy, and tobacco-related mortality.

### **Program Administration and Management**

This component included funding for personnel (7.5 FTEs), printing, temp services, VISTA Volunteers, support for the Tobacco Prevention Advisory Board and Native American Work Group meetings, in state and out of state travel and training, rent, phones, utilities, off site records storage, janitorial, newspaper clipping service, grounds maintenance and supplies.

#### **Outcomes**

Montana Tobacco Quit Line – Over, 10,000 Montanans have used the quit line services since its inception in May 2004. Among persons completing the counseling program but who did not receive NRT, 25% reported that they were tobacco free at six-months follow-up. Among persons completing the counseling program and who received NRT, 32% reported that they were tobacco free at six-months follow-up.

Youth – Data from the Youth Behavior Risk Survey, indicate the prevalence of smoking among high school aged youth in Montana is decreasing from 38% in 1997 to 20% in 2005. Data from the AMDD Prevention Needs Assessment Survey of high school youth indicate an increase in the awareness of youth who believe that regular smoking puts one at great risk (67% in 2000 vs. 72% in 2004). Recently published data from the Prevention Needs Assessment survey indicate continued decreases in the prevalence of smoking among Montana youth from 19% in 2004 to 17% in 2006.

Adults – Attention will need to be focused on adults and pregnant women in Montana that smoke. The prevalence of smoking among adults and pregnant women in Montana remained stable between 2000 and 2005. In FY 2006, MTUPP developed a plan to address the important problem of spit tobacco use. The prevalence of spit tobacco use in Montana adult males in 2005 was 13% and the prevalence in eighth, tenth and twelfth grade boys was 15%, which is considerably higher than the prevalence in the U.S.

MTUPP was also encouraged to identify additional opportunities to implement tobacco use prevention and cessation activities in FY 2007 (Legislative Budget Analysis 2009 Biennium, Volume 4, page B-91), and the following activities were completed.

MTUPP worked with the Cardiovascular Health and Diabetes Section to promote tobacco cessation counseling through the primary care practices that the Diabetes Program is working with across the state. MTUPP has also collaborated with Women's and Men's Health Section and the Oral Health Program in the Family and Community Health Bureau to promote cessation counseling and services through family planning clinics and dental offices in Montana.

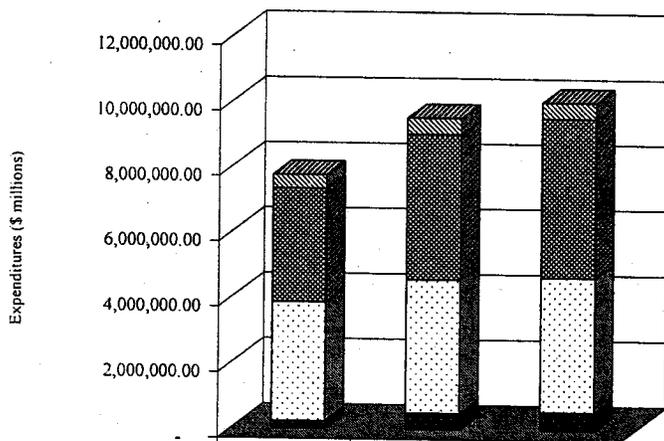
MTUPP is collaborating with Medicaid and Medicaid providers to promote tobacco cessation. MTUPP mailed an educational package to all licensed physicians and dentists in Montana that included information on the state-of-the-art regarding cessation counseling and information promoting the utilization of the Montana quit line. Additionally, MTUPP contracted with Greg Holzman, MD, MPH to provide onsite education and continuing medical education credits to physicians and their staff promoting cessation counseling and the quit line. MTUPP has also conducted outreach to pharmacies in Montana and has provided Quit Line promotional materials to these facilities. MTUPP has met with Medicaid to review current tobacco cessation policies (e.g., eliminating co-pays for cessation therapies, increasing the number of lifetime cessation attempts where therapy is covered by Medicaid). And potential changes that could be made to support cessation in Medicaid recipients. MTUPP to date has not incorporated quit line information in mailings to state-supported programs or developed chart audits for health care providers.

MTUPP is working currently to develop a policy for DPHHS that would promote that meetings and conferences sponsored by DPHHS programs would be conducted in totally smoke free facilities. If adopted by DPHHS, we will promote that this policy be adopted by all state agencies. MTUPP is also developing additional policies that the DPHHS and all state agencies could adopt (e.g., comprehensive cessation services provided through state insurance, smoke free state campus).

## 2009 BIENNIUM BUDGET

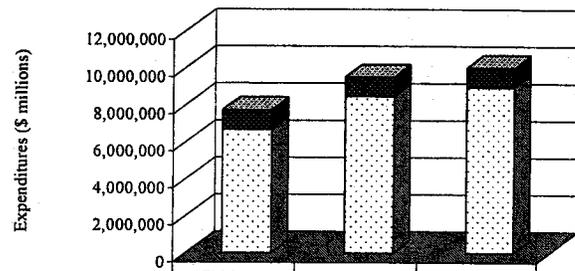
The following figures show the proposed HB 2 budget for the 2009 biennium.

Public Health and Human Services  
2009 Biennium HB2 Budget



	FY 2006	FY 2008	FY 2009
Debt Service	0	0	0
Transfers	0	0	0
Benefits & Claims	419,097.00	499,097	499,097
Grants	3,486,183.00	4,464,263	4,874,263
Local Assistance	-	0	0
Capital Outlay	-	0	0
Equipment	-	0	0
Operating Expenses	3,617,983.00	4,076,395	4,104,537
Personal Services	227,176.00	486,363	549,205

Public Health and Human Services  
2009 Biennium HB2 Budget



	FY 2006	FY 2008	FY 2009
Proprietary	0	0	0
Federal Special	1,075,439	1,049,551	1,049,683
State/Other Special	6,674,982	8,476,567	8,977,419
General Fund	0	0	0

## Goals and Measurable Objectives

The following figure shows the department base year and budgeted biennium goals and performance measures that are associated with the proposed 2009 biennium HB 2 budget.

Public Health and Human Service Public Health and Safety Division		
Measurable Objectives for the 2009 Biennium		
Goal	Measurable Objective	Current status of measures
Prevent youth initiation of smoking	1. By June 2009, decrease the proportion of high school students who report smoking cigarettes in the past 30 days to the Healthy People 2010 National Objective of 16%.	20% (2005)
Prevent youth initiation of spit tobacco use	2. By June 2009, decrease the proportion of high school students who report spit tobacco use in the past 30 days to the Healthy People 2010 National Objectives of <1%.	15% (2005)
Help people already addicted to tobacco to quit using it	3. By June 2009, decrease the proportion of adults who report smoking to the Healthy People 2010 National Objective of 12%.	19% (2005)
Help people already addicted to tobacco to quit using it	4. By June 2009, decrease the proportion of pregnant women who report smoking to the Healthy People 2010 National Objective of 12%.	18% (2005)
These objectives are related to DP 70106.		

## BUDGET AND POLICY ISSUES

**LFD Page B-89, DP 70106 - Tobacco Use Prevention** - This budget request is for 1.00 FTE and \$1,700,000 in state special revenue from the Master Settlement Agreement with the tobacco companies for each year of the biennium for expansion of activities of Montana Tobacco Use Prevention. Please see the "significant issues expanded" section below for a detailed description of this request.

## SIGNIFICANT ISSUES EXPANDED

**LFD Page B-89, DP 70106 – Tobacco Use Prevention Increase** - This request is for 1.00 FTE and \$1,700,000 in state special revenue (Master Settlement Agreement Funds) for each year of the biennium for expansion of current prevention activities. These funds will support a) new community-based programs, b) program to prevent spit tobacco use, c) programs to reduce smoking during pregnancy, d) new college campus prevention programs, e) youth public education campaigns, targeted promotion of the Montana tobacco quit line, f) and enhanced surveillance.

**1. Fund Remaining Montana Counties for Community-based Tobacco Prevention Activities -**

This proposal would provide funding for the fifteen remaining Montana counties that currently do not have tobacco prevention funding for community-based efforts. These counties include Glacier, Granite, Jefferson, Broadwater, Meagher, Madison, Sweetgrass, Big Horn, Valley, Garfield, McCone, Prairie, Wibaux, Fallon, Carter, all of which are rural counties. Funding all 56 Montana Counties will ensure comprehensive tobacco use prevention for all Montana citizens. Funding for these community-based programs will be used to implement and enforce the Montana Clean Indoor Air Act, and to implement community-level activities to prevent youth initiation, and promote tobacco use cessation. The community-based programs will be evaluated based on the quarterly and annual progress reports they submit to MTUPP. These activities address objectives 1-4.

\$458,100 per year ongoing to support and fund additional counties:

- \$300,000.00 to fund twelve unfunded counties with small populations
- \$ 98,100.00 to fund three counties with larger populations
- \$ 60,000.00 for salary and benefits for 1.00 FTE to manage, train and offer technical assistance to the additional county programs

**B. Prevent Spit Tobacco Use in Montana** - This proposal would utilize funding to implement the action plan recommended by the Spit Tobacco Strategic Initiative Committee to prevent and reduce spit tobacco use in Montana. The FY08 action plan will include the following activities.

\$200,000 per year

- \$155,000 Develop and implement a statewide public education campaigns focusing on spit tobacco use prevention.
- \$15,000 Create support materials to assist in the adoption of tobacco-free policies for hospitals, colleges and other targeted institutions.
- \$10,000 Create and distribute spit tobacco cessation materials through the Montana Tobacco Quit Line to promote spit tobacco cessation.
- \$20,000 Expand surveillance, evaluation and the publishing of reports on spit tobacco use in Montana to help direct effective intervention strategies.

Data from the Youth Risk Behavior Survey and the Prevention Needs Assessment survey will be used to assess changes in youth attitudes toward spit tobacco, prevalence of spit tobacco use, and the age of initiation of use prior to and after initiation of the interventions. Data from the Adult Tobacco Survey will be used to assess changes in the prevalence of spit tobacco use in adults prior to and after initiation of these interventions. These activities address objective 2.

**C. Reduce Smoking During Pregnancy in Montana** - This proposal would focus on reducing the prevalence of smoking during pregnancy among Montana mothers.

\$240,000 per year

- \$150,000 to develop and implement a public education and awareness campaign focusing on the benefits of smoking cessation during pregnancy and where to go for help (e.g., provider and the Quit Line).
- \$80,000 to conduct outreach to primary care providers regarding:
  - state-of-the-art counseling and pharmacologic techniques to assist their patients to quit using tobacco
  - free counseling services and cessation aids provided by the Montana Tobacco Quit Line, and information on how to refer women to the quit line
- \$10,000 to develop and disseminate pregnancy specific cessation materials for patients and primary care providers.

This pilot program will be evaluated using the Montana birth records and intake data collected through the Montana Tobacco Use Quit Line. The overall goals will be to increase utilization of Montana Tobacco Use Quit Line, and to reduce the prevalence of smoking during pregnancy among women. These activities address objective 4.

**Establish New College Campus Tobacco Prevention Programs** - The 18-24 age group is the only population

segment in Montana that shows an increase in tobacco use. As described under our progress report, MTUPP is collaborating with the BACCHUS Network to coordinate and provide tobacco prevention at Montana colleges and universities. This program has been implemented at the University of Montana, Montana State University (Bozeman), Flathead Kootenai College, and Montana State University Billings. This proposal requests \$200,000 per year to expand this program to additional colleges in Montana. These activities address objective 3.

**E. Statewide Youth Public Education for Tobacco Prevention** – This proposal would utilize \$381,900 of funding to develop and implement ongoing statewide public education campaigns targeting youth to increase awareness of the health impact of tobacco use (both smoking and spit tobacco), and to promote effective messages that prevent youth initiation of tobacco use. These funds will be used to develop and place television, radio, newsprint advertisements. These activities would be coordinated with the youth empowerment initiative described in the progress report to ensure that the local youth activities and the statewide campaigns work together. These activities address objectives 1-2. Additional objectives and baseline measures address youth attitudes toward tobacco use and perceived risk of harm for tobacco use will be developed.

**F. Targeted Quit Line Promotion** – This proposal would utilize \$120,000 per year to develop and implement targeted tobacco quit line outreach to subpopulations at high risk for tobacco use including Montanans with low-incomes, American Indians, and rural Montanans. These funds would be used to develop and disseminate mass and small media messages promoting tobacco cessation and the Montana tobacco quit line. These activities address objective 3.

**G. Enhanced surveillance Activities** – This proposal would utilize \$100,000 per year to enhance surveillance for tobacco prevention including expanding the sample size for our Adult Tobacco Survey, enhanced surveillance for the Montana Central Tumor registry, and to conduct additional surveillance and program evaluation that is not currently funded.

#### **DIVISION CONTACTS**

The division administrator and chief financial officer for the department and their contact information are:

Division Administrator	Jane Smilie	444-4141	<a href="mailto:jsmilie@mt.gov">jsmilie@mt.gov</a>
Chief Financial Officer	Dale McBride	444-3635	<a href="mailto:dmcbride@mt.gov">dmcbride@mt.gov</a>

# PUBLIC HEALTH AND HUMAN SERVICES

Public Health and Safety Division  
Children's Special Health Services

## DIVISION CONTACTS

The department, division, program director and chief financial officer for the department, division, program and their contact information are:

Title	Name	Phone Number	E-mail address
Administrator	Jane Smilie	444-4141	<a href="mailto:jsmilie@mt.gov">jsmilie@mt.gov</a>
Financial Officer	Dale McBride	444-3635	<a href="mailto:dmcbride@mt.gov">dmcbride@mt.gov</a>
Bureau Chief	Jo Ann Dotson	444-4743	<a href="mailto:jdotson@mt.gov">jdotson@mt.gov</a>
Section Supervisor	Mary Runkel	444-3617	<a href="mailto:mrunkel@mt.gov">mrunkel@mt.gov</a>

## WHAT THE PROGRAM DOES

The purpose of Children Special Health Services (CSHS) is to improve the health and quality of life of children with special health care needs and their families. Children with special health care needs (CSHCN) are defined as "children who have, or are at increased 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".<sup>1</sup> According to a national survey conducted in 2001, 26,981 children in Montana, or 11.8% of children aged age 0-18, fall under the definition of CSHCN.

Federal law mandates that states provide and promote family-centered, community-based, coordinated care for CSHCN and facilitate the development of community-based systems of services for such children and their families.<sup>2</sup> Montana's CSHS program contracts for and supports regional specialty clinics which provide access to sub-specialists and other health providers with expertise in caring for children with often rare conditions. The program also coordinates the follow up of newborn metabolic and hearing screening activities in birthing facilities, monitors the incidence of and follow up for birth defects through the birth defects registry, refers children to appropriate services and to available resources, and provides limited financial assistance for medical services for children with specific diagnosis and whose families are income eligible.

## SPENDING AND FUNDING INFORMATION

Federal law requires that at least 30 percent of the Maternal Child Health Block Grant awarded to each state be spent on services for children with special health care needs.<sup>3</sup> The following figures show funding and expenditure information for FY 2001 - 2006 for all sources of funding of the Children's Special Health Services. Because the figures include all sources of funding there are no direct relationships between these figures and appropriation levels presented in the Budget Analysis for the 2007 Biennium.

<sup>1</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *The National Survey of Children with Special Health Care Needs Chartbook 2001*. Rockville, Maryland: U.S. Department of Health and Human Services, 2004.

<sup>2</sup> Title V of the Social Security Act, Section 501(1)(d). [42 U.S.C. 701]. Maternal and Child Health Services Block Grant. [http://www.ssa.gov/OP\\_Home/ssact/title05/0501.htm](http://www.ssa.gov/OP_Home/ssact/title05/0501.htm)

<sup>3</sup> Title V of the Social Security Act, Section 505(a)(3)(b). [42 U.S.C. 705]. Maternal and Child Health Services Block Grant. [http://www.ssa.gov/OP\\_Home/ssact/title05/0505.htm](http://www.ssa.gov/OP_Home/ssact/title05/0505.htm)

## STATUTORY AUTHORITY FOR THE PROGRAM

Federal authority for the Children's Special Health Service Program is contained within Title V of the Social Security Act (CFR 701-710, subchapter V, chapter 7, Title 42). State authority exists within Chapter 57 of the Administrative Rules of Montana (Subchapter 1, 37-57-101 - 125).

## HOW SERVICES ARE PROVIDED

CSHS is part of the Family and Community Health Bureau, within the Public Health and Safety Division. The Bureau mission is to "promote and improve the health and safety of Montana's women, men, children, and families. The target population is infants, children, youth to age 21, women of childbearing age, including those who are pregnant, and their families.

CSHS contracts for **regional specialty clinics** in Missoula, Great Falls and Billings. These specialty clinics provide diagnosis and follow up for children and their families with abnormalities of the cardiac, endocrine, musculoskeletal, neurological, and pulmonary systems. Specific conditions addressed at the clinics include: cerebral palsy, cleft lip and palate and craniofacial conditions, cystic fibrosis, diabetes, juvenile rheumatoid arthritis, muscular dystrophy, metabolic disorders (including phenylketonuria or PKU), genetic conditions, spina bifida and other neural tube defects. In many states CSHCN programs contract with medical schools or medical university systems to oversee and coordinate statewide clinics. CSHS employees staffed most clinics in the past, but over the last five years have instead contracted with medical centers in these three communities to coordinate and staff the various clinics. State employees still schedule clients for, and staff several clinics in remote sites. These clinics are being transitioned to regional clinic structures, which will ultimately free state employees to support, train and monitor regional clinics. The CSHS program also contracts for some specialty providers to staff regional specialty clinics. The potential to transfer this contracting responsibility to regional clinics continues to be explored.

CSHS is responsible for assuring for timely follow up to definitive diagnosis and clinical management for condition(s) identified through mandated **newborn screening**. Newborn screening consists of tests on dried blood samples obtained by heel stick on the infant. Mandated tests in Montana include phenylketonuria (PKU), galactosemia, congenital hypothyroidism, and hemoglobinopathies (Montana ARM 37.57.301) CSHS receives reports of abnormal screening at the same time the results are sent to the primary care physicians (PCP) or medical home that ordered the tests. CSHS supports medical homes in partnership with the laboratory, by providing information about regional specialty clinics and access to and information about specialty providers who provide clinical consultation. CSHS staff also record and report testing activities to federal agencies. Clinical management is the responsibility of health care providers, but due to the rarity of metabolic conditions, linkages and referrals are an important function of the program. Legislation to create a newborn screening program is being introduced in the 2007 session. Contingent upon passage of that legislation, ARM will be revised to expand the newborn screening panel to 29 tests, as recommended by the American College of Medical Genetics and endorsed by the American Academy of Pediatrics and the March of Dimes.

CSHS also is responsible for supporting **newborn hearing screening** in Montana. Newborn hearing screening is not mandatory in Montana, but has become a standard of care. CSHS has the Newborn Hearing Screening grant, which supports part of an FTE who is responsible for implementing the program, and partially pays for equipment and reporting software for birthing facilities in Montana. CSHS provides resources to local hospitals to help purchase screening equipment and reporting software. Approximately 90% of newborns in Montana are presently being screened for hearing abnormalities by one month of age. CSHS also assures that infants with positive screens are referred to audiologists for further testing, and, if identified as having hearing abnormalities are referred to the Montana School for the Deaf and Blind for follow up and management in partnership with local health providers. Legislation to mandate newborn hearing screening is being introduced in the 2007 legislative session.

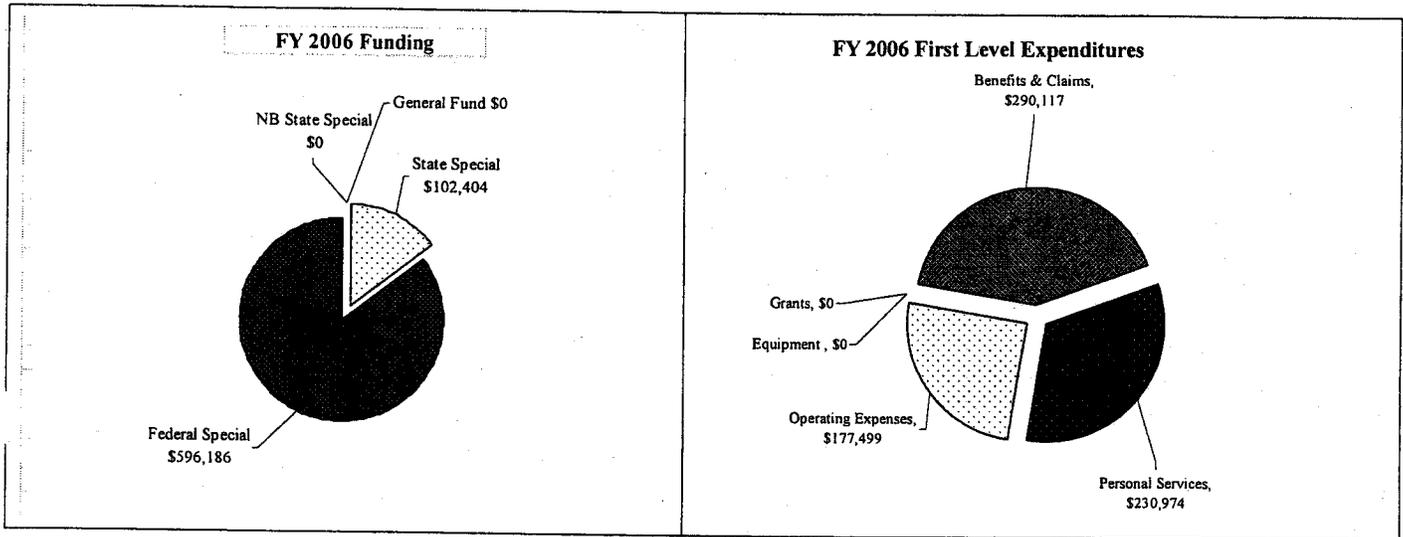
CSHS manages the **birth defects registry**. Montana's birth defects registry application was approved, but not funded by CDC in 2005. The birth defects registry, which had begun active case ascertainment requiring medical records check for defined birth defects, moved to passive surveillance due to lack of funding. CSHS staff receives and tracks birth defects reported to them by health providers in Montana.

CSHS also oversee contracts for other services important to CSHCN, including **genetics services** with Shodair Hospital and **family support services** with Parents Let's Unit for Kids (PLUK).

CSHS offers **direct pay for medical services** for income eligible (<200% of poverty) families with CSHCN who have a diagnosis which are covered by the program. Covered diagnoses are contained within Montana ARM 37.57.110. Services paid for by CSHS must be prior authorized and directly related to the covered diagnosis. Direct pay was the primary mode of service delivery by the CSHS program, previously known as the Handicapped Children's Program, in the 1970s and 1980s, but changes in Medicaid and CHIP, as well as increased cost of services, have resulted in direct pay activity being reduced in Montana and in many states in the U.S.

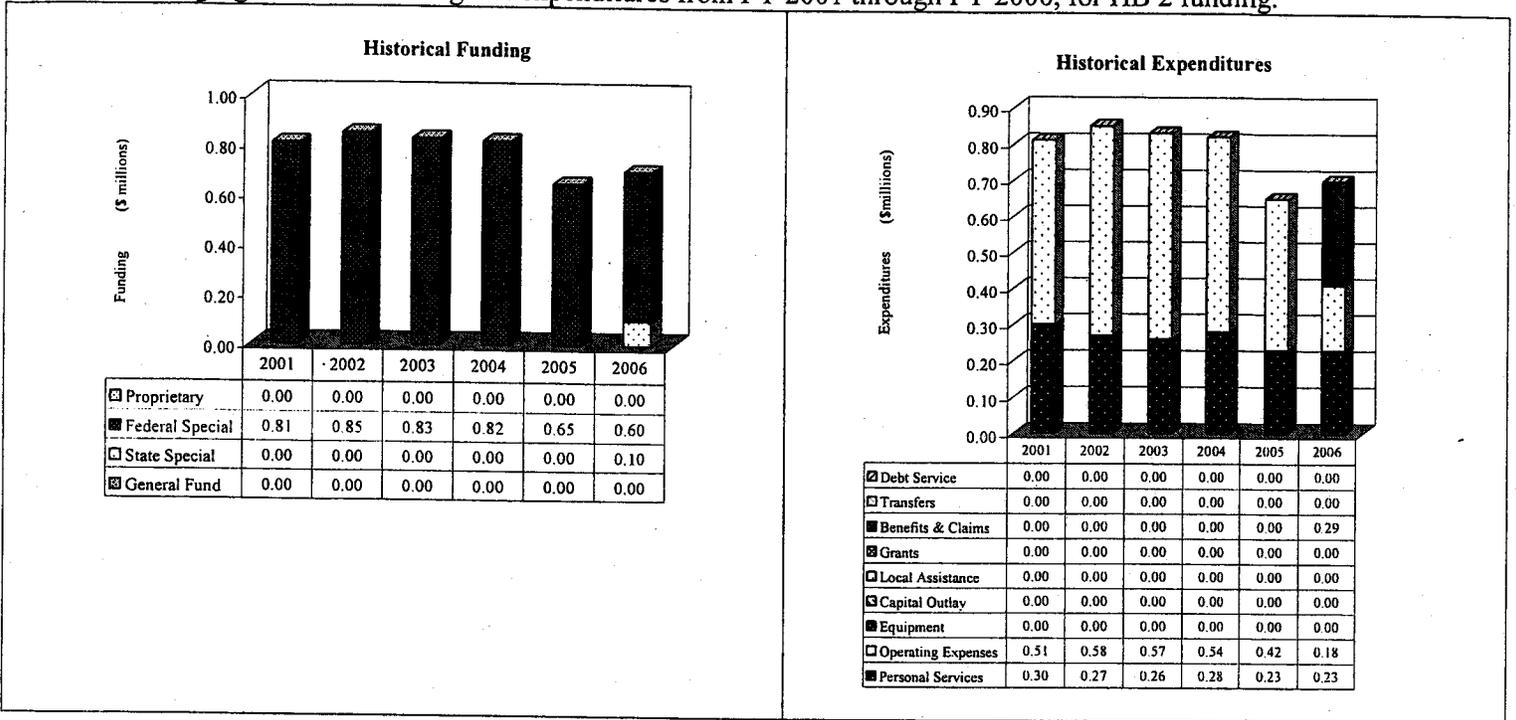
## SPENDING AND FUNDING INFORMATION

The following figures show funding and expenditure information for FY 2006 for all sources of funding of the Public Health and Safety Division. Because the figures include all sources of funding there are no direct relationships between these figures and appropriation levels presented in the Budget Analysis for the 2007 Biennium.



The above information does not include administrative appropriations. The program had \$0 in administrative appropriations in fiscal year 2006. Departmental indirect charges are not included as expenditures or revenues in the above tables.

The following figures show funding and expenditures from FY 2001 through FY 2006, for HB 2 funding.



The change in revenues and expenditures between fiscal year 2005 and year 2006 resulted from a state appropriation for the initiation of a satellite specialty clinic for children with metabolic disorders and cleft lip and palate in Great Falls, Montana.

## 2007 BIENNIUM NEW PROGRAM IMPLEMENTATION AND PROGRAM EXPANSION

### PROGRAM EXPANSION

Funding received during the 2006-2007 biennium allowed for the addition of the third regional clinic site in Great Falls. State staff also developed codes which allow for billing of multi-specialty clinic services such as cleft craniofacial clinics. The first bills were generated in 2006. Billing revenue was used to expand services at regional clinic sites, including contract nutritionists. Future plans are to shift billing to regional clinics, allowing them to receive payment directly.

The CSHS program was moved from the Health Resources Division to the Public Health and Safety Division effective January 2006. This move allowed reorganization within the Family and Community Health Bureau, moving the Newborn Metabolic and Hearing screening and the birth defects registry to CSHS.

### FTE

No additional FTE are requested in 2007 Biennium.

2007 Biennium FTE Hire Dates	FTE	Date

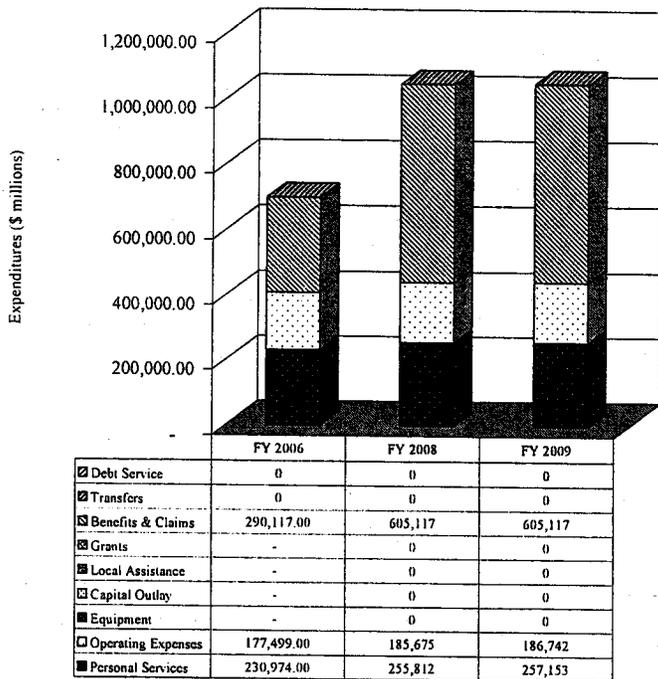
### CORRECTIVE ACTION PLANS

No corrective action plans are in place.

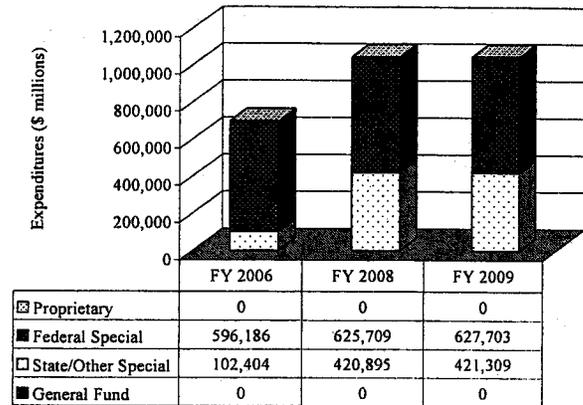
# 2009 BIENNIUM BUDGET

The following figures show the proposed HB 2 budget for the 2009 biennium.

Public Health and Human Services  
2009 Biennium HB2 Budget



Public Health and Human Services  
2009 Biennium HB2 Budget



## GOALS AND MEASURABLE OBJECTIVES

The following figure shows the department base year and budgeted biennium goals and performance measures that are associated with the proposed 2009 biennium HB 2 budget.

Public Health and Human Service Public Health and Safety Division		
Measurable Objectives for the 2009 Biennium		
Goal	Measurable Objectives	Current Status of Measure
Increase availability and quality of services for children with special health care needs and their families in Montana.	By June 30, 2009, 100% of newborns will receive timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their state-sponsored newborn screening programs.	100% (2005)
	By June 30, 2009 increase accessibility to specialty services for children with special health care needs through specialty clinics by 10%.	2,510 (2005)
	By June 30, 2009, increase the percentage of newborns who have been screened for hearing before hospital discharge to 98%.	87.9% (2005)
These objectives are related to DP 70005.		

## BUDGET AND POLICY ISSUES

The following budget or policy issues are included in the program budget submission to the Governor's Office.

- LFD Page B-94, DP 70005 – Newborn Screening Follow Up Program** – this request is for \$290,000 in Tobacco Trust Fund Interest (SSR) for each year of the biennium to support a comprehensive newborn screening follow-up program to assure the availability of appropriate clinical diagnostic and support services for families and primary providers of those babies with an abnormal condition for an expanded panel of newborn screening tests. This new funding is contingent upon passage of legislation (LC 0986).
2. **LFD Page B-93, DP 70104 – Genetics Program Reduction** – During the last biennium the Montana Genetics Program was granted a fee increase only for the current biennium. The fees on insurance premiums to support the Montana Genetics Program will revert from \$1.00 for the biennium back to \$.70 effective July 1, 2007. This request is to remove \$242,559 in SSR from the state budget to reflect the sunset of this fee increase.
  3. **HB 117 – An act requiring provision of and reporting regarding newborn hearing screenings and education** – this legislation would require that a hearing screening test be performed for all newborn infants before discharge from a hospital or no later than 1 month after birth, so that the DPHHS can plan, establish and evaluate a comprehensive system of services for infants and children who are deaf or hard of hearing.
  4. **SB 162 – An act expanding the genetic and metabolic conditions required to be screened in newborns and allowing the state to contract with one or more providers of follow up services for newborns suffering from such conditions.** This legislation authorizes the department to contract for one more or entities to provide medical and health services for infants and children identified as having inborn errors of metabolism which are detected from a blood sample at birth. Contingent upon passage of this legislation, the state will modify Administrative Rules of Montana to expand the newborn screening from four mandatory screening tests done on a blood sample to 28 metabolic and endocrine tests and a newborn hearing screening for a total of 29 tests.

## SIGNIFICANT ISSUES EXPANDED

**LFD Page B-94, DP 70005 Newborn Screening Follow-up funding and LC 0986 NBS program creation and authorization to contract** - Screening of newborns for metabolic and other disorders through a blood test has become a standard of care in the U.S. In 2005, the Maternal and Child Health Bureau of the federal Department of Health and Human Services published a report entitled "Newborn Screening: Toward a Uniform Screening Panel and System" (<http://www.mchb.hrsa.gov/screening/summary/htm>). This report calls for national adoption of a mandatory panel of 29 tests (hearing screening and 28 tests for metabolic and other disorders detected by testing of blood samples) in order to ensure that all babies born in the United States have equal access to the same screenings.

This federal recommendation was reviewed and considered by the Montana Newborn Screening/Genetics Task Force. This task force, which included medical and health providers, families, policy makers and advocates, met from January through March of 2006. These proposals supports the conclusions of the Newborn Screening/Genetics Task Force, which met January – March 2006. The task force asserts that it is the responsibility of the state to assure that:

- a. Every Montana-born baby will receive the panel of newborn screening tests which are currently recommended by the American College of Medical Genetics and endorsed by the American Academy of Pediatrics and the March of Dimes. In March 2006, the Academy is recommending 29 tests; a hearing screening and 28 metabolic and other disorders detected through testing of blood.
- b. Every person in Montana with positive newborn screening test results will receive an appropriate continuum of follow-up care.

Technological advances have made available screening for multiple metabolic conditions that can be accomplished in a timely and cost effective manner. Montana is one of only eight states (Arkansas, Kansas, Montana, New Mexico, Oklahoma, Pennsylvania, Texas and West Virginia) who still test for fewer than 10 conditions. Three of those states (New Mexico, Oklahoma and Texas) have law or rule in place, but not yet implemented, that will increase the number of conditions for which they will screen. Of the remaining five states, Montana screens for the fewest conditions (PKU, Galactosemia, congenital hyperplasia, and three

hemoglobinopathies). Expansion of the screening panel via rule making is possible only if a follow up system exists which can respond to positive findings, and assure that care is available for newborns with abnormal findings.

Newborn Screening is far more than a laboratory test. Newborn screening it is a complex system that begins with laboratory screening, continues through confirmatory testing and diagnosis to medical management and care coordination for those with confirmed disorders. The system must also have an evaluation component, to assure that what is being done is effective, efficient and responsive to the needs of the public. The proposed program would be responsible not only for the initial identification and referral presently provided, but to assure access to specialty services required to accurately diagnose, treat and support primary care providers and families in their care of infants and children with abnormal conditions, and to evaluate effectiveness of the program.

Montana had approximately 11,400 births per year. Based on the numbers of births for the last three years, and using national incidence rates, Montana would expect to have 5 infants to be identified with metabolic or congenital conditions based on the existing panel of tests. If the panel were expanded to the full recommended panel, Montana would expect to have an additional 20 infants identified, for a total of 25 infants. Almost half of those infants would be expected to have hearing abnormalities, with the remaining half with metabolic or other congenital conditions. This increase is substantial, requiring resources and services not presently available in the state. These services would include:

- a) Metabolic specialists, pediatric endocrinologists and developmental pediatricians' services
- b) Case management
- c) Nutritionists services
- d) Family Support
- e) Training and education of the public and providers re NBS

The goal of this program will be to assure the availability of appropriate clinical diagnostic and support services for babies identified with an abnormal condition from the expanded panel of newborn screening tests, for their families, and primary care providers. Upon passage of the legislation, rule making will begin to expand the panel of mandatory tests in Montana. Requests for proposals for required services will be done in the first year of the 2009 biennium, and contracts finalized in spring of 2008. The expanded panel of tests will take effect July 1, 2008.

Failure to implement the national standard for newborn screening for inborn errors of metabolism and other recommended conditions detected by blood sample testing will result in babies born with conditions not currently screened remaining undetected unless the specific optional test is ordered by the baby's physician.

It is estimated that an expanded panel of tests will increase the cost from approximately \$40 to \$80 per newborn. This increased cost will be paid by insurers, including Medicaid, who covers approximately 40% of the approximately 11,500 births in the state. This could result in a general fund increase of between \$55,000 and \$95,862 per year. The lifetime costs for children with metabolic conditions vary by condition, but Florida's Newborn Screening Program estimates that they save \$17 for every \$1 spent on newborn screening.

**HB 117 – Newborn Hearing Screening** - Left undetected, hearing impairments in infants can negatively impact speech and language acquisition, academic achievement, and social and emotional development. If detected, however, these negative impacts can be diminished and even eliminated through early intervention. Because of this, the National Institutes of Health's (NIH) Consensus Development Conference on Early Identification of Hearing Loss (1993) concluded that all infants should be screened for hearing impairment, preferably prior to hospital discharge. Montana has received grant funding to support testing and screening, and birthing hospitals and health providers have supported this effort, with approximately 90% of newborns being screened. This legislation, which is linked to NP 70005 because hearing is the 29<sup>th</sup> test in the full panel, mandates that all newborns be screened by one month of age. This the first step in a 1,3,6 approach, which means that all newborns will be screened by 1 month of age, receive confirmatory testing from audiologists (if needed) by 3 months of

age, and begin intervention and treatment by six months of age. This proactive approach has the best potential of eliminating or finishing delays in development.

**DIVISION CONTACTS**

The division director and chief financial officer for the department and their contact information are:

Division Director      Jane Smilie      444-4141      [jsmilie@mt.gov](mailto:jsmilie@mt.gov)  
Chief Financial Officer      Dale McBride      444-3635      [dmcbride@mt.gov](mailto:dmcbride@mt.gov)

# **PUBLIC HEALTH AND HUMAN SERVICES**

## **Public Health and Safety Division Public Health Emergency Preparedness**

### **DIVISION CONTACTS**

The department, division, program director and chief financial officer for the department, division, program and their contact information are:

Title	Name	Phone Number	E-mail address
Administrator	Jane Smilie	444-4141	<a href="mailto:jsmilie@mt.gov">jsmilie@mt.gov</a>
Financial Officer	Dale McBride	444-3635	<a href="mailto:dmcbride@mt.gov">dmcbride@mt.gov</a>
Section Supervisor	Jim Murphy	444-4016	<a href="mailto:jmurphy@mt.gov">jmurphy@mt.gov</a>

### **WHAT THE PROGRAM DOES**

The Office of Public Health Emergency Preparedness and Training coordinates with local and tribal public health agencies, hospitals, health care providers, state and local emergency response agencies, federal agencies, and other state agencies to coordinate emergency preparedness efforts.

- Grants administered include: Centers for Disease Control and Prevention's (CDC) Public Health Emergency Preparedness and Pandemic Influenza related initiatives, and the Health Resources Services Administration's (HRSA) National Bioterrorism Hospital Preparedness Program.
- Preparedness efforts are currently coordinated through contractual agreements with 62 local health jurisdictions, including seven Tribal Health Departments, emphasizing an all-hazards approach to emergency response that can be applied to day to day operations.
- Hospital preparedness efforts are closely coordinated with the Montana Hospital Association and funding has supported a variety of activities focusing on professional training, protection of personnel, and surge capacity/regional response.

### **SPENDING AND FUNDING INFORMATION**

The following figures show funding and expenditure information for FY 2001 - 2006 for all sources of funding of the Public Health Emergency Preparedness and Training. Because the figures include all sources of funding there are no direct relationships between these figures and appropriation levels presented in the Budget Analysis for the 2007 Biennium.

### **Statutory Authority For Program**

Federal authority for the Public Health Emergency Preparedness and Pandemic Influenza grants is authorized under 42 U.S.C. 247d-3. The National Bioterrorism Hospital Preparedness Program is authorized under Section 319c-1 and 319I of the Public Health Service Act.

### **HOW SERVICES ARE PROVIDED**

The Office of Public Health Emergency Preparedness and Training oversees a variety of related grants, coordinating with local health agencies and other state and local partners to ensure a coordinated response to events of public health significance. These efforts are organized through state-level activities, contracts with local health agencies, and awards to hospitals to develop, refine and exercise a variety of plans and procedures.

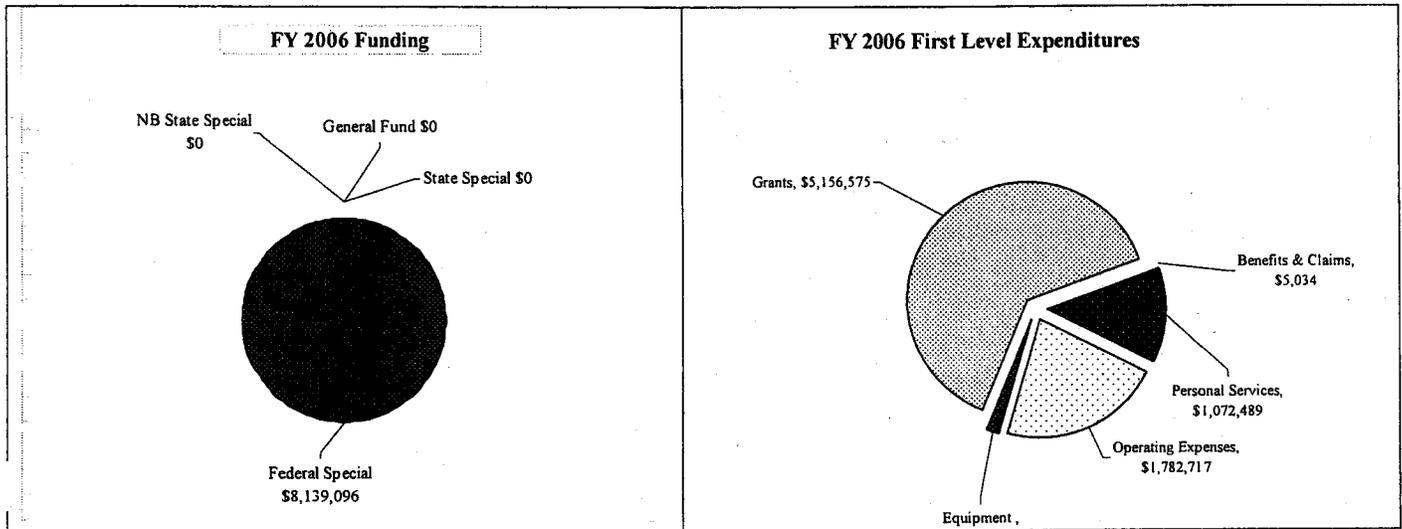
In the case of local health agencies, receipt of funding is contingent on performance of mutually defined activities that address goals established by the Centers for Disease Control and Prevention. Monitoring and summarizing state and local performance is emphasized through quarterly assessments and after action reports. As a result, efforts to improve state

and local response plans are continual and measurable. To assist local agencies, DPHHS provides technical assistance directly as well as through a variety of contractors and agencies.

ospital preparedness efforts are coordinated through the Montana Hospital Association. All hospitals in Montana are eligible to apply. Activities to be addressed are defined by HRSA and focus on professional training, protection of personnel, and surge capacity/regional response.

### Spending and Funding Information

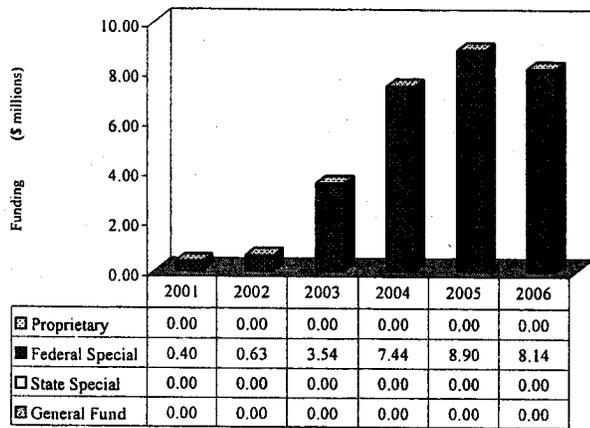
The following figures show funding and expenditure information for FY 2006 for all sources of funding of the Office of Public Health Emergency Preparedness and Training. Because the figures include all sources of funding there are no direct relationships between these figures and appropriation levels presented in the Budget Analysis for the 2007 Biennium.



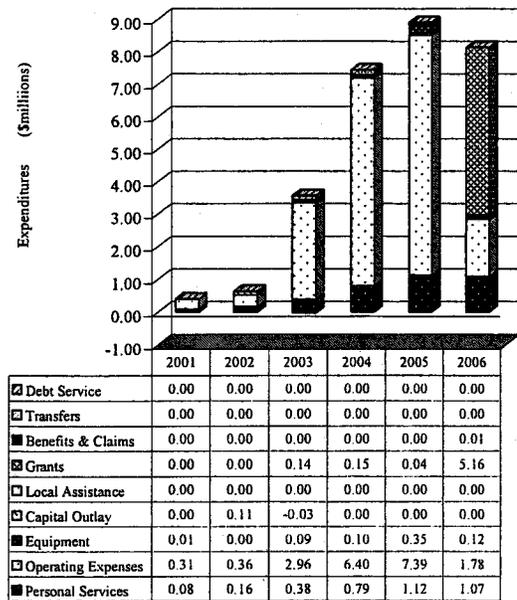
The above information does not include administrative appropriations. The program had \$0 in administrative appropriations in fiscal year 2006. Departmental indirect charges are not included as expenditures or revenues in the above tables.

The following figures show funding and expenditures from FY 2001 through FY 2006, for HB 2 funding.

**Historical Funding**



**Historical Expenditures**



The change in revenues and expenditures between fiscal 2001 and 2006 resulted from an increased federal commitment to public health preparedness following the events of September 11, 2001, the dissemination of Anthrax spores through the mail in the eastern United States, and the Iraqi conflict.

In general, this funding promoted local and state emergency preparedness efforts emphasizing the development and updating of response plans and the infrastructure necessary to support this response. During this period, significant progress was made integrating the principles of emergency response into public health and public health concepts into emergency response. The introduction of the incident command system (ICS) and the infrastructure necessary to support the statewide Health Alert Network are just two examples of recent successes. The majority of funding was allocated directly to local tribal and county health agencies to support activities related to preparedness planning and infrastructure development. The remainder of funding supported state level activities strengthening the ability of the state health agency and public health system to respond to day to day and significant public health events.

During most of this period, Montana received additional funding from the Health Resources and Services Administration (HRSA) to support hospital preparedness efforts. Training, the purchasing of personal protective equipment and the development of data systems supporting and tracking management of hospital assets were emphasized. Efforts continue in this area to support the further development of a regional response among Montana's many hospitals.

In late 2005, funding (app. \$725,000) was received to address concerns regarding pandemic influenza after documenting the increased transmission of novel influenza strains in Asia. Additional funding (app. \$1,100,000) specific to pandemic influenza preparedness and response efforts was received in 2006 supplementing our preparedness funds. These efforts, targeting objectives identified by CDC, are intended to improve our ability to plan for and respond to an influenza pandemic. Many of the activities can be generalized to other health events that would require a significant commitment of public and private health resources.

As new funding opportunities became available, hospitals and state and local health departments have responded by taking on additional responsibilities and developing or improving partnerships with other response agencies. DPHHS anticipates additional responsibilities related to preparedness will be promoted during the next several years and our public health system will adapt and strengthen as a result of these demands.

# 2007 BIENNIUM NEW PROGRAM IMPLEMENTATION AND PROGRAM EXPANSION

## Program Expansion

The Office of Public Health Emergency Preparedness and Training coordinates statewide preparedness efforts with a variety of state and local partners, including 62 local health jurisdictions and the state's 62 hospitals, to improve our capability to respond to significant public health events. Existing efforts to develop, refine and exercise local and state response plans were expanded in the 2007 biennium to address CDC funded pandemic influenza initiatives. Activities related to pandemic influenza were integrated into existing preparedness efforts of DPHHS and the contracting local health jurisdictions to maximize the effectiveness of this funding.

We understand that evaluating our efforts is essential to determine what works and what areas need improvement. Our evaluation efforts include formal evaluations of our performance during actual events and exercises as well as monitoring a variety of other indicators at the local and state level. Further, in conjunction with the Montana State University School of Nursing, we performed a 2006 follow up to our 2002 and 2004 preparedness assessments to continue to monitor and track our progress in preparing for and responding to emergencies. The report is attached here.

During the 2007 biennium, DPHHS and county and tribal health agencies, via federal funding and guidance from the Centers for Disease Control and Prevention (CDC) and the Health and the Health Resources and Services Administration (HRSA), continued to make significant progress with emergency preparedness efforts. Specific activities included: the review and refinement of state and local response plans, facilitation and participation in exercises, and maintenance and evaluation of many routine public health functions. Specific grant requirements and critical capacities addressed during the period are detailed below and additional information is available upon request.

Funding authority related to emergency preparedness supported the following initiatives:

- Continuous testing, improvement and upgrading of local, regional, and state plans, protocols, equipment and response systems. An emphasis continues on integration of public health and hospital emergency response with existing local, regional, state, and federal response systems and assets.

Result: Through contractual agreements with 62 local/tribal jurisdictions, DPHHS required the review of local plans detailing the response to events of public health significance. In addition to review and/or revision of local all-hazard plans, participation in exercise and drills to test local plans and systems were conducted in each jurisdiction. Jurisdictions submitted progress reports detailing efforts to review and test plans as well as outlining steps taken to improve response systems.

Related DPHHS efforts included the review and revision of state-level plans to ensure compliance with the National Incident Management System (NIMS) and participation in selected state and local exercises. The Department participated in a major statewide functional exercise that involved biological and chemical agents, and included health care, hospital and public health participation. Further, the DPHHS was very involved in the state's Hurricane Katrina assistance efforts, including establishing and manning a donations hotline and planning for health and human service needs of victims anticipated to arrive in Montana, as well as those that actually did. Efforts to refine and exercise state and local public health response plans will continue.

- Strengthening state and local-level food and water-borne illness investigation, and response capabilities.

Result: Several initiatives related to improving state, local and tribal response to disease investigations were implemented during the period. In addition to testing response systems through formal exercises, individual protocols outlining routine response to reports, after-hours systems and mobilization of local epidemiological teams were revised and submitted to DPHHS. State level plans guiding our response to human disease outbreaks and a specific plan related to pandemic influenza were also reviewed, revised and distributed during the period.

- Enhancing active (health department initiated) and passive (health provider/laboratory initiated) surveillance in cooperation with local public health agencies and health care providers to provide early identification of public health threats.

Result: Through contractual agreements with 62 local/tribal health jurisdictions, DPHHS is supporting and evaluating active and passive disease reporting systems. All local jurisdictions contracting with DPHHS have developed specific protocols, reviewed and approved by local health boards and health officers, detailing specific procedures.

At the current time, active solicitation of disease reports is in place to supplement traditional passive systems. Local jurisdictions currently target approximately 350 local health care providers and 70 laboratories weekly or bi-weekly to share information. Results are regularly reported to DPHHS and evaluated on a quarterly basis.

A related initiative to monitor visits to emergency departments of major medical facilities through a near real-time web-based software program is currently in place in two facilities and being implemented in others. The "syndromic surveillance" system is intended to identify trends of interest among individuals seeking services prior to formal diagnoses and laboratory results. To complement hospital based sources, efforts to utilize this system to monitor school absenteeism are currently being implemented.

- Continuing development of laboratory capacity for adequate response to a chemical terrorism event, including physical plant renovation as well as the purchase of additional equipment to necessary to meet CDC expectations. DP187 also requested a laboratory chemist to assist with implementation of new equipment and testing procedures related to preparedness.

Result: DPHHS continues to improve our capabilities to assist and communicate with local jurisdictions for response to actual or suspected events involving chemical agents. While many efforts are still underway to improve our capabilities and physical infrastructure, significant progress has been made in many areas. During the period, we have developed the capability to conduct on-site prescreening of specimens for chemical, radiological and explosive hazards to insure safety of the laboratory staff and other staff housed in the Cogswell Building prior to testing for biological agents. In addition, basic testing capabilities have been expanded allowing in-house testing for many common chemical agents, including cyanide in blood and heavy metals in urine. In addition, two staff are training at CDC for nerve agent testing in humans. Staffing levels necessary to support preparedness efforts have been achieved by hiring an FTE to supervise preparedness activities in the laboratory. Additional upgrades to the chemical laboratory are in progress and when complete will further enhance our testing capabilities by building an organics testing laboratory and segregating laboratory testing areas from general public access areas in order to comply with CDC recommendations for safety and security.

- Expanding technological capacity of the state, county, and tribal public health system to better support both routine and emergency operations at the local level (i.e. installing cost effective connectivity and merging immunization and emergency preparedness functionality)

Result: In response to CDC and HRSA initiatives, several software applications are currently being evaluated or developed to support routine and emergency preparedness functions. These applications include software to improve our ability to track routine communicable disease reports through implementation of CDC's National Electronic Disease Surveillance System (NEDSS); the CDC Outbreak Management System (OMS); the development of a system to track interventions implemented during a significant public health event-Countermeasure Response Administration (CRA).

Related efforts include integrating existing immunization registries used by DPHHS, local health agencies, and the Indian Health Service with our emergency response applications. These efforts include developing methods to rapidly exchange relevant data between systems and support real time data collection methods (i.e. wireless interfaces, tablet PC applications).

- o Continuing public health and emergency preparedness training to hone skills of state and local public health personnel in the areas of advanced incident command systems, use of communication and information technology, conducting and using the results of preparedness drills and exercises, and understanding legal issues in emergency preparedness.

Result: DPHHS continued to work with local agencies and contractors, including the Northwest Center for Public Health of the University of Washington (UW), to provide a variety of training opportunities during the period. In addition to the week-long DPHHS/UW sponsored Summer Public Health Institute, support of the web-based Montana Training and Communication Center (TCC) provided additional opportunities for a variety of training opportunities. Training has included basic and advanced epidemiology, disease and outbreak investigation techniques, risk communication, agro-terrorism, incident command structures and national incident management system.

A primary focus of recent efforts have included requiring local health partners via contract, as well as DPHHS staff to receive training related to the incident command system (ICS) and NIMS, and conducting and making the most of drills/exercises. Other topics included risk communication skills as well as more general health related topics related to public health methods, authorities and assessment.

**FTE**

The legislature approved appropriations for an additional 6 FTE in the 2007 Biennium. The following figure shows the positions and hire dates for the new FTE.

2007 Biennium FTE Hire Dates	FTE	Date
Statewide Emergency Preparedness	69107724	08/06/2005
Statewide Emergency Preparedness	69107725	08/06/2005
Statewide Emergency Preparedness	69107728	08/06/2005
Clinical Lab Specialist	69107726	08/06/2005
Communicable Disease Monitoring	69107731	08/06/2005
Environmental Lab Chemist	69107701	05/15/2006

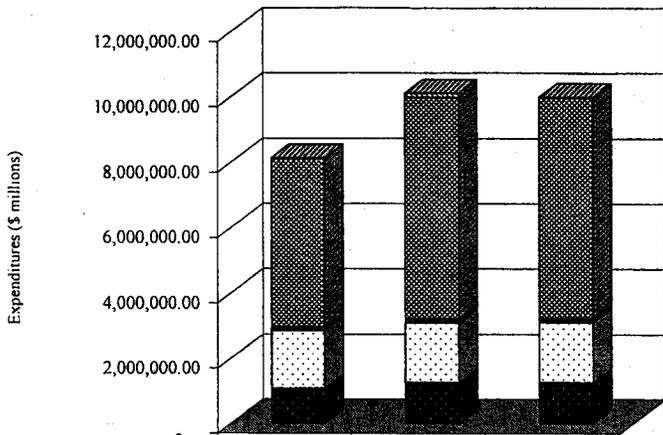
**CORRECTIVE ACTION PLANS**

No corrective action plans are in place.

**2009 BIENNIUM BUDGET**

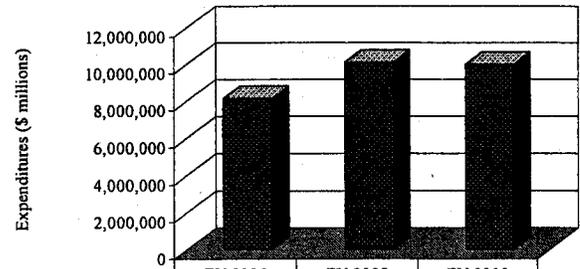
The following figures show the proposed HB 2 budget for the 2009 biennium.

**Public Health and Human Services  
2009 Biennium HB2 Budget**



	FY 2006	FY 2008	FY 2009
Debt Service	0	0	0
Transfers	0	0	0
Benefits & Claims	5,034.00	123,034	5,034
Grants	5,156,575.00	6,756,574	6,756,574
Local Assistance	-	0	0
Capital Outlay	-	0	0
Equipment	122,281.00	122,281	122,281
Operating Expenses	1,782,717.00	1,858,514	1,860,756
Personal Services	1,072,489.00	1,255,147	1,260,346

**Public Health and Human Services  
2009 Biennium HB2 Budget**



	FY 2006	FY 2008	FY 2009
Proprietary	0	0	0
Federal Special	8,139,096	9,997,550	10,004,991
State/Other Special	0	0	0
General Fund	0	118,000	0

**Goals and Measurable Objectives**

The following figure shows the department base year and budgeted biennium goals and performance measures that are associated with the proposed 2009 biennium HB 2 budget.

Public Health and Human Service Public Health and Safety Division		
Measurable Objectives for the 2009 Biennium		
Goal	Measurable Objectives	Current status of Measures
<p><b>Office of Public Health Emergency Preparedness and Training:</b> A strong public health system that provides the foundation for Montanans to live safe and healthy lives.</p>	<ul style="list-style-type: none"> <li>By June 30, 2009, 75% of Montana's local and tribal health jurisdictions, in collaboration with local hospitals/clinics, will have participated in <u>multi-jurisdictional</u> pandemic influenza exercises that are evaluated, and result in improved response plans. <b>DP 70105, DP 70015</b></li> <li>By June 30, 2009, the Public Health &amp; Safety Division will make public health training and continuing education opportunities available that are accessible to 85% of Montana's public health workforce on an on-going basis. <b>DP 70105</b></li> </ul>	<p>In-Progress, app. 25-30% participated in a multi-jurisdictional exercise in 2006.</p> <p>In- Progress</p>

## BUDGET AND POLICY ISSUES

The following budget or policy issues are included in the program budget submission to the Governor's Office.

**LC 142: An act requiring a public health emergency plan and establishing powers and duties in public health emergencies** - This act would assure the necessary role of public health agencies as part of the Disaster and Emergency Services response system. The legislation would define and allow the Governor to declare a public health emergency and provide the Governor with powers and authorities that could be used in one; require a public health emergency plan; provide powers and authorities for which the DPHHS would be the lead agency during a declared public health emergency, in collaboration with local public health agencies, Disaster and Emergency Services, and other relevant agencies; and allow for recognition of interstate licensure for volunteer health care and public health professionals and immunity for volunteer health care providers.

### Other Activities (non contingent on passage of LC- 0480):

#### LFD Page B-105, DP 70015 – Public Health Emergency Preparedness

Present law adjustment of \$1,800,000 per year of the biennium for federal spending authority related to pandemic influenza.

#### LFD Page B-106, DP 70107 – Purchase of Tamiflu (Withdrawn)

Request for a biennial appropriation of \$118,000 general fund for a one time purchase of an additional 8,174 treatment courses of Tamiflu (an anti-viral medication targeting influenza). This supply will supplement a federally reserved allocation of anti-virals and will provide an additional measure of protection during an influenza pandemic.

## SIGNIFICANT ISSUES EXPANDED

#### LFD Page B-105, DP 70015 – Public Health Emergency Preparedness

Present law adjustment of \$1,800,000 per year of the biennium for federal spending authority related to pandemic influenza.

Funding to improve our ability to plan for and respond to an influenza pandemic was received in 2006. The majority of funding supports local efforts to develop systems capable of responding to an influenza pandemic. The Centers for Disease Control and Prevention required us to address specific goals with the intent of developing response systems during the next three years. Many of the activities can be generalized to other health events that would require a significant commitment of public and private health resources.

Detail: The federal guidance requires DPHHS and local partners to address five target capabilities in our application during the first year of the project. Four additional target capabilities are to be addressed in year 2 and 3 with the intent of being able to respond to a pandemic after three years of preparation. In short- the application emphasizes developing plans to

address and exercise the target capabilities.

### 1) Target Capability: Planning

Proposed Activity:

- 1) Based on the local/tribal jurisdiction's self assessment and activities performed to address gaps/needs during phase 1 activities, develop and implement a work plan to prioritize and address/complete work on identified gaps/needs. Ideally, the work plan would be developed in coordination with LEPCs/TERCs and other local partners, including health care providers. DPHHS will require a summary of local efforts and documentation that work plans were reviewed by health boards and health officers.

Measure: By June 30, 2008, 100% of county and tribal jurisdictions contracting with DPHHS will have included pandemic influenza preparedness issues in local response plans approved by local and tribal health boards and health officers.

#### **4) Target Capability: Community Medical Surge Capacity**

Four Proposed Activities:

- 1) Establish a state level work group to address the legal issues relevant to the operation of alternate care sites.
- 2) Each Local Health Jurisdiction (LHJ) will convene a specific subcommittee to develop and implement strategies for augmenting medical surge in their jurisdiction.
- 3) Provide orientation to new medical surge or established unified health command groups.
- 4) Identify state owned/operated institutions housing special populations. Engage those institutions in pandemic influenza planning to assure that client populations are adequately represented in state emergency operations plans for health and medical surge.

Measures:

By June 30, 2007, 100% of local jurisdictions contracting with DPHHS will have established local work groups addressing surge capacity issues.

By June 30, 2007, DPHHS will have identified contacts in state institutions to assure that client populations are adequately represented in state emergency operations plans for health and medical surge.

#### **3) Target Capability: Isolation and Quarantine**

Proposed Activities:

- 1) DPHHS will assist local/tribal health jurisdiction in the development of a written operational plan for the non-pharmaceutical control of pandemic influenza. This assistance will consist of the production of:
  - a) a detailed, comprehensive, written guidance for local/tribal health jurisdictions, and
  - b) a model operational plan for use at the local level.
- 2) Each local/tribal health jurisdiction to develop a written operational plan for the non-pharmaceutical control of pandemic influenza. This plan is to be included as an annex in the local agency's overall pandemic influenza preparedness/response plan. The plan will be required to be reviewed and approved by local health jurisdiction administration, including chief legal counsel.

Measures: By January 31, 2007, DPHHS will have developed and distributed detailed guidance related to the implementation of isolation and quarantine procedures in local jurisdictions.

By June 30, 2007, 100% of local jurisdictions contracting with DPHHS will have developed an annex to the local response plan detailing isolation and quarantine procedures.

#### **4) Target Capability: Mass Prophylaxis /Treatment**

Three Proposed Activities:

- 1) DPHHS and local agencies will review and revise existing receiving, storing, and staging (RSS), security, and distribution portions of the Montana Strategic National Stockpile (SNS) and local plans to ensure an adequate response for vaccination and other mass prophylaxis efforts is in place. Reviews will address all issues described in the above critical task, including use of investigational new drugs or emergency use authorizations forms prior to administering a vaccine.

2) Each county or tribe must develop and/or update a plan to respond to mass prophylaxis of the total population of its jurisdiction. In addition to refining state and local SNS plans, DPHHS and local agencies will develop plans to preposition antiviral medication and the procedures to further distribute material to each LHJ (including tribes) when deemed necessary. Multi-jurisdictional events will be coordinated through the DPHHS Emergency Operations Center.

3) The DPHHS preparedness section will work closely with the informatics section to implement and test use of CDC's Countermeasure Response Application (CRA). The system will maintain a database of individuals who receive a vaccination or prophylaxis during a campaign as well as allow limited tracking of individuals isolated or quarantined.

Measures: By May 31, 2007, local and tribal jurisdictions contracting with DPHHS will have submitted revised local SNS plans to DPHHS for review.

## 5) Target Capability: Communications (Ensuring Interoperable Data and Communication Systems)

Three Proposed Activities:

1) Gap Analysis - review of selected current data and communication systems to determine compatibility with CDC Public Health Information Network (PHIN) standards. An emphasis will include the Partner Communication and Alerting (PCA) system; comparing present system functionality with the PHIN PCA requirements.

2) Data transfer to Montana's implementation of the NEDSS Base System (NBS) from the State of Montana Public Health Laboratory.

3) Conduct a functional and standards-based comparison of an existing communicable disease tracking application (CDD) used in Montana's more populous local health jurisdictions. Review the CDD database and make recommendations regarding its viability relative to the PHIN functional and data standards governing the outbreak management system (OMS).

Measures: Above activities are ongoing.

The activities above are intended to integrate and complement existing local and state-level activities related to emergency preparedness and response. Every effort is being made to ensure the procedures and policies being developed and refined related to preparedness and response improve day to day activities conducted by public health agencies.

### DIVISION CONTACTS

The division director and chief financial officer for the department and their contact information are:

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