Missoula County Maternal, Infant, Early Childhood Needs Assessment

Developed on behalf of the Missoula County MBBC/MCCFIC Joint Council for the MT Department of Public Health and Human Services MIECHV-ID Program

September 30, 2012

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ASSESSMENT OVERVIEW

Background

The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) established a number of prevention initiatives including a provision creating the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program (Section 2951). This initiative is based on the premise that a trajectory of decline in the lives of at-risk children and families is not inevitable and can be reversed. Evidence-based home visiting is "viewed as one of several service strategies embedded in a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development, as well as strong parent-child relationships" (HRSA, SIR, p. 2). Assuring the success of home visiting efforts and positive outcomes for children requires a coordinated and collaborative childhood system delivering scope, vision, and capacity greater than any one agency, department, or division of government acting alone. A childhood system by this definition would embody interacting and interdependent elements that join forces/create alliances (Neuman, 1995) to better support life course development and positive health and well-being of children and families.

Purpose

The purpose of the Montana Maternal, Infant, and Early Childhood Home Visiting Infrastructure Development (MT MIECHV ID) program is to:

1. Build infrastructure in communities to develop and support a system of early childhood comprehensive services.

2. Create or support an existing early childhood community council(s) to assure collaboration, community partnership, continuation, and sustainability (**community collaboration assessment (link**).

3. Develop a plan and justification for choosing a specific evidence-based early childhood home visiting model consistent with community needs and preferences (**Zero to Three Home Visiting Community Planning Tool (link**).

4. Conduct a maternal, child, and family-focused **community needs assessment** to inform the community council about system strengths, gaps, duplications, and needs of children and families in the community.

The MIECHV-ID directive establishes the importance of a needs assessment that is broad in scope, based on existing/available data, and inclusive of the comprehensive factors that could influence the health and well-being of children and families. The goal of the assessment was to uncover assets and needs along with strength (protective) factors and risk factors to inform the development of the community's strategic plan.

Missoula County Partnership

The history of partnership development in Missoula County involves two councils (Missoula Best Beginnings Council [MBBC] and Missoula Community Council for Families, Infants, and Children [MCCFIC]) with joint oversight of the early childhood system. The goal of MCCFIC is to support and develop the infrastructure to transition to and sustain an evidence-based home visiting program as part of early childhood comprehensive services. The MBBC focuses on early care and education and the availability of quality services for Missoula children. The table below provides a crosswalk between the objectives guiding the work of each council.

MBBC and MCCFIC Council Objectives Crosswalk

Obj #	MBBC Objective	Obj #	MCCFIC Objective
1	Increase access for children to high quality early childhood programs.	4	Improve school readiness and achievement.
2	Increase community support for families with young children.	1	Improve coordination and referrals for community resources and support.
		3	Reduce the incidence of child injuries, child abuse, neglect, and maltreatment.
		6	Improve family economic self-sufficiency.
3	Increase children's access to a medical home and health insurance.	1	Improve coordination and referrals for community resources and support.
		2	Improve maternal, child, and family health collaborative comprehensive services.
		6	Improve family economic self-sufficiency.
4	Increase support for the social, emotional, and mental health needs of young children and families	3	Reduce the incidence of child injuries, child abuse, neglect, and maltreatment.
		5	Reduce the incidence of domestic/intimate partner violence.

A plan to merge the two councils developed as a result of work conducted together during the summer of 2012. Members of MBBC and MCCFIC met jointly to discuss questions related to both the needs assessments and home visiting planning tool, have restructured, and will move forward as one council with two subcommittees beginning October 1, 2012; one targeting early childhood readiness while the other focuses on evidence-based home visiting.

Methods

Assessment Framework**.** To guide the assessments and assure community engagement, the National Association of County and City Health Officials (NACCHO) Mobilizing for Action through Planning and Partnerships (MAPP) framework was adapted and applied. This model guides community users through six phases. The first three phases include partnership development (MCCFIC/MBBC partnership); community visioning and valuing activity (joint council shared hope exercise 5/24/12); and the assessment phase which involved research of existing data, focus groups, and a parent survey. The final phases, identification of strategic issues; a goals and strategy session; and, the action (plan, implement, evaluate) cycle will take place after community partners have an opportunity to complete a review of all the assessments.

Data Sources and Data Collection Methods**.** Data for the three assessments were gathered from existing resources or collected from key stakeholders by the council assessment team between May-August 2012. A variety of quantitative and qualitative tools were used including an adapted parent survey, community expert interviews, meeting minutes, and questions for focus groups adapted from the Best Beginnings Assessment Guide. Local, state, and national data were compared to highlight strengths and weaknesses within the early childhood system in Missoula.

A number of excellent datasets available online or by request represent reliable and relevant information sources. Dropbox ™, an electronic file share, was utilized by team members to store assessments and updated files.

Acknowledgements
The MIECHV-ID assessment team, Susan Barmeyer (MBBC), Lavonne Blunt (MCCFIC), Michelle Voigt (MCCFIC), Evelyn Interis, Graduate Student/University of Alabama with the Maternal and Child Health Bureau's Graduate Student Internship Program, and Sandra Kuntz, MIECHV-ID contractor, would like to thank the members of the Joint Council and the Executive Committee who participated in the assessment.

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PART II
MISSOULA COUNTY RANKING

Ordinal ranking is a method of determining the relationship between a set of topic indicators that define the highest to lowest position among a group of entities (e.g. counties and the residents of a county). Population-based health and education determinants frequently rely on comparison measures or ranking to evaluate gaps, needs, and successes. Early childhood system improvement is aided by both a general and target (early childhood) population examination of county rankings. Three distinctively different organizations provide insight into risk and protective factors for Missoula children. First, the University of Wisconsin Population Health Institute, *County Health Rankings*, 2012 funded by the Robert Wood Johnson Foundation provides a general population assessment of the overall health status of citizens for counties in each of the 50 states. Second, the *New Kids Count Index* funded by The Annie E. Casey Foundation, while not county specific, ranks Montana with other States based on four measures—economic well-being, education, health, and family and community context. Finally, Montana Department of Public Health and Human Services (MT DPHHS) Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program has highlighted specific risk factors for counties based on a variety of data sources.

RWJF UW County Health Rankings (2012)—for Missoula County (1=Best 47=Worst)

Missoula County Rankings

Measure/Indicator	County Rank/47
Health Outcomes	**4**
• Mortality	2
• Morbidity	10
Health Factors	**5**
• Health Behaviors	6
• Clinical Care	5
• Social and Emotional Factors	18
• Physical Environment	33

Source: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute (2012).

Annie M. Casey Foundation New KIDS COUNT Index (2012) state comparisons

- Ranked — MT 28/50 states overall
- Economic well-being — MT 20/50
- Education — MT 13/50
- Health — MT 50/50 (last place)
- Family/Community — MT 13/50

MIECHV County Profile (2011) (Based on 12 Childhood Risk Factors)

- High Risk:
- Medium Risk
- Low Risk: (Missoula County (ranked based on indicators + population score)
- No Risk

MIECHV Risk Indicators Missoula and Statewide

MIECHV Risk Indicators (indicators for which the county has higher risk than the state are in bold)		
Indicator	**Missoula**	**Statewide**
Premature/preterm births (% before 37 completed weeks), 2005-2009[1]	**10.2**	9.7
Low birth weight births (% <2,500 grams), 2005-2009[1]	6.8	7.1
Infant mortality rate (per 1,000 live births), 2005-2009[1,2]	4.5	6.3
Under age 18 in poverty (%), 2009[3]	19.1	20.9
Crime rate (per 100,000 people), 2009[4]	**2867**	2813
High school drop out rate (%), 2009/2010 school year[5]	2.3	4.3
Unemployment rate (%), 2010[6]	**7.3**	7.2
Child abuse (substantiated) rate (per 10,000 children <18 years), 2010[7]	38	38
Domestic violence rate (per 10,000 women 15-44 years of age), 2009[4,9]	193	229
Teens who reported ever smoking cigarettes (%), 2008[8]	28.0	35.8
Teens who reported binge alcohol use in last two weeks (%), 2008[8]	23.1	23.5
Maternal smoking during pregnancy (%), 2008-2009[1]	13.0	16.9
Additional Risk Indicators		
Indicator	**Missoula**	**Statewide**
Teen (15-19) pregnancy rate (per 1,000 women 15-19), 2007-2009[1,9]	37.6	48.8
Deliveries paid for by Medicaid (%), 2008-2009[1]	32.5	34.3
Births to women without a high school education (%), 2008-2009[1]	7.5	14.1
Prenatal care initiated after the first trimester or not at all (%), 2008-2009[1]	21.4	26.8

Source: MT Department of Public Health and Human Services (2011). MIECHV County Rankings.

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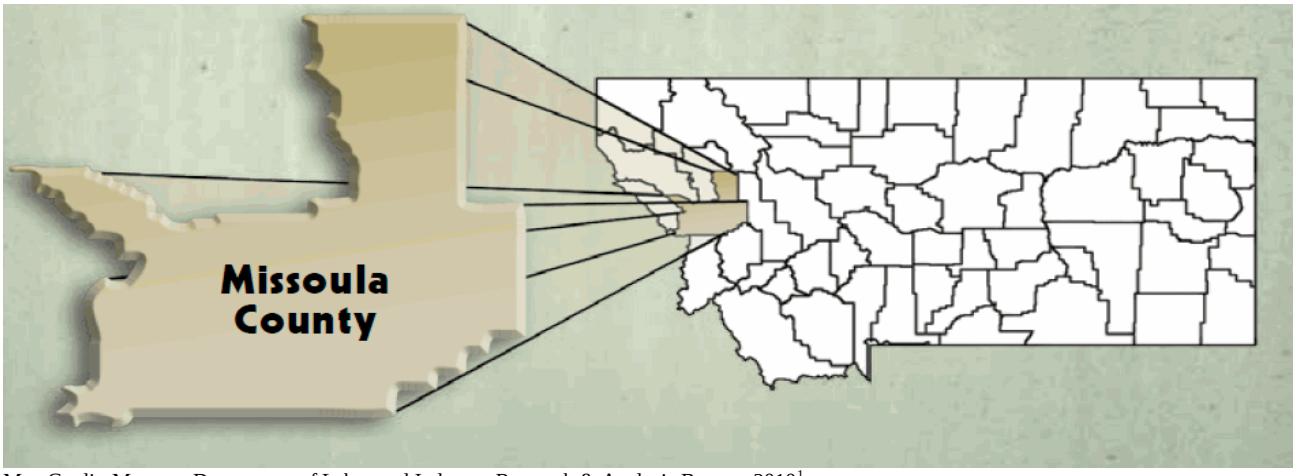
PART III
PEOPLE and PLACE



Map Credit: Montana Department of Labor and Industry, Research & Analysis Bureau, 2010[1]

Missoula County is located in the western portion of the state with a land area of 2,593.42 square miles.[2] The City of Missoula is the county seat and the only incorporated city in Missoula County, with a population of approximately 67,290 people or 61% of Missoula County's total population.[1] Other towns and communities in Missoula County include Bonner/West Riverside, Clinton, East Missoula, Evaro, Frenchtown, Greenough, Huson, Lolo, Milltown, Orchard Homes, Potomac, Seeley Lake, Swan Valley, Turah, and Wye.[2, 3 (p. 8)] Missoula County is bordered on the east by Mineral, south by Ravalli and Granite, west by Powell, and north by Sanders, and Lake counties and the Flathead Reservation. Approximately 104,678 acres of Missoula County are located within the exterior boundary of the Confederated Salish and Kootenai Tribes' Flathead Reservation.[4]

Map: MT Department Commerce Census and Economic Information Center (CEIC), 2012

HISTORY

"The first inhabitants of the Missoula area were American Indians from the Salish tribe. They called the area 'Nemissoolatakoo,' from which 'Missoula' is derived. The word translates roughly to 'river of ambush/surprise,' a reflection of the inter-tribal fighting common to the area. The Indians' first encounter with whites came in 1805 when the Lewis and Clark expedition passed through the Missoula Valley. There were no permanent white settlements in the Missoula Valley until 1860 when C. P. Higgins and Francis Worden opened a trading post called the Hellgate Village on the Blackfoot River near the eastern edge of the valley."[5] Growth of the Missoula valley steadily increased as a logging, trading, and agricultural area. In 1895, the University of Montana was established to serve Western Montana higher education needs.

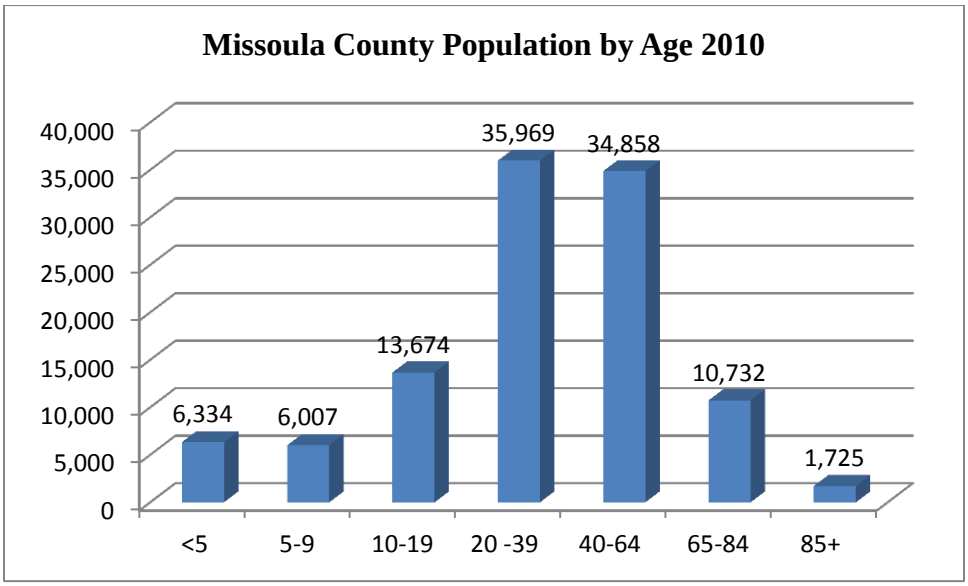
Missoula is a child-friendly place. The Missoula Convention and Visitors Bureau devotes a website page to "25 Things to do with Kids" and in 2009 and again in 2012, Missoula was honored with a "Playful City USA" award. Missoula is the only Montana community that has received this award.[6,7] In addition, the chamber of commerce websites for cities and towns in Missoula County offer a wide array of resources for families. For the sixth year,

Missoula was honored by America's Promise Alliance "for its commitment to the positive development of young people. Missoula has many programs in place to support youth. One of the greatest accomplishments has been decreasing the dropout rate by 48 percent through Graduation Matters, a community-wide partnership that teaches students, parents, school personnel and community leaders about the importance of education. Missoula is also dedicated to raising healthy and civic-minded young people through YMCA's Active 6 Program, which teaches all Missoula County sixth graders about good nutrition while promoting an active lifestyle. Additionally, each month, one elementary school organizes Superheroes of Kindness, an initiative which incorporates community service projects including food collection for the food bank and delivering handmade flowers to an assisted living center."[6]

POPULATION DEMOGRAPHICS

Age and Gender

The United States (US) 2010 Census indicates that the population in Missoula County is both youthful (median age of 34.6) and growing in numbers with a 14% increase (13,500 people) in population between 2000-2010 compared to just a 10% increase in population statewide.[2, 9] However, this percentage increase may be more due to an increase in the adult rather than the child population. The total 2010 Missoula county population overall was 109,299 with growth estimated at 110,138 in 2011. Approximately 5.8% of residents are <5 years; 5.5% are 5-9; and, 12.5% are in the 10-19 age range. A little over one-fifth of the total population is made up of infants, children, and adolescents[2] (see exhibits below). While the number of children <5 years showed a small but steady population increase based on the 2000-2010 Census comparison (from 5,455 to 6, 334), the number of children ages 5-13 and 14-17 slightly decreased in number (11,015 to 10,631; 5, 447 to 4,863 respectively).[2,9] The target of this focused needs assessment, approximately 6,000 children <5 years in Missoula County and approximately 15,000 children >5 to age 17, represent ± 20% of the total population.



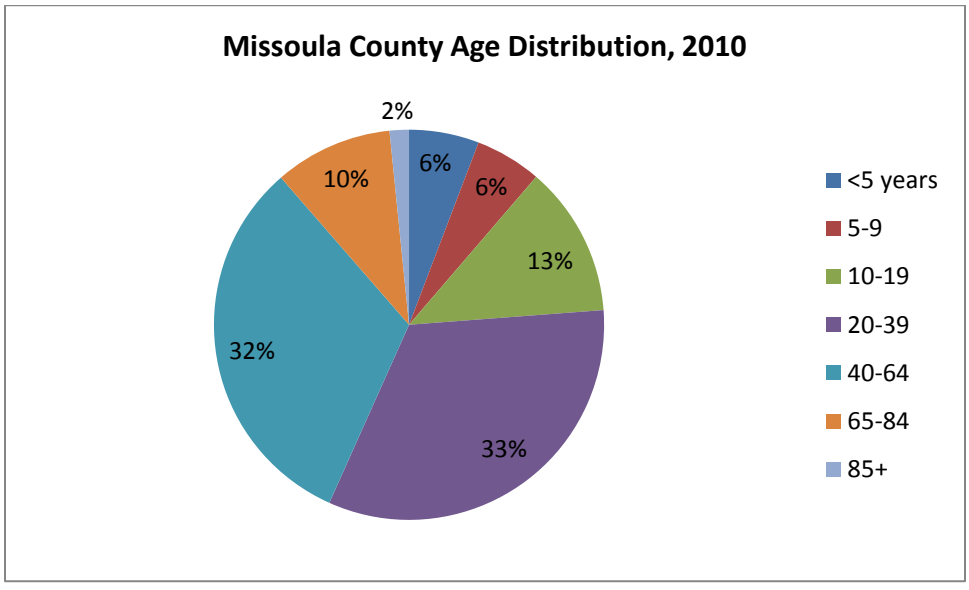
Source: U.S. Census, 2010

Further age and gender demographic breakdown (see the MT DPHHS Community Health Data—Missoula below) highlights a population estimate of the number/percentage of infants otherwise compiled as total children less than five in the Census 2010 statistics and compares the population with Montana population age group estimates.[8]

Demographic Profile: Age and Gender Missoula and Montana

Age Group	Missoula					Montana				
	Number			Percentage		Number			Percentage	
	Male	Female	Total	Male	Female	Male	Female	Total	Male	Female
<1	707	670	1377	1.3	1.3	6,576	6,197	12,773	1.4	1.3
1 – 4	2622	2453	5075	4.8	4.6	24,747	23,594	48,341	5.1	4.9
5 – 9	3093	2999	6092	5.7	5.6	29,903	28,391	58,294	6.2	5.9
10 – 14	3140	2955	6095	5.8	5.6	31,154	29,282	60,436	6.4	6.1
15 – 19	4018	3734	7752	7.4	7.0	34,388	32,209	66,597	7.1	6.7
<18	11630	10992	22622	21.5	20.7	113,112	107,246	220,358	23.3	22.2
18 – 24	7532	6887	14419	13.9	12.9	50,516	44,716	95,232	10.4	9.3
25 – 44	15531	15068	30599	28.7	28.3	119,677	116,620	236,297	24.7	24.1
45 – 64	14249	14111	28360	26.3	26.5	139,114	139,127	278,241	28.7	28.8
65+	5159	6161	11320	9.5	11.6	62,066	75,246	137,312	12.8	15.6
Total	54101	53219	107320	100	100	484,485	482,955	967,440	100	100

Source: Population Estimates Source: National Center for Health Statistics. Postcensal estimates of the resident population of the United States for July 1, 2000-July 1, 2008, by year, 'county, age, bridged race, Hispanic origin, and sex (Vintage 2008). Prepared under a collaborative arrangement with the U.S. Census Bureau; released May 14, 2009. Available from:'http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm as of September 2, 2009



Source: U.S. Census, 2010

Race/Ethnicity

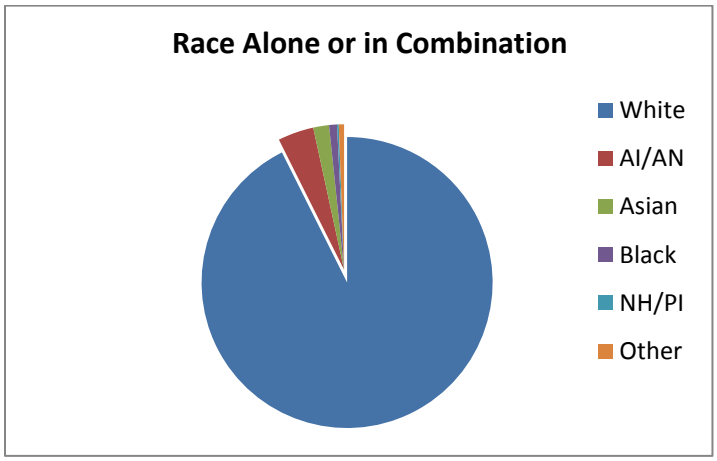
Missoula County population is composed of primarily White (92-95%) followed by American Indian/Alaska Natives (2.6-4.1%); Asian (1.1-1.8%); African American (0.4-0.9%); Native Hawaiian and Other Pacific Islander (0.1-0.2%); and, other races (0.4-0.6%). The range

represents the 2010 Census "race alone" category and the corresponding documentation of "the race in combination" with one or more other races. The following exhibits depict the racial makeup of Missoula County and roughly reflect race/ethnicity findings reported in 2011 Kids Count for children <20 years of age.[2, 9] In addition to Native Americans from different tribal groups, Eastern European (Russian) and Asian (Hmong) immigrants contribute to Missoula's limited diversity. Approximately 2,861 individuals (2.6%) of the total population in Missoula County identify themselves as Hispanic or Latino (Mexican, Puerto Rican, Cuban, or other) of any race.

Race Alone; Race in Combination with Other Races

RACE	RACE Alone		Race in Combination	
	#	%	#	%
White	101,320	92.7	104,004	95.2
American Indian & Alaska Native (AI/AN)	2,872	2.6	4,502	4.1
Asian	1,236	1.1	1,925	1.8
Black or African American	445	0.4	970	0.9
Native Hawaiian & Other Pacific Islander (NH/PI)	105	0.1	239	0.2
Some Other Race	478	0.4	708	0.6

Source: U.S. Census, 2010



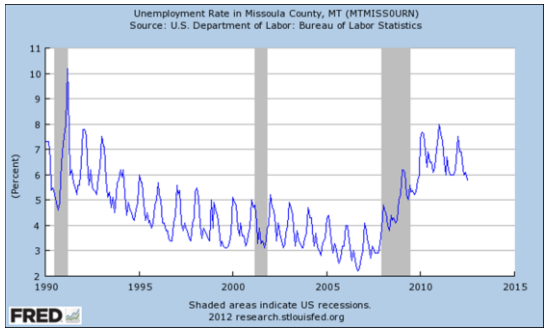
Source: U.S. Census, 2010

Economic Circumstances

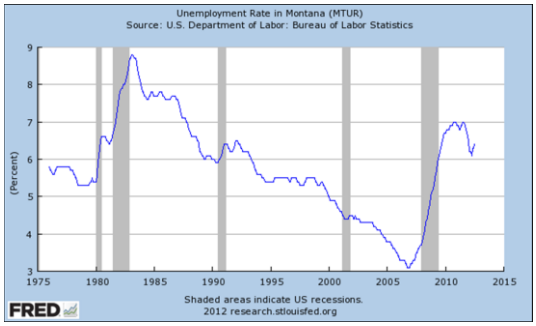
The well-being of children is directly linked to the economic health of the family and the community. Poverty, fragile parental employment, and food insecurity impact health, development, educational attainment, and the overall welfare of children.[10] The percent of children living in poverty (below or lower than 100% of the federal poverty level [FPL]) has increased steadily between 2000-2010 both nationally (16%-22%) and in Montana (17%-20%)[2,9,]. Although this rate over the past ten years has decreased slightly in Missoula County (20%-19%),[2,9] the current rate still represents potentially 1/5 of Missoula children living in conditions that could contribute to risk. Adult and family indicators of poverty and the economic status of children include unemployment rate, family income, food insecurity, enrollment in special programs, and homelessness. Missoula Health Kids Indicators (2011) describes the status of children living in poverty in Missoula County (see "Children in Low Income Homes").[15, p.18]

Unemployment. Compared to other parts of the country, Missoula County's unemployment rate is relatively low at 5.8% with the Montana rate at 6.4% slightly higher than in Missoula.[11] The 1990-2012 fluctuating trend is captured in the exhibits below through data monitored by the U.S. Federal Reserve Board. Unemployment rates while important to note, do not indicate the number of underemployed individuals with low wage jobs or the impact of consistent unemployment and underemployment in the population.

Missoula County Unemployment Rate 8/29/12



Montana Unemployment Rate 8/17/12



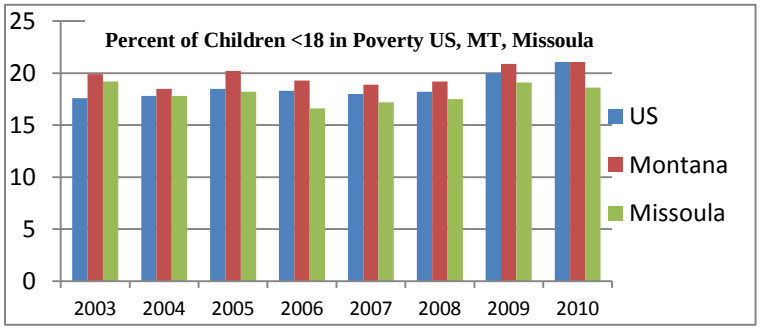
Source: U.S. Department of Labor, Bureau of Labor Statistics (August 2012)

Family Income. Family is defined by the U.S. Census as "a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together" whereas household is defined as "all the people who occupy a housing unit" either related or unrelated.[12] The median household income in Missoula County is $42,888; median family income is $58,302, slightly higher than the Montana ($55,725) level. Approximately 25,485 groups were identified as "family" during the 2010 Census. The Missoula County Family Income Level table provides a breakdown of income level for families. However, the economic status of the family is determined through other measures including the Federal Poverty Level (FPL) guidelines highlighted in the Montana Kids Count Data Book (2011). For instance, a family of four with an income of $22,350 or less would meet the FPL. A family of six would meet the criteria if they made $29,990 or less. The percentage of children under 18 years-of-age living in poverty has fluctuated in Missoula County over the last ten years. On the positive side, except for 2003, the Missoula percentage has been slightly lower than the U.S. or State poverty level.

Missoula County Family Income Level

Income Amount	Number	Percentage
Less than $10,000	1,248	4.9
$10,000 to $14,999	671	2.6
$15,000 to $24,999	2,103	8.3
$25,000 to $34,999	2,753	10.8
$35,000 to $49,999	3,659	14.4
$50,000 to $74,999	5,676	22.3
$75,000 to $99,999	3,842	15.1
$100,000 to $149,999	3,525	13.8
$150,000 to $199,999	1,072	4.2
$200,000 or more	936	3.7

Source: American Community Survey 2006-2010, 5 Year Estimates



Percent Children in Poverty

Source: U.S. Census 2003-2010 Small Area Income and Poverty Estimates[13]

Percent of Children <18 Years-of-Age Living in Poverty US, Montana, Missoula

	2003	2004	2005	2006	2007	2008	2009	2010
US	17.6	17.8	18.5	18.3	18	18.2	20	21.6
Montana	19.9	18.5	20.2	19.3	18.9	19.2	20.9	21.1
Missoula	19.2	17.8	18.2	16.6	17.2	17.5	19.1	18.6

Source: U.S. Census 2003-2010 Small Area Income and Poverty Estimates[13]

Other income related support measures of child well-being include the number of families receiving Temporary Assistance for Needy Families (TANF) support (@$388/family/month); the number of participants of all ages in the Supplemental Nutrition Assistance Program (SNAP) support (@ $134/participant/month); and, children in pre-kindergarten through 12th grade who receive free/reduced-price lunch during the 2010-2011 academic year. The following table from the Kids Count 2011 Data Book examines Missoula levels in 2000 and 2011 compared to the State (2011).[9]

Economic Indicators and Children

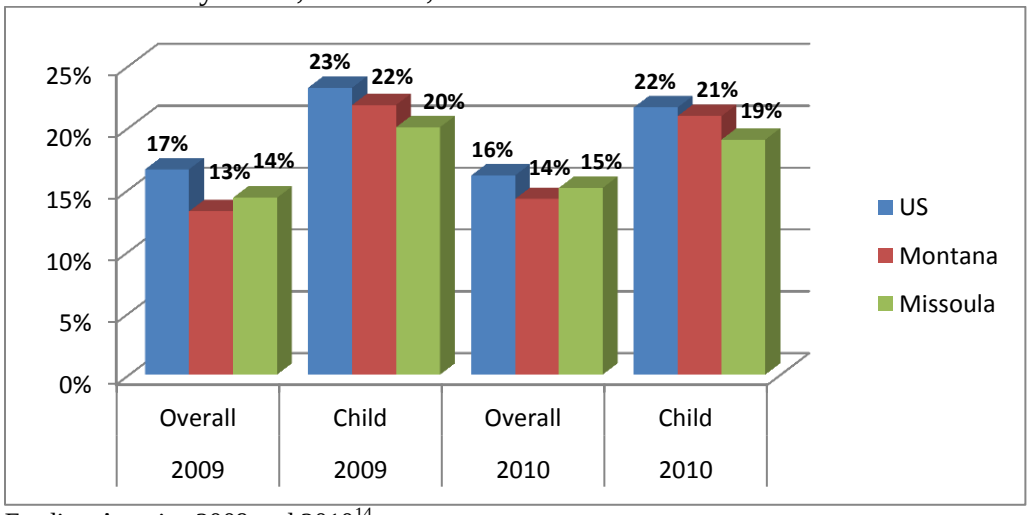
Indicator	Missoula 2000	Missoula 2011	Montana 2011
TANF Families*	N/A	258	3,565
SNAP Participants*	6,305	12,787	109,330
Children & School Lunch	4,009	5,526	58,054

*Annual monthly average

Source: Montana KIDS COUNT 2011 Data Book

Food Insecurity: The USDA created the term food insecurity to measure the occasional or constant "lack of access to enough food necessary for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Food insecure children live in households experiencing food insecurity. Food insecure households are not necessarily food insecure all the time. Food insecurity may reflect a household's need to make trade-offs between important basic needs, such as housing or medical bills, and purchasing nutritionally adequate foods" (Feeding America, 2012).[14]

Food Insecurity in US, Montana, and Missoula



Source: Feeding America 2009 and 2010[14]

The findings indicate that children have more food insecurity than the population in general. In 2010, the overall percentage rate of 15% represents 16,170 individuals; the 2010 percentage of 19% represents 4,120 children. In 2011, the Montana Foodbank Network served 30,026 clients, 11,187 households, and distributed 4,549,664 pounds of food. Emergency food distribution in Missoula County between January and May 2012 resulted in service to 16,783 clients and 5,995 households.[16] The coalition should follow the HP 2020 Objectives on Food Insecurity (Nutrition and Weight Status [NWS-12; NWS 13]) to reduce food insecurity in Missoula children.

Housing Uncertainty and Homelessness. Just as food insecurities exist for children and families, housing availability and affordability cause uncertainty for Missoula's low income families. Each year the National Low Income Housing Coalition develops state reports to highlight the growing housing threat for low wage earning families.

Fair Market Housing in Montana

In Montana, the Fair Market Rent (FMR) for a two-bedroom apartment is $655. In order to afford this level of rent and utilities – without paying more than 30% of income on housing – a household must earn $2,182 monthly or $26,181 annually. Assuming a 40-hour work week, 52 weeks per year, this level of income translates into a **Housing Wage* of $12.59.**

In Montana, a minimum wage worker earns an hourly wage of $7.65. In order to afford the FMR for a two-bedroom apartment, a minimum wage earner must work 66 hours per week, 52 weeks per year. Or a household must include 1.6 minimum wage earners working 40 hours per week year-round in order to make the two-bedroom FMR affordable.

In Montana, the estimated mean (average) wage for a renter is $10.16. In order to afford the FMR for a two-bedroom apartment at this wage, a renter must work 50 hours per week, 52 weeks per year. Or, working 40 hours per week year-round, a household must include 1.2 workers earning the mean renter wage in order to make the two-bedroom FMR affordable.

*Housing wage is the wage one must earn in order to afford a modest rental home in a community.
Source: National Low Income Housing Coalition, Out of Reach 2012: Montana[17]

Housing is more expensive in Missoula County so the FMR for a two bedroom apartment is higher than the state average. The housing wage for Missoula County is $14.44 compared to $12.49 for the state.[17] However this projected rate likely underestimates the actual cost of a one or two bedroom rental in Missoula.

A transition from low-income housing to homelessness can rapidly overtake families with limited resources and few defenses for managing sudden impact health or social events. According to the "Homeless and Housing Instability in Missoula Needs Assessment" (2010), "almost half of respondents were living in Missoula's permanent housing when they experienced their first episode of homelessness . . . these were more likely to be women and families with children. . . women and families were more likely to report domestic abuse and family conflicts as reasons for homelessness."[19, p.vi] During school year 2011-2012, WORD, Inc. counted 614 homeless children and youth under the McKinney-Vento Homeless Assistance Act and another

175 were considered at-risk of homelessness. On a single day in September 2012, a total of 58 children were living in housing for the homeless in Missoula County: 23 at the Joseph Residence with a 4-6 month waiting list; 9 at YWCA Emergency Housing (4-5 week wait list); and, 26 at the YWCA Transitional Housing. Much to the credit of over 82 service agencies listed as District 11 (Mineral, Missoula, and Ravalli Counties) resources for the homeless and the Missoula County Office of Planning and Grants at Risk Housing Coalition, constant attention is directed to the service needs of this vulnerable population including families and children. In addition, a new initiative is underway to work toward a 10-year plan to eliminate homelessness through community partnership, coordination, and planning.

Foster Care. According to Judith Birr from Missoula City County Health Department (August 2, 2012), the current caseload includes 88 children with 45 male and 43 female. The children are <1 year (6); 1-5 years-of-age (31); 16-18 years-of-age (9). Of the children in foster care in Missoula County, 47 have a medical or mental health diagnosis in addition to dental needs. Of the 47 children, nine have complex medical needs (i.e. an acute unstable condition) or two or more medical issues.

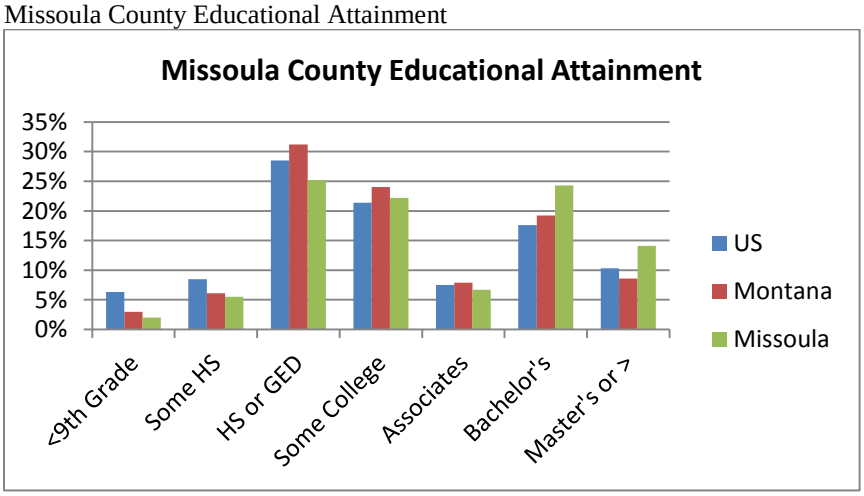
Education Level

School Enrollment by Grade

School Enrollment	Montana		Missoula	
Population 3 Years & Older	235,983		31,843	
Nursery school, preschool	13,206	5.6%	1,048	3.3%
Kindergarten	12,085	5.1%	1,307	4.1%
Elementary school (grades 1-8)	96,195	40.8%	9,098	28.6%
High school (grades 9-12)	52,304	22.2%	5,145	16.2%
College or graduate school	62,193	26.4%	15,245	47.9%

U.S. Census, 2010

Missoula County Educational Attainment



Source: U.S. Census 2010

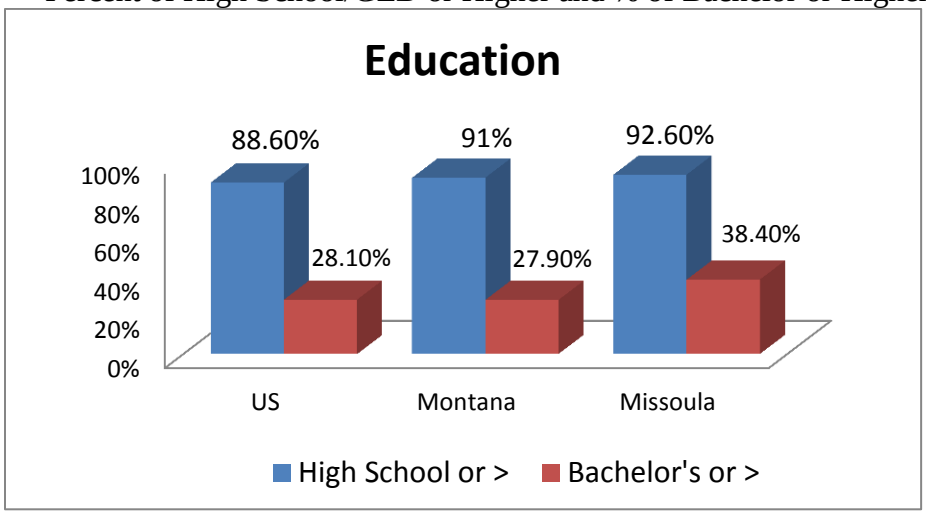
US, MT, Missoula Educational Attainment

	<9th Grade	Some HS	HS or GED	Some College	Associates	Bachelor's	Master's or >
US	6.30%	8.50%	28.50%	21.40%	7.50%	17.60%	10.30%
Montana	3%	6.10%	31.20%	24%	7.90%	19.20%	8.60%
Missoula	2%	5.50%	25.20%	22.20%	6.70%	24.30%	14.10%

Source: U.S. Census

Educational attainment is relatively high in Missoula compared to MT and the US with most residents holding a high school diploma or greater (92.6%) and 38.4% having a bachelor degree or higher.

Percent of High School/GED or Higher and % of Bachelor or Higher



Source: U.S. Census, 2010

HEALTH PROFILE

Health Status

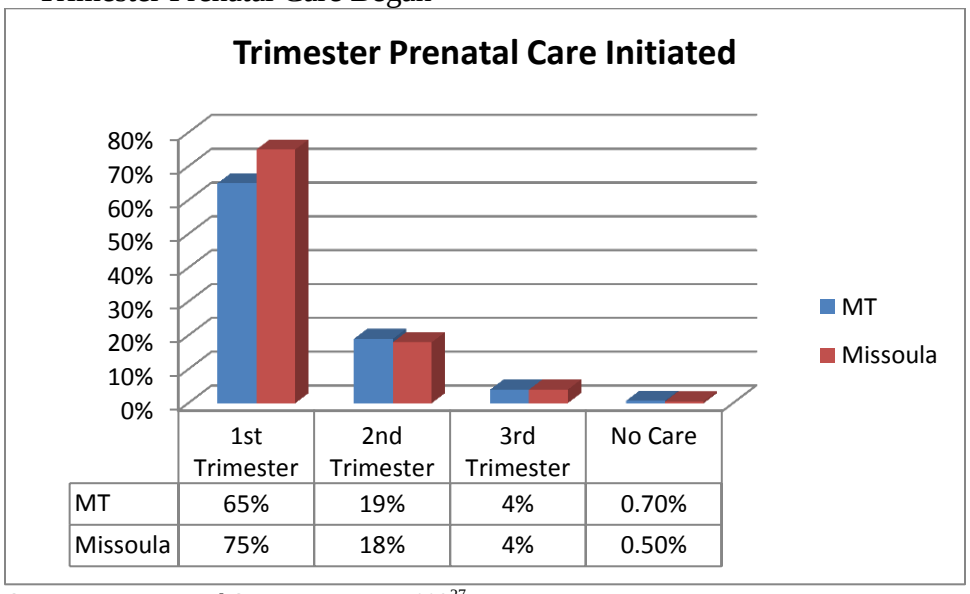
Birth Rate: Data collected for Kids Count 2011 through a special request from the Office of Epidemiology & Statistics Support (Vital Statistics Analysis Unit) for MT DPPHS documents a birth rate in Missoula County (live births per 1,000 total population, 2008-2010) of 11.3 compared to a rate of 12.6 for the state. The current Missoula County rate represents a small decrease in the birth rate recorded in 2000 of 11.7/1,000. MT DPHHS 2008 vital statistics records document a total of 1,638 children born in a hospital and 142 babies born at home in Missoula County for a total of 1,780 children. Since Community Medical Center in Missoula is a primary birth center for the county and surrounding counties, the number of births does not reflect the number of newborns in the county. The gradual decrease in the crude birth weight in the U.S. (30.1/1000 population in 1910 to 13.8/1000 in 2009) is believed to be in part due to family planning efforts and birth control. The fertility rate (births per 1,000 women 15-44) between 2004-2008 was 52.9 in Missoula County compared to 77.7 for Lake County, and 67.1 for the state.

Preconception Health. In 2006, the Center for Disease Control and Prevention (CDC) developed ten recommendations to improve preconception health and reduce risks related to adverse pregnancy outcomes.[20] Healthy People 2020[21] targets an "increase in the proportion of women delivering a live birth who received preconception care services and practiced key recommended

preconception health behaviors" (p. MCH-11) including: discussed preconception health with a health care provider prior to pregnancy (MCH-16.1); took multivitamins/folic acid prior to pregnancy (MCH-16.2); did not smoke prior to pregnancy (MCH-16.3); did not drink alcohol prior to pregnancy (MCH-16.4); healthy weight prior to pregnancy (MCH-16.5); and used contraception to plan pregnancy (MCH-16.6). In 2008, the Montana MCH Needs Assessment (2010)[22] indirectly tracked preconception health through census, BRFSS, and vital statistics data to uncover categories of risk. At particular risk were women less than 30 years-of-age, American Indian/Alaska Natives, and those with an income less than $25,000.

Prenatal Care. No single factor contributes more to a healthy start for a fetus, infant, or child than early (first trimester) prenatal care. Numerous studies link poor birth outcomes including low birth weight, premature births, neonatal and infant mortality to late initiation (defined as beginning in the third trimester) or no prenatal care.[23] "Mothers who do not receive prenatal care are three times more likely to give birth to a low-weight baby, and their baby is five times more likely to die."[24] In 2008, 27 states including Montana used the revised birth certificate (2003 revision) to expand the report of demographic, medical, and health information including month prenatal care began.[25] Nationally, 71% of all women began prenatal care during the first trimester compared to 73.4% in Montana with the percentage of late or no care at 7% (U.S) and 6.3% (MT).[26] The MT DPHHS 2009 Vital Statistics Report (2011) identifies a slightly higher percentage of first trimester care initiation in Missoula County compared to the state (75% versus 65% respectively). However, approximately 5% of pregnant women (MT, and Missoula) had late or no prenatal care; 618 women in Montana and 55 in Missoula. The combined number of Missoula women with second or third trimester initiation or no care, represent the high risk population. Higher risk is also associated with age, education, economic status, and race. Only half of Native American women start prenatal care during the first trimester; one-third start during the second trimester; 12% delay until the third trimester.[35]

Trimester Prenatal Care Began



	1st Trimester	2nd Trimester	3rd Trimester	No Care
MT	65%	19%	4%	0.70%
Missoula	75%	18%	4%	0.50%

Source: Montana Vital Statistics Report, 2009[27]

Frequency of Live Births by Month Prenatal Care Began

2009	Total Live Births	1st trimester	2nd trimester	3rd trimester	No Care	No Data
MT # births	12,280	8061(65%)	2350 (19%)	532 (4%)	86 (0.7%)	1251
Missoula # births	1,195	900 (75%)	223 (18%)	48 (4%)	7 (0.5%)	24

Source: Montana Vital Statistics Report, 2009[27]

Kids Count 2011[9] vital statistics estimate (2008-2010) of births to mothers starting prenatal care during 1st trimester was similar to the 2009 percentages with Missoula at 75% and Montana at 69%.

Preterm Births is defined as gestation <37 completed weeks; as percent of live births (approximately three weeks or more before an infant's due date). Children born preterm experience higher rates of health problems including mental retardation, learning and behavioral problems, cerebral palsy, lung problems, vision and hearing loss, diabetes, high blood pressure, and heart disease.[28, 29] Preterm birth has also been linked to autism and challenges related to early learning.[28] Missoula's preterm births in 2011 equaled 9% of live births compared to the state at 10%.[9]

Low Birth Weight. Preterm births are often related to low birth-weight factors (<2500 grams or 5lbs 8 oz.; as percent of live births). For 2008-2010, Kids Count (2011) estimated Missoula's percentage of low birth weight babies at 7% compared to the state, also at 7% of live births.[9] "Babies who are very low in birth weight (less than 1500 grams or three pounds, four ounces) have a 24% chance of dying within their first year. Mortality among low birth weight (1500-2499 grams) is much lower at 2%. . . (low birth weight babies) are more likely to experience delayed motor and social development . . .and increased chances of school-age learning disabilities, lower IQ, and the possibility of being placed in special education and dropping out of school."[28] In Missoula County in 2009, 87 children were born with either very low or low birth weight putting this group of children at risk for excess mortality or morbidity.

Frequency and Percent Distribution of Live Births by Birthweight

2009	# Live Births	Very Low Birthweight <1500 grams		Low Birthweight <2500 grams		Normal Birthweight >2500 grams	
		#	%	#	%	#	%
MT	12,280	127	1	743	6.1	11401	92.8
Missoula	1195	16	1.3	71	5.9	1108	92.7
Lake	385	5	1.2	18	4.7	361	93.7

Source: Montana Vital Statistics Report, 2009[27]

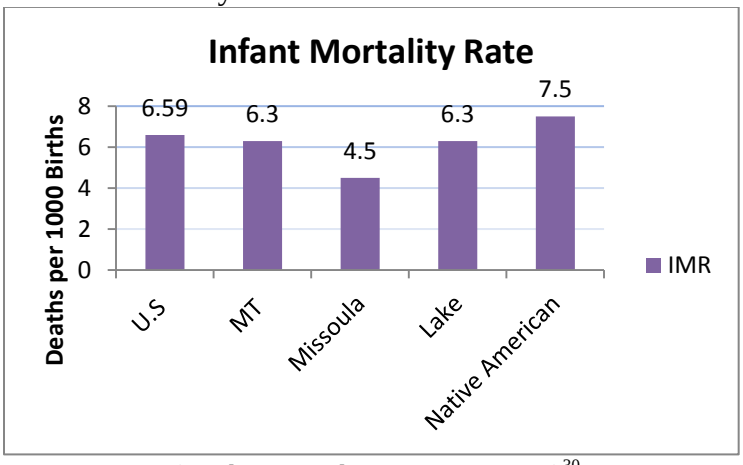
Postpartum Care/Postpartum Depression "affects 10-15% of mothers within the first year after giving birth. Younger mothers and those experiencing partner-related stress or physical abuse might be more likely to develop PPD (MMWR, April 11, 2008). Montana was not one of the 17 states reporting postpartum depression so actual level of risk in Missoula women is unknown.

Infant Mortality Rate (IMR). Infant mortality is a local, statewide, national, and international comparable measure of overall health and the availability of services for a specific population.

Nationally between 1980 and 2001 infant mortality decreased from 1,288/100,000 to 683/100,000 but increased slightly to 700/100,000 in 2003. The increase was believed to be due to an increase in very low birth weight babies. In 2010 the number decreased again to 622/100,000 babies born.[28] The top five causes of death nationally by order of frequency include: congenital malformations, disorders related to short gestation and low birth weight, sudden infant death syndrome, newborns affected by maternal complications of pregnancy, and accidents (unintentional injury).[30]

The U.S. IMR for 2008 was 6.59 infant deaths per 1,000 live births (all races).[30, p.22] In Montana, the 2005-2009 IMR average was 6.3 infant deaths/1000 live births. Missoula's IMR was 4.5/1000 live births. Regionally, the Western Montana Urban Indian Health Organization Service Area reports a significantly higher IMR for Native American infants (7.5/1000 live births).[31] The Healthy People 2020 Objective is 6.0/1000 live births for all infants.[21]

Infant Mortality Rate



Source: US (Final 2007/Preliminary 2008, IMR)[30]
Montana, Missoula, Lake (2005-2009)[27]
Native American IMR (2002-2006 Western MT Urban Indian Centers) [27, 31]

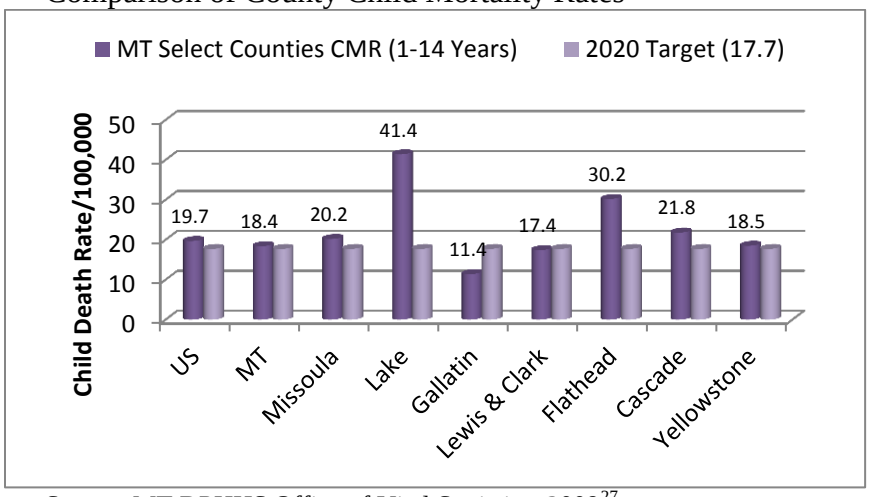
Child Mortality Rate. Nationally, unintentional injuries and violence are the leading causes of death, hospitalization, and disability for children ages 1-18. The child (1 through 14 years) mortality rate for Montana is 18.4/100,000 and 20.2/100,000 in Missoula County[27]. The Healthy People 2020 Objectives are established for children years 1-4, 5-9, 10-14, 15-19, and 20-24 (MCH-3.1-3.2; MCH-4.1-4.3).

Healthy People 2020 Child Mortality Rate Objectives

Objective	Description	Target/100,000	Baseline/100,000 (2007)
MCH 3.1	Reduce rate of child deaths ages 1-4	25.7	28.6
MCH 3.2	Reduce rate of child deaths ages 5-9	12.3	13.7
MCH 4.1	Reduce rate of adolescent deaths 10-14	15.2	16.9
MCH 4.2	Reduce rate of adolescent deaths 15-19	55.7	61.9
MCH 4.3	Reduce rate of young adult deaths 20-24	88.5	98.3

Source: Healthy People 2020 Maternal Child Health Objectives[21]

Comparison of County Child Mortality Rates



Source: MT DPHHS Office of Vital Statistics, 2009[27]

The Children's Safety Network documents cause of death for each age group from 0-24 years. Two National Performance Measures relate to child mortality: NPM #10 rate of deaths to children 0-14 due to motor vehicle crashes and #16 rate of suicide among youths aged 15-19. Both measures are higher for Montana children than US children.[33, 34] In 2005-2006 a total of 412 children died across Montana. In each age category, Native American children died at a higher rate than White children. Montana Fetal, Infant, Mortality Review (FICMR) is a statewide effort to reduce preventable fetal, infant, and child deaths. If a death is deemed preventable, the team takes action on recommendations, policies, and activities to decrease risk to children[32]. Of the deaths of 1-17 year olds, 94% of the unintentional deaths were preventable; 94% of the reviewed motor vehicle deaths were due to a preventable factor—alcohol and drug use, lack of seat belts and child safety seats, inattentive and reckless driving or driver inexperience.[36]

Immunization Rate. Immunization in early childhood effectively prevents the spread of infectious disease and protects children from life-altering illnesses. Healthy People 2020 objectives target 90 percent coverage for each of the recommended vaccines for young children (19-35 months). The immunization series include: 4 doses of diphtheria, tetanus, and pertussis; 3 doses of poliovirus, 1 dose of measles, mumps, and rubella; 3 doses of Haemophilus influenza' 3 doses of Hepatitis B; 1 dose of varicella; and 4 doses of pneumococcal conjugate vaccine is also given. In 2008, vaccine coverage for children 19-35 months of age was as follows for the US and MT.[36, 37]

Vaccine Coverage of Children 19-35 months MT, US

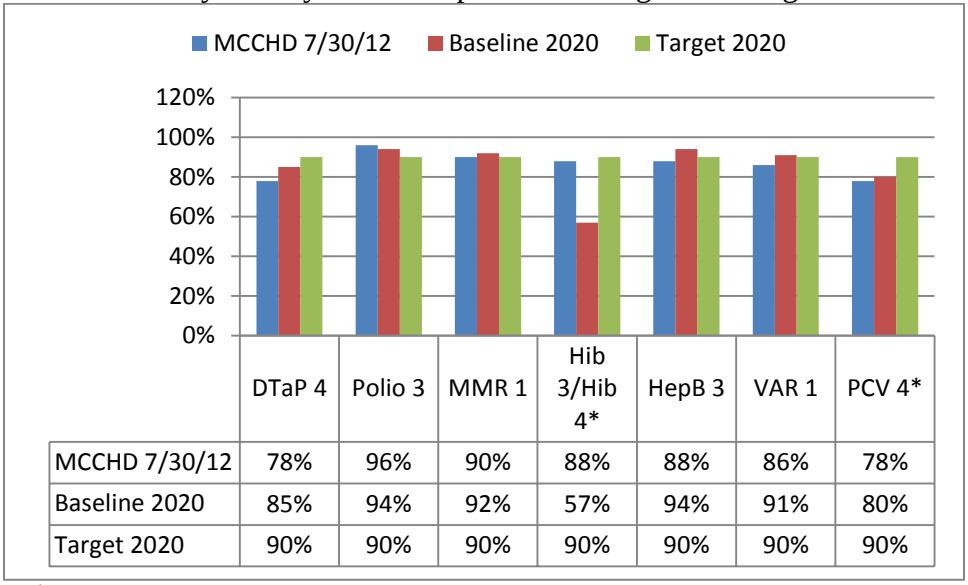
Vaccine Coverage	MT	US
Immunized with 4:3:1:3:3 series	66%	78%
Immunized with 4:3:1:3:3:1 series	59%	76%

Source: MT DPHHS MCH Needs Assessment (2010)[36]

In Missoula County ten Vaccine for Children (VFC) vendors serve the area. The practice trends for one of the vendors, Missoula City County Health Department was assessed to determine the vaccination status of two-year-old children. The following graph displays the single antigen coverage levels for each vaccine compared to the 2020 objective of 90 percent coverage per vaccine. For the review, 50 records were randomly selected from 122 possible records in this

practice. The antigens targeted for improvement are the DTaP #4 (MT 72.8%) and Varicella #1 (MT 76.9%). Missoula City County Health Department's level exceeds the state percentage for both antigens. However, there are nine other VFC sites yet to be evaluated to determine immunization coverage for all Missoula children.[38]

Missoula City County Health Department Antigen Coverage Level



	DTaP 4	Polio 3	MMR 1	Hib 3/Hib 4*	HepB 3	VAR 1	PCV 4*
MCCHD 7/30/12	78%	96%	90%	88%	88%	86%	78%
Baseline 2020	85%	94%	92%	57%	94%	91%	80%
Target 2020	90%	90%	90%	90%	90%	90%	90%

*Hib and PCV coverage levels are based on the number of doses indicated to complete the series. The number of doses indicated depends on the vaccine brand (Hib), the age at which the child receives the first dose, and the age at which the doses were administered.
Source: MT DPHHS, Immunization Section[38]

Well Child Visits. The following section is quoted verbatim from Child Health USA, 2011.[37] No data was found for Missoula County to document the extent or likelihood of well-child visits for Missoula children.

Child Health USA, 2011
"In 2009, 78.0 percent of children under 18 years of age were reported by their parents to have had a preventive, or "well-child", medical visit in the past year. The American Academy of Pediatrics recommends that children have eight preventive health care visits in their first year, three in their second year, and at least one per year from middle childhood through adolescence. Well-child visits offer an opportunity not only to monitor children's health and provide immunizations, but also to assess a child's behavior and development, discuss nutrition, and answer parents' questions.

The proportion of children receiving well-child visits declines with age. In 2009, 88.7 percent of children 4 years of age and younger received a preventive visit in the past year, compared to 78.5 percent of children 5–9 years of age, 71.6 percent of children 10–14 years of age, and 69.0 percent of children 15–17 years of age.

Receipt of preventive medical care also varies by race and ethnicity. In 2009, non-Hispanic Black children were significantly more likely to have received a well-child visit in the past year (83.6 percent) than non-Hispanic White and Hispanic children (77.6 percent and 74.9 percent,

respectively). Non-Hispanic American Indian/Alaskan Native children had the lowest reported rate of preventive care in the past year (72.1 percent), but this was not statistically different than estimates for other racial/ethnic groups."[37]

Breastfeeding. Because of the protective benefits of breastfeeding for mother and child, the Healthy People 2020 devotes eight objectives to this topic. In 2012 the American Academy of Pediatrics (AAP) adopted a resolution divesting from formula marketing in pediatric care including obstetric units[39] and published a policy statement (March 30, 2012, *Pediatrics*) to reaffirm the recommendation of exclusive breastfeeding for six months.[40]

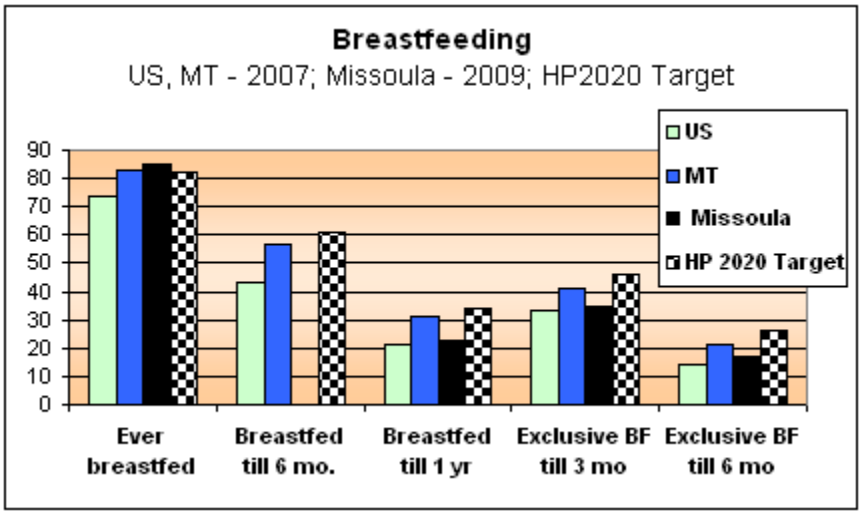
Healthy People 2020 Breastfeeding Objectives

Objective	Description	Target (%)	Baseline (%) (2007-09)	Montana (%) 2012[41]
MCH 21.1	Increase the proportion of infants who are breastfed--**ever**	81.9	74	83.5
MCH 21.2	Increase the proportion of infants who are breastfed at **6 months**	60.6	43.5	45.4
MCH 21.3	Increase the proportion of infants who are breastfed at **1 year**	34.1	22.7	27
MCH 21.4	Increase the proportion of infants who are exclusively breastfed through 3 mos.	46.2	33.6	40.1
MCH 21.5	Increase the proportion of infants who are exclusively breastfed through 6 mos.	25.5	14.1	12.5
MCH 22	Increase the proportion of employers that have worksite lactation support programs	38	25	
MCH 23	Reduce the proportion of breastfed newborns who receive formula supplements within the first 2 days of life	14.2	24.2	
MCH 24	Increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers	8.1	2.9	

Source: Healthy People 2020 Maternal Child Health Objectives and CDC Breastfeeding Report Card[21, 41]

In Missoula, a breastfeeding coalition was successful during the 2011 MT legislative session in joining 16 other states that both mandate employer lactation support and support breastfeeding in public. As of January 2011, the Missoula City County Health Department reported 175 Missoula businesses in support of breastfeeding. The Center for Disease Control and Prevention Report Card 2012, indicates statewide progress set to meet the 2020 Objectives but with a number of process indicators unmet.[41]

Percent Breastfeeding



Source: Missoula Healthy Kids Indicators, 2011[15]

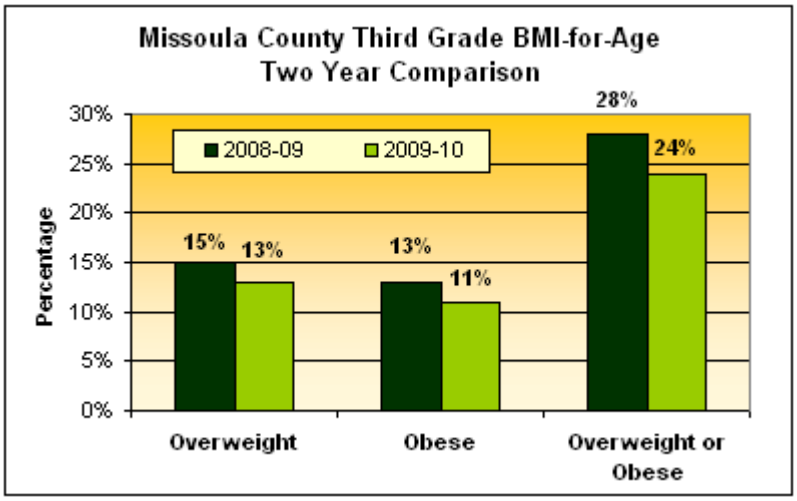
Physical Activity, Nutrition, and Weight Status. This trio of building blocks become essential needs of early and middle childhood and adolescence. Attention to nutrition and physical activity helps children and youth achieve normal growth and development, strong immune systems, and lifelong mental, emotional, and physical health benefits. The 15 Healthy People 2020 Physical Activity Objectives primarily address middle childhood and adolescence but embedded in the goal and indicators of each objective is a message to parents, providers, and communities to improve opportunities and expectations related to both physical activity and excellent nutrition for children.

Two Missoula County resources baseline current efforts to advance physical activity and fitness in our community. First, Dr. Steven Gaskill, an exercise physiologist with the University of Montana Department of Health and Human Performance was the first to monitor physical activity in Missoula youth. His work has also linked physical activity interventions to improved cognition and learning and behavior outcomes in youth[42]. In collaboration with Dr. Gaskill, the Missoula City County Health Department physical activity link in Healthy Kids Indicators establishes goals and objectives for advancing improved activity and nutrition for children and youth.[15] http://www.co.missoula.mt.us/measures/HealthyKids/PhysicalActivity.html

Regarding nutrition and the overweight/obesity epidemic that often begins in early childhood, Missoula County has measures in place to detect overweight and obesity in children at the community level with programs like the MCCHD Body Mass Index (BMI) Project with Missoula County Schools that screens all third graders and interventions like *Let's Move! Missoula*, *Unplug and Play*, and the CATCH program (Coordinated Approach to Child Health) which blends physical activity and nutrition curriculum for elementary school children. Mary McCourt (MCCHD Interim Supervisor for the Health Promotion division) takes the pulse on childhood obesity in Missoula and has helped organize the Summit to Prevent Childhood Obesity (9/29/12) with community partners. Again, the Healthy Kids Indicators (2011) provide a valuable snapshot of healthy weights for school age children. What do we know about incidence of physical inactivity and overweight and obesity in early childhood?

In 2010, height, weight and BMI were calculated on 911 third graders in the Missoula County School system. The following graph depicts the results and the positive data trend. However, there is room to grow based on the Healthy People 2020 Objectives (Nutrition and Weight Status [NWS] 10.1, 10.2, 10.3, 10.4): Reduce the number of children 2-5, 6-11, 12-19 who are obese with a baseline of 16.2 and a target of 14.6 percent. The target and baseline is lower for younger children.[21]

Missoula Third Grad BMI-for-Age



Source: MCCHD Healthy Kids Indicators 2011[15]

Environment and Safety

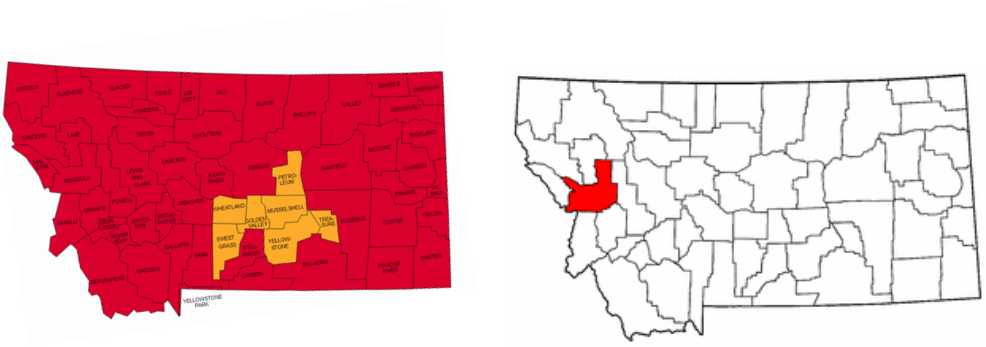
Infants and children are completely dependent on adults for the quality and safety of their environment. Children rely on adults to assure that their fetal environment is safe and free from toxins throughout gestation; that the physical environment is safe and they are protected from contaminants, unintentional injury or direct/indirect harm; that they are nurtured, prepared, and readied for school through their many enriched educational environments; and, that their family and community environment allows them to live with enough resources to meet their basic and self-actualization needs. As adults we know our charge and do our best to meet and exceed a child's unspoken expectations especially related to preventable hazards.

Environmental Contaminants: Infants and children by virtue of their continuous development are uniquely susceptible to environmental toxins. Immature and developing respiratory, immune, and nervous systems can undergo permanent damage in utero or during the first few years of life from toxins that may have little impact on an adult. A fetus, infant or child needs special protection due to their biological sensitivities, exploratory behaviors, and the impact of multiple exposures. The list of possible environmental contaminants is long but a few Missoula County-specific hazards are highlighted.

Radon Exposure. Radon is a colorless, odorless gas that comes from the natural radioactive breakdown of uranium in soil and rock. Radon is estimated to cause thousands of deaths each year and is the leading cause of lung cancer after tobacco smoke. Exposures at home or school comes from the ground and cracks in solid floors, construction joints, basements, gaps around pipes and even water from a well. Mitigation through venting, wicks the radon gas away from living and breathing spaces. Every home/rental and school where children spend time

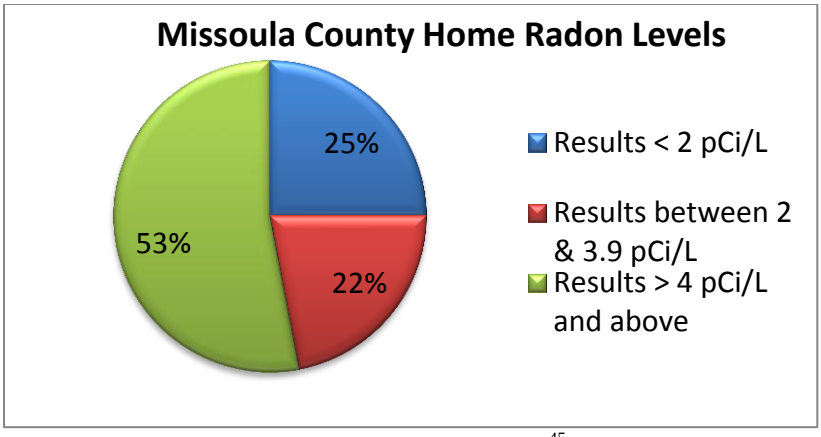
should be tested. Radon is found in most counties in Montana (see maps below). All counties in red including Missoula County have high levels of radon.[42,43,44]

High radon counties in Montana[43].



The average national indoor radon level is 1.3 pCi/L. The average indoor radon level of Missoula County is 7 pCi/L. The U.S. EPA has established the "action level" for deciding when a home or school needs radon mitigation at 4 pCi/l (picocuries per liter).[43, 44]

Missoula Radon Levels



Source: MT DPHHS Missoula Radon Information[45]

Lead Levels. According to CDC (2012) protecting children from exposure to lead is important to lifelong good health. Even low levels of lead in blood have been shown to affect IQ, ability to pay attention, and academic achievement. Effects of lead exposure cannot be corrected[46]. In January 2012 the standards for blood lead levels of concern changed from ≥ 10 micrograms per deciliter of lead in blood to any amount less than 10 micrograms/dcl of blood or above. No amount of lead found in the blood of children is safe and even at low levels could cause a child to suffer from damage to the developing brain and nervous system; behavior and learning problems; slowed growth; hearing problems; headaches; anemia; and in rare cases seizures, coma and even death[46]. In addition, pregnant women exposed to lead could result in the accumulation of lead in their bodies over time. Lead is stored in bones along with calcium. During pregnancy, lead is released from bones as maternal calcium and is used to help form the

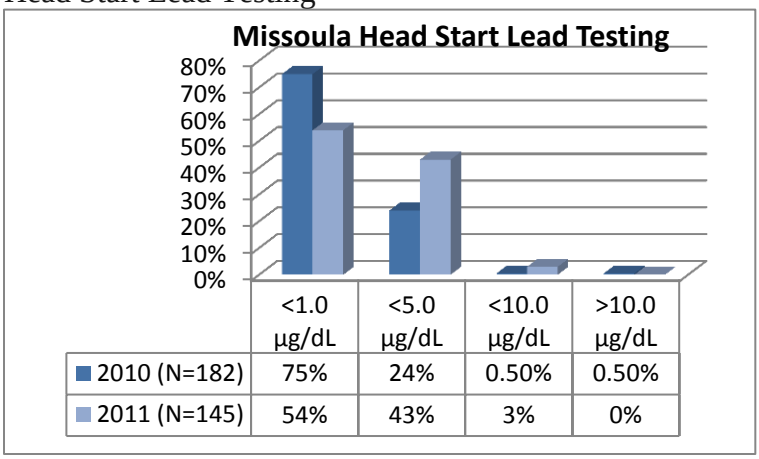
bones of the fetus. This is particularly true if a woman does not have enough dietary calcium. Lead can also be easily circulated from the mother's blood stream through the placenta to the fetus. Mothers with high levels of lead in their bodies can expose their developing fetus, resulting in serious and developmental problems including increased chance of miscarriages, premature births or a low birth weight infant, or delivering a baby with brain damage, decreased mental abilities and learning difficulties, and/or reduced growth in young a young child.[46, 47]

Lead levels are detected through a blood test. Results from Head Start lead screenings in Missoula County (2010 and 2011) indicate that some young children have been exposed to lead[48]. The value of screening lies in the opportunity to detect and remove possible sources of lead from the child's environment to eliminate effects from additive exposures. The results of the Missoula screenings are displayed in the following table and figure. A total of 182 children (106 boys, 76 girls between ages 1-6) were tested in 2010 with 75% of the children found to have <1.0 UG/DL; 24% had <5.0 UG/DL; one child had <10.0 UG/DL; and one child had >10.0 UG/DL. In 2011 a total of 145 children (81 boys, 64 girls between ages <1-8) were tested with 54% of the children found to have <1.0 UG/DL; 43% had <5.0 UG/DL; 3% had <10.0 UG/DL; and no children had >10.0 UG/DL blood lead level.[48]

Head Start Lead Testing Results

Head Start Lead Testing	2010	2011
Age		
<1 yr.	0	1
1-3 yr.	64	44
4-6 yr.	118	99
7-8 yr.	0	1
TOTAL:	182	145
Gender		
Male	106	81
Female	76	64
TOTAL:	182	145
Test Results		
<1.0 µg/dL	136 (75%)	79 (54%)
< 5.0 µg/dL	44 (24%)	62 (43%)
<10.0 µg/dL	1 (0.5%)	4 (3%)
>10.0 µg/dL	1 (0.5%)	0 (0)
TOTAL:	182	145

Head Start Lead Testing



The Head Start Risk Assessment voluntary survey was completed by some parents with results pointing to possible exposures in a home or child care setting due to a variety of exposure pathways. No specific linked data between children with high or moderate lead levels and potential exposure pathways is available. Follow-up of children determined to have possible lead exposure would be initially conducted by a public health professional who would then refer the child for additional follow-up or testing. In the table below parents identify possible exposure pathways.[48]

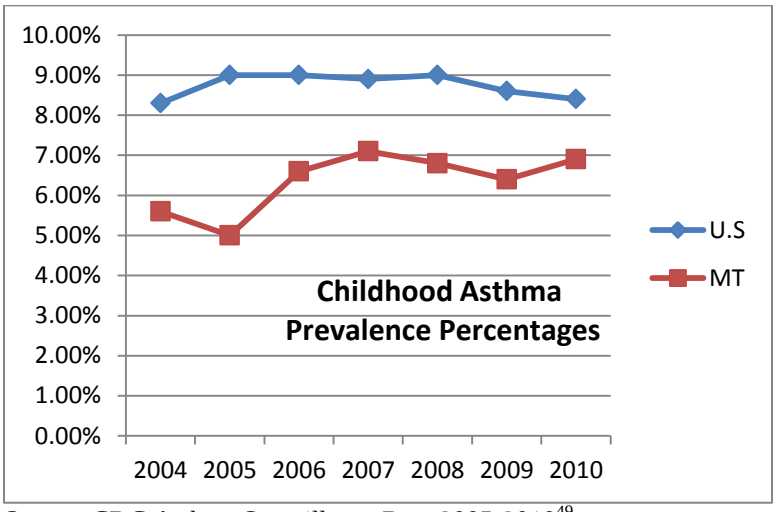
Head Start Lead Risk Assessment, Missoula

Head Start Risk Assessment *	2010	2011
Own/Rent	41/123	26/80
Renovating/Remodel	10	14
Exposure Vinyl Miniblinds	26	23
Car Repair/Reloading Bullets	10	2
Home Older Than 1950	20	10
Chipping/Peeling Paint	13	13
Imported or Antique Dishes	3	4
Child Attend Day Care	54	34

*Not all parents/guardians answered all Risk Assessment questions.

Asthma Rates. In 2009 about one in ten children (10%) in the U.S. suffered from asthma.[49] Asthma is a chronic inflammatory disorder of the airways characterized by episodic and reversible airflow obstruction and inflammation[50] that can be triggered by single or multiple environmental irritants such as dust mites, pest dander, mold, outdoor air pollution like wildfire smoke, and secondhand smoke. Symptom control is possible with correct treatment and avoidance of exposure to environmental allergens[50] Although Montana's childhood asthma rate is lower than U.S. averages, the prevalence of asthma in Montana has been steadily increasing since measurements were initiated in 2004. Asthma disproportionately impacts children from lower-income families and children from various racial and ethnic groups especially Hispanic populations.[49]

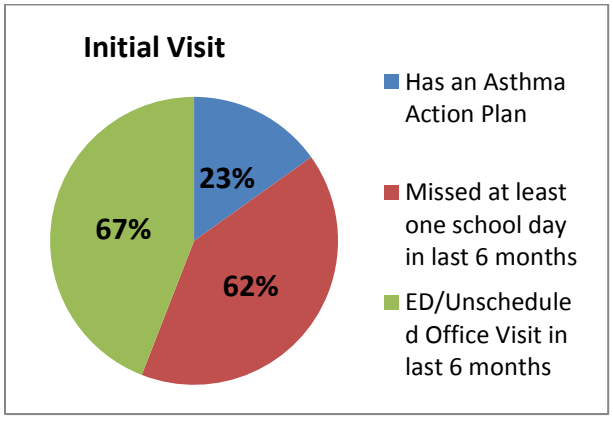
U.S. and MT Childhood Asthma Prevalence



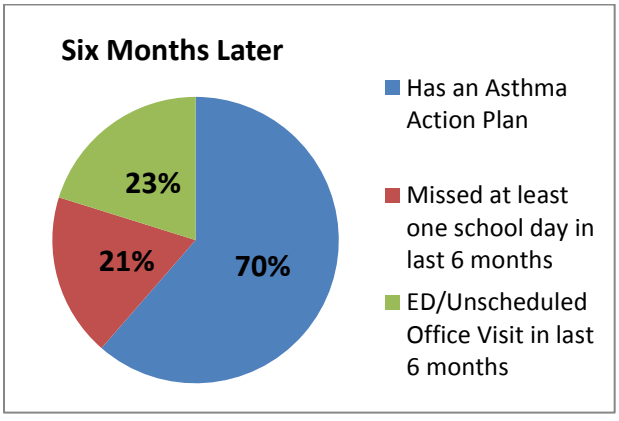
Source: CDC Asthma Surveillance Data 2005-2010[49]

Children and families can improve management of asthma by working with a health care provider and developing an asthma action plan. In 2011 Missoula City County Health Department received one of three regional grants (from CDC and MT DPHHS) to provide an evidence-based asthma-specific home visit model that includes case management and coordination, an environmental home assessment, standardized asthma education for children and their caregivers, and six visits by an RN with specialized education in asthma care. As of June 15, 2012 the statewide results from three intervention sites indicate that 84 children had received the initial home visit; 65 children had received two visits (initial and one month); 58 children had received at least three home visits; and, 48 had received a 4th visit at six months. Results related to availability of an asthma action plan, missed days of school, visits to an emergency department or an unscheduled medical office visit have shown a dramatic improvement from the initial visit to results collected six months later.[51] These early results point to the effectiveness of health care provider/home visitor/caregiver partnerships to reduce exposures and improve health outcomes for children with asthma.

Initial Asthma Home Visit



Six-Month Asthma Home Visit

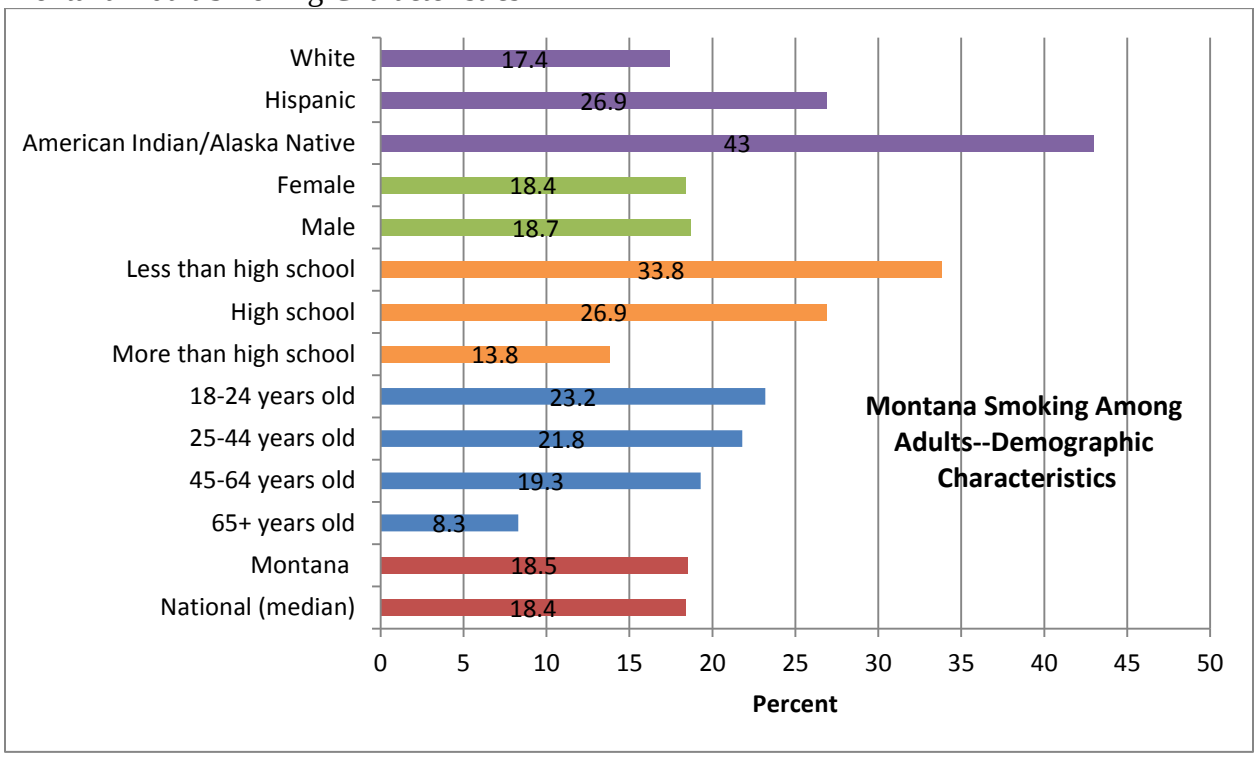


Source: MT DPHHS Asthma Control Program and the Three Montana Asthma Project Sites

Second-hand Smoke. One irritant directly linked to asthma also causes low-birth weight and pre-term births, ear infections, respiratory infections (bronchitis, pneumonia), and greater risk for sudden infant death syndrome (SIDS). Over a lifetime, secondhand smoke increases a non-smokers lung cancer risk by 20-30%.

According to CDC and the MT DPHHS statistics, in Montana "18.5% of the adult population (aged 18+ years), approximately 138,000 individuals are current cigarette smokers. Across all states the prevalence of cigarette smoking among adults ranges from 9.3%-26.5%. Montana ranks 28th among the states. Among youth aged 12-17 years, 12.2% smoke in Montana. The range across all states is 6.5% to 15.9%. Montana ranks 41st among the states in youth tobacco use."[52] Despite the positive effects of the Clean Indoor Air Act passed by the Montana legislature in 2005, children continue to be exposed to secondhand tobacco smoke in confined locations. Some children are at higher risk for exposure based on demographic smoking trends among adults. For instance, Native American children are more likely to be exposed to secondhand smoke than White or Hispanic children. The 2007 a national survey estimated 26.8% of Montana children lived in a household with someone who used tobacco (compared to 26.2% nationally) and 5.3% lived in a household with an adult who smoked indoors (compared to 7.6% U.S.).

Montana Adult Smoking Characteristics



Source: CDC Montana U.S Comparison and Montana Smoking Demographics

Safety Factors

Children of all ages from newborns to adolescents need safe places to grow and thrive—safe communities, safe neighborhoods, and safe homes. Protection is assured through education, policies, legislation, enforcement, community action groups, and conscientious citizens. The Montana Prevention Needs Assessment is conducted on even years and is a valuable source of

county level data on youth (grades 8, 10, and 12) regarding their concerns and perceptions of engagement and support from family, school, and the community.

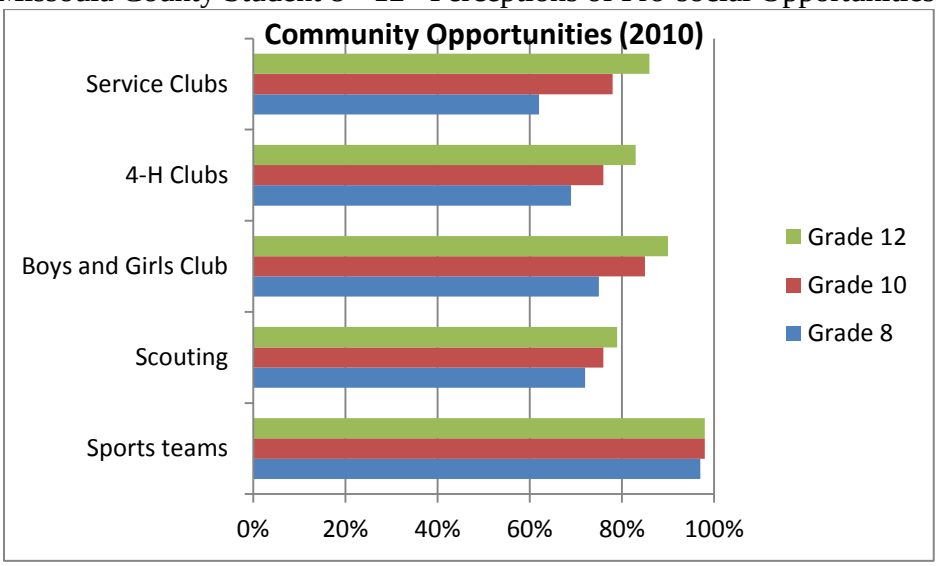
Neighborhoods: In general, Missoula County neighborhoods appear to be positive and supportive places for our children and youth. Approximately 74% of eighth graders reported in the 2010 Montana Prevention Needs Assessment that they would miss or strongly miss their neighborhood if they had to move, while 79% said they liked or very much liked their neighborhoods. These percentages are comparable to statewide rates, which were slightly lower at 73% and 78% respectively.[54]

Most eighth graders feel safe or very safe in their neighborhoods, although this statistic has declined slightly, from 86.9% in 2006 to 82.4% in 2010. Crime or the sale of drugs appears to be low in most neighborhoods, with 91.4% (*n* = 449) of eighth graders agreeing or strongly agreeing that these activities did not occur in their neighborhood in 2010. This percentage is also down slightly from 93.2 percent in 2006 (*n* = 780). Again, these statistics are better than perceptions of peers from across Montana in 2010 with 85.1% reporting "feel safe in my neighborhood" and 89% responding no to concerns of "crime and drug selling."[54]

Missoula County neighborhoods appear to be somewhat stable, with 63.5% of eighth grade youth reporting in 2010 that they had moved only 0-2 times since kindergarten. However, 36.6% had moved three or more times, including 11.1% who had moved seven or more times. Across Montana, 64.3% reported moving 0-2 times since kindergarten and 35.7% moved three or more times, with 9.5% of those moving seven or more times.[54]

Community. A variety of activities designed specifically for children and youth are good indicators of supportive communities and engaged parents who encourage participation. Missoula County school children identified strongly with opportunities available through sports, scouting, boys and girls clubs, 4-H clubs, and service clubs. When asked, "Which of the following activities for people your age are available in your community? The students provided the following responses.

Missoula County Student 8th-12th Perceptions of Pro-social Opportunities



Source: Montana Department of Public Health & Human Services, Addiction and Mental Disorders Division, Chemical Dependency Bureau. 2010 Montana Prevention Needs Assessment Survey[54]

Faith Community Influences. A community resource seldom mentioned in needs assessments is the impact of faith and churches on a child's development. A national study conducted by Hart Research Associates in 2009 found that parental faith and religious background exert a considerable influence on how parents approach parenting. Approximately two-thirds of parents surveyed said that faith/religious background plays a major (41%) or moderate (23%) role in their approach to childrearing.[61] A quick scan of the Missoula telephone book (2012) found a listing for 84 churches and 41 different denominations. A survey of the Missoula faith community conducted by Casey Dunning (University of Montana Master of Social Work-Student) found that churches may be an untapped resource. When asked what assets or resources the faith community could offer to charity, service, or advocacy, the following responses were received: large group of volunteer (85%); under-utilized building space (74%); budgeted service funds (37%); and, capacity for mentoring relationships (26%).[62]

Crime and Violence: Missoula's property and violent crime rates have decreased every year since 2005. The violent crime rate in Missoula is lower than the national rate but higher than the statewide rate. Property crimes were consistently higher than both the state and national rates until 2009, when Missoula's rate was about the same as the national rate.[55]

Intimate Partner Violence. (The following information is from the Office of Planning and Grants [Crime Victim Advocates Program]). "Missoula is the second largest city in the state and includes the University of Montana with approximately 15,000 students. As population sizes grow, so do the number of crimes in a community. Additionally, individuals at the highest risk of victimization of intimate partner violence are women ages 16 – 24 and individuals most likely to commit these crimes are men between the ages of 18 – 26. According to 2010 Census data, Missoula County grew 14.1% as compared to a state average of 9.7%. The percentage of young people (ages 15 – 29) living in Missoula County is 27.2% as compared to 20% for the state. Finally, in a comparison of the six most populous counties in Montana, (Cascade, Flathead, Gallatin, Lewis & Clark, Missoula and Yellowstone) Missoula County sees consistently high rates of intimate partner violence."[56]

Missoula County Crime 2010

Offenses Known to Law Enforcement -- Missoula County, 2010				
Offense Type	All Crimes Reported	No DV* Reported	DV Related	Percentage Involving DV
Total (all crimes reported to law enforcement)	11,776	11,051	727	6.2%
Aggravated Assault	243	189	54	22.2%
Forcible Fondling	93	90	3	3.2%
Forcible Rape	37	35	2	5.4%
Forcible Sodomy	7	6	1	14.3%
Incest	2	2		0.0%
Intimidation	79	68	11	13.9%
Kidnapping/Abduction	38	27	11	28.9%
Murder and Nonnegligent Manslaughter	3	3		0.0%
Sexual Assault With An Object	1	1		0.0%
Simple Assault	1,024	556	470	45.9%
Destruction/Damage/Vandalism of Property	1,558	1,506	52	3.3%
Family Offenses (Nonviolent) (90F)	29	26	3	10.3%

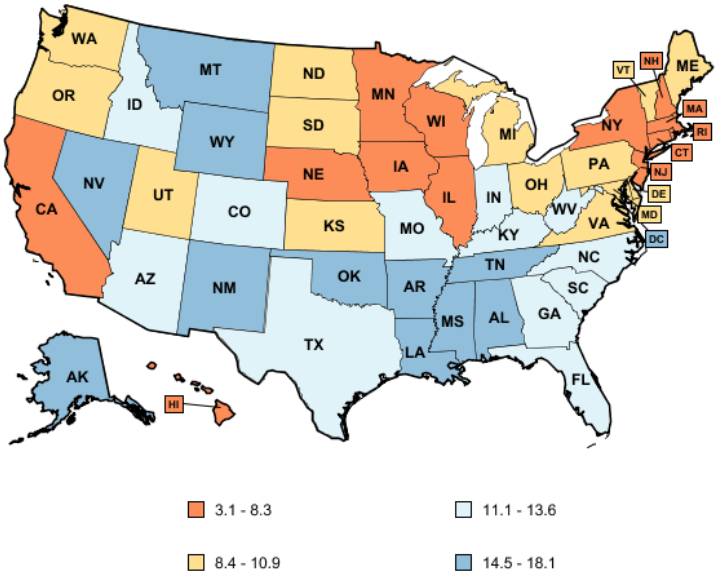
*DV (domestic violence)
Source: Montana Board of Crime Control – Montana Incident-Based Reporting System
The offences listed above are primarily crimes against persons and do not included property crimes or crimes against society unless they were domestic violence related.

Missoula Measures, a website originally developed by Greg Oliver and updated by the MCCHD Health Promotion Division is an excellent resource with links to crime data for Missoula County including domestic violence and youth delinquency along with a host of additional topics to inform citizens regarding the physical, mental, and social health status of their community. The reader is encouraged to access this resource as well as the Missoula Health Kids Indicators http://www.co.missoula.mt.us/measures/

Seat Belt Use. The Missoula County DUI Taskforce has determined that 4 out of 5 child safety seats are used incorrectly. Both Community Medical Center and St. Patrick Hospital sponsor community service events to help parents establish safe practices for children. "St. Patrick Hospital is deeply committed to injury prevention. Activities include safety legislation, support of enforcement of existing laws, minimizing severity of injury through programs encouraging proper use of child safety seats, seatbelt and helmet use, as well as active support of a state-wide trauma system."[57]

Protecting Children from Firearms. In 2009, Montana was 45th out of the 50 states in number of deaths due to injury by firearms with a rate of 16/100,000 population compared to the U.S. rate of 10.1. Some states safeguard children by passing firearm laws such as safe storage requirements and trigger locks offered or required at point of gun sales; Montana has not enacted these protections.[58]

Number of Deaths Due to Injury by Firearms US and MT

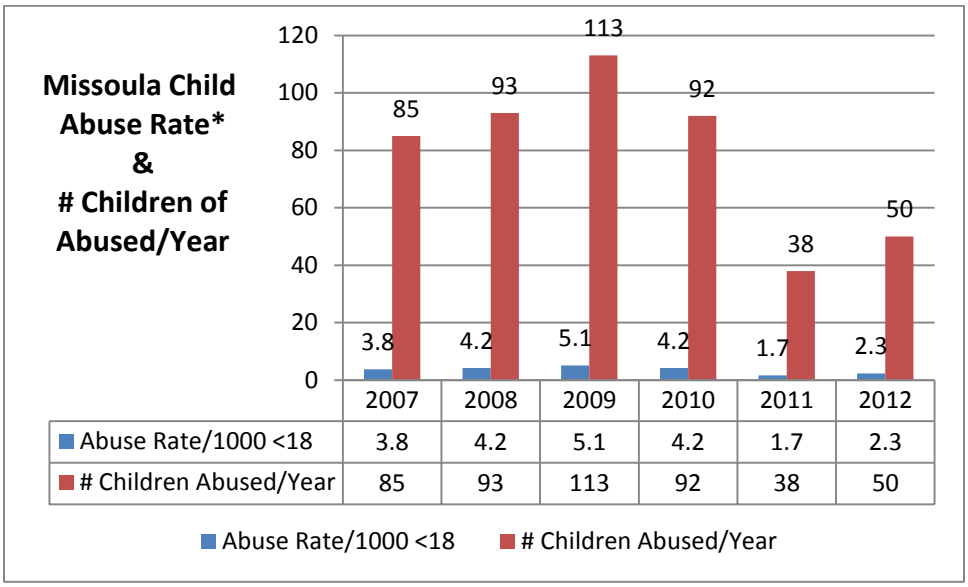


Source: Kaiser Family Foundation State Health Facts (2009)[58]

Child Abuse. A recent report commissioned by Prevent Child Abuse America documents the societal costs of child maltreatment in America. "At least 1.25 million children in the United States experienced child maltreatment in 2005-2006 . . .Victims of child maltreatment are at high risk for a host of adverse short and long-term outcomes, including chronic health problems, mental health issues, developmental delays, poor educational well-being, and future involvement with the criminal justice system. The injuries and adverse outcomes associated with child maltreatment underscore the importance of identifying effective and cost-effective prevention strategies . . . the total direct and indirect cost of child abuse and neglect (estimated at $94 billion) . . . include hospitalization, chronic health problems, mental health costs, costs incurred by the child welfare system, law enforcement, and costs of the judicial system. Indirect costs include special education, mental health and health care (and more) . . ."[59]

The Healthy People 2020 target for "non-fatal victims of maltreatment per 1000 under age 18 is 8.5 with the baseline rate documented at 9.4. Missoula is well below the target and baseline rate with a six year average of 3.55/1000 children. Nevertheless, from 2007-2012, this rate represents 471 substantiated cases--children in Missoula County who suffered the immediate and long term impact of abuse.[60]

Missoula Child Abuse Rate & Number of Children Abused/Yr

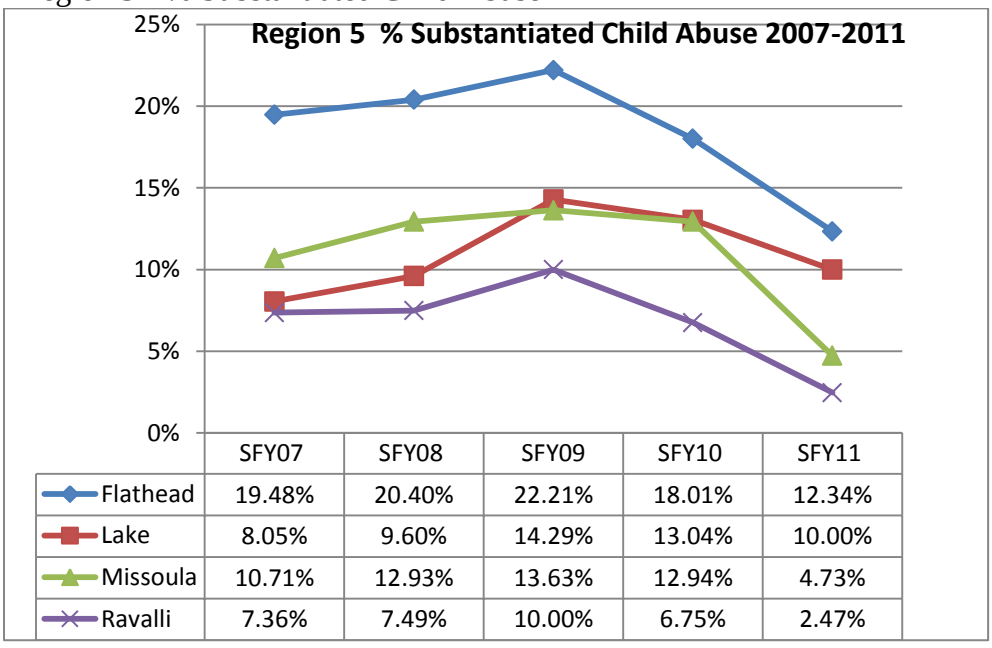


	2007	2008	2009	2010	2011	2012
Abuse Rate/1000 <18	3.8	4.2	5.1	4.2	1.7	2.3
# Children Abused/Year	85	93	113	92	38	50

Source: MT DPHHS Child and Adult Protective Services

*Substantiations: Upon investigation, the child protection specialist determines that the facts showing that abuse, neglect, sexual abuse, or exploitation occurred are more convincing than the facts offered to show the abuse, neglect, sexual abuse, or exploitation did not occur. Based on the number reported, the graph above and table below report the substantiated cases in Missoula county and across Region 5.

Region 5-- % Substantiated Child Abuse



	SFY07	SFY08	SFY09	SFY10	SFY11
Flathead	19.48%	20.40%	22.21%	18.01%	12.34%
Lake	8.05%	9.60%	14.29%	13.04%	10.00%
Missoula	10.71%	12.93%	13.63%	12.94%	4.73%
Ravalli	7.36%	7.49%	10.00%	6.75%	2.47%

Source: MT DPHHS Child and Adult Protective Services

EDUCATION PROFILE
Early Childhood

Data Collection Challenges

Determining the overall county-wide status of early childhood is challenging. Although some data are available from Early Head Start (1-3 year-olds) and Head Start (3-5 year-olds) through self-assessment and annual reports, these valuable services only cover the most vulnerable, lower income families in the community. A data-gap exists that prevents fully understanding the status of the entire early childhood population because care and education is managed often exclusively by parents/family members or in combination with private, publicly funded, or community-based organizations that receive public funds for childcare. No central system exists to assure collaboration among agencies or the collection of data to determine every child's early childhood progress related to the five domains: physical well-being and motor development; social and emotional development; approaches to learning; language development; cognition and general knowledge.[63] A recent report from the New America Foundation (9/18/2012) cites "the dearth of reliable, complete, and comparable data on pre-K and kindergarten in school districts and local communities."[64, p. 1] Specific problems related to available data include: a fragmented system of funding and jurisdictional data collection; missing information on the impact of dosage (full-day versus part-day exposure to a learning environment); and, non-comparable district data since data are collected for different purposes based on various criteria. [64, pp. 4-7] Finally, the authors write, "To close achievement gaps between economically disadvantaged and advantaged students, policy makers and educators desperately need access to the most basic data on enrollment and public funding for all young children . . . poor data can lead to poor policies"[64, pp. 7 & 1] that can ultimately result in impacting a child's readiness to learn and the earliest challenges of preparing for life.

The 2011 report from the National Institute for Early Education Research (NIEER) compares states committed to quality pre-K programs (funded through state funds or public/private partnerships) and ranks them based on a quality standards checklist. Quality standards include:

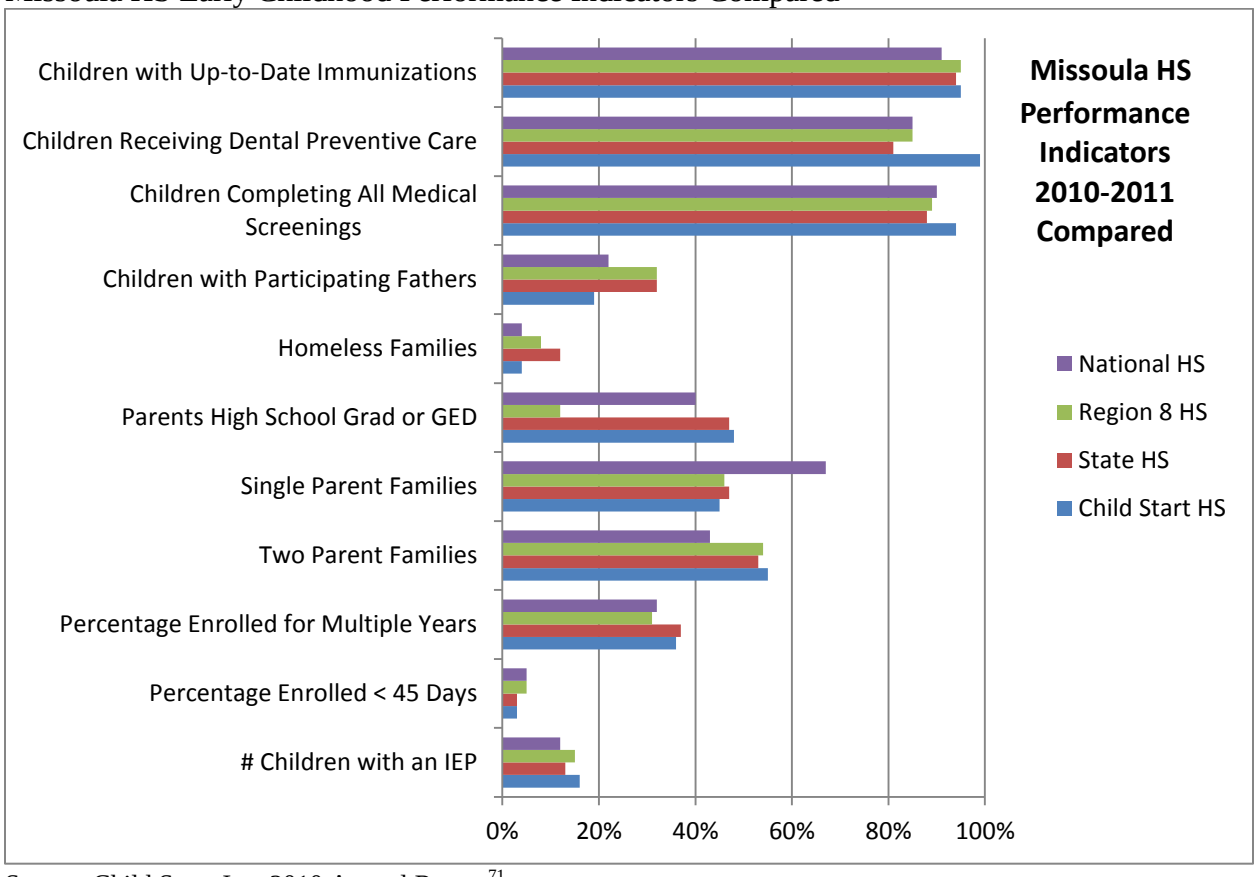
- evidence-based policies supporting early learning standards;
- teacher degree (lead teacher much have a bachelor degree with specialized training in pre-K);
- assistant teacher must have a Child Development Associate (CDA) or equivalent credential;
- teachers must participate in at least 15 hours/year of in-service professional development and training;
- maximum class size must be 20 or fewer for both 3 and 4 year-olds;
- staff child ratio (maximum number of students per teacher must be 1:10 or better);
- screening/referral and support services for vision, hearing, and health must be required;
- at least one meal must be required daily;
- site visits are required to demonstrate ongoing adherence to state program standards.[66, p. 27]

"Montana is among 11 states not committed to state-funded pre-K as an education reform strategy . . . and was one of 15 states to not submit an application for the federal Race to the Top Early Learning Challenge funds (although) research confirms that high quality early education narrows the achievement gap . . . (and addresses) concerns about literacy, school readiness and long-term educational and social outcomes."[67]

Early Head Start is a "federally funded community-based program for low-income pregnant women and families with infants and toddlers up to age 3 with 1,027 programs which provide EHS child development and family support services . . . over 147,000 children under the age of three were served in fiscal year 2011."[68] Nationally, 12.7% of EHS enrollment consist of children with disabilities; 97% had health insurance; and, about 20% of EHS staff are Head Start (HS) or EHS parents.[68] Locally, Missoula EHS is "funded for 64 infants, toddlers, and prenatal mothers. There are 48 home based, 16 center-based, and six prenatal slots (with) two classes (offered) in the center-based option." EHS has 22 employees including focus area managers, case managers, infant/toddler teachers, a cook, and a mental health professional.[69]

Child Start Inc., Head Start is a comprehensive child development program serving children 3-5-years and their families in five counties (Sanders, Mineral, Granite, Powell, and Missoula) by providing opportunities for education and growth in a nurturing and supportive environment.[70] At least once a year each Head Start program must conduct a self-assessment to determine if the HS Performance Standards are being met and if sufficient progress is being made toward fulfillment of program goals and objectives.[70] In 2010 the program served 389 children with 45% from a single parent family. In May 2011 there were over 100 children on the waiting list. Out of 21 employees 4 hold a BS/BA in early childhood education, 8 have an AA in early childhood, and 9 have a CDA credential.

Missoula HS Early Childhood Performance Indicators Compared

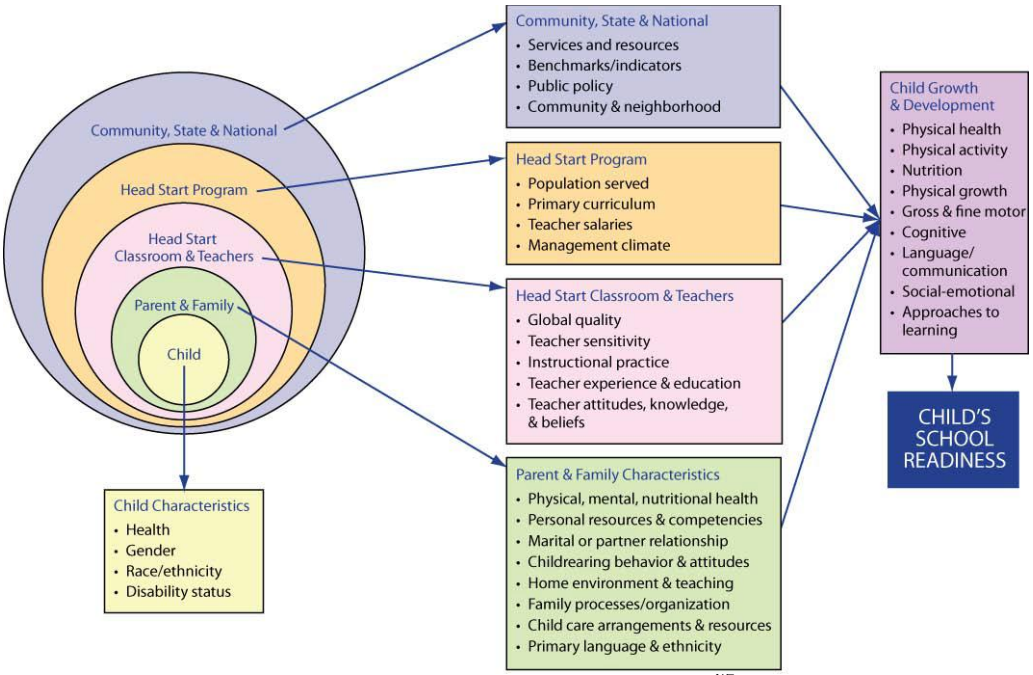


Source: Child Start, Inc. 2010 Annual Report[71]

Based on the comparison of local, regional, state, and national performance measures, Child Start exceeds the regional, state, and national rate of immunization, dental preventive care, children with medical screenings, parents with at least a high school education, the number of children coming from a two parent family and the number of children with an individual educational plan.[71]

Nationally, the conceptual model developed for the Family and Child Experiences Survey (FACES) illustrates the "complex interrelationships that help shape the developmental trajectories of children in Head Start . . . FACES uses a multistage sample design to select a nationally representative probability sample of Head Start children and their families." [64, p1] A variety of tools are used including direct child assessments, parent interviews, teacher interviews/teacher reports, and interviewer ratings.

Head Start Model Framework



Source: Head Start FACES OPRE Report 2011-33a[65]

The 2011 FACES assessment gathered a demographic profile of Head Start families from across the nation and information on home learning activities and parenting practices. On average 76% of parents indicated that they read to their child at least three times a week with significant variation found based on race/ethnicity, number of family risk factors, and primary home language.[64, p. 9] Family engagement in the past week (stories, letters/words/numbers, songs/music, arts/crafts, toys/games indoors, games outdoors, errands, household chores, counted different things, and talked about Head Start) was also high at 90% with most indicating a high level of engagement. Other areas measured included health care and nutrition and child care and an extensive evaluation of cognitive and social-emotional development.[64]

In 2010, the Montana Head Start State Collaboration Office commissioned a statewide needs assessment through Montana Kids Count on behalf of the 24 Head Start or Early Head Start

programs. Data was gathered through focus groups and a survey in areas including education, health/mental health, child care, disabilities, child welfare, homelessness, family literacy, and community service. Prevailing themes include the need to "improve communications among Head Start managers; improve support of struggling families especially those with mental health issues or children with disabilities; address dental health needs of children; and the challenge of finding qualified staff that meet the professional development standards of the Head Start system." [72, pp. 18-19]

Child Care

Regulation of child care facilities by the Department of Public Health and Human Services Child Care Licensing Bureau falls into the following categories.[73]

Child Care Facility Types

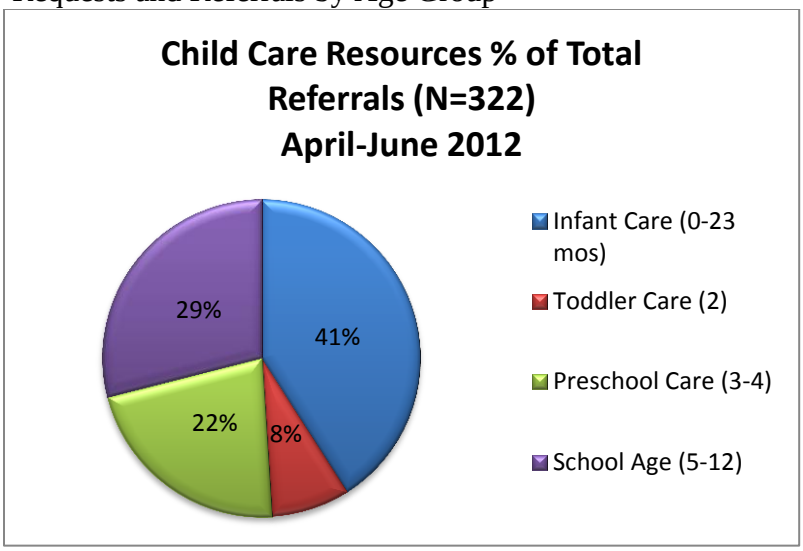
Type	# Children	Licensed	Staff	Other
Child Care Center	13 or more (staff to child ratio based on age of children)	Yes, inspections twice/yr + health & fire	Center Director—educated or experienced in child care	Caregivers--8 hours training/yr Center Director—15 hours training/yr All—CPR & First Aid certified
Group Home	7-12/2 adults (limit of 6 under 2 years)	Yes	Providers attend a child-care orientation session within 60 days	Complete a self-assessment of health, safety, regulations
Family Home	Up to 6 children/caregiver—no more than 3 under 2	Yes		
Other Non-Licensed				
Legally Certified Provider	Parent or legal guardian cares for all children in one family or up to two unrelated children	No	FBI criminal background check Child Protective Services background check	
Before or After School Programs		No		
Drop-in Programs		No		
Preschool Programs		No		

Source: MT DPHHS Child Care Licensing Bureau

A child care inventory was conducted as a part of the 2010-2011 Child Start, Inc., Head Start community assessment. A total of 64 facilities were counted in Missoula (city) and 10 facilities were located in surrounding towns of Bonner, Florence, Frenchtown, Lolo and Seeley Lake.[74] Child Care Resources (CCR) helps parents find childcare through an online referral.[75] service. Since the recession began, CCR has noticed a trend toward increased use of informal care arrangements, such as using family, friends or neighbors as caregivers including 15-25 new applicants every other month from those interested in becoming a "legally certified" provider. These providers may have a stronger bond with the children since they may be related, but they also generally have no formal preparation related to caring for children. CCR also provides training opportunities for providers who must complete at least eight hours of training every year. Although online databases are convenient for locating a child care provider, families are often disappointed by the new centralized information and referral system. Delays in receiving

information, the lack of opportunity to talk to an expert about specific facilities, and inaccuracies and lack of updates to the system often leads to dissatisfaction. Generally, quality child care in Missoula County is limited and often unaffordable for families (see Focus Group summaries). In the three-county area managed by Child Care Resources, the regulated child care supply provides a total capacity (all age groups) of 3,917 children. A total of 206 regulated facilities are in the CCR area including 50 Centers, 89 Group Homes, and 67 Family Homes.[75] During a three month period (April-June 2012), CCR made 322 referrals for families searching for placement of an infant, toddler, pre-schooler, or school age child.

Requests and Referrals by Age Group



Source: Child Care Resources, Michelle Parks Program Director

In Montana 17 Child Care Centers are accredited by the Montana Association for the Education of Young Children and seven (14%) of the accredited Centers are located in Missoula County. Accreditation requirements increase quality for children and families by assuring staff education, qualifications, and training; ratio/group size; family and community partnerships; leadership and program management; and environments for care and learning.[76]

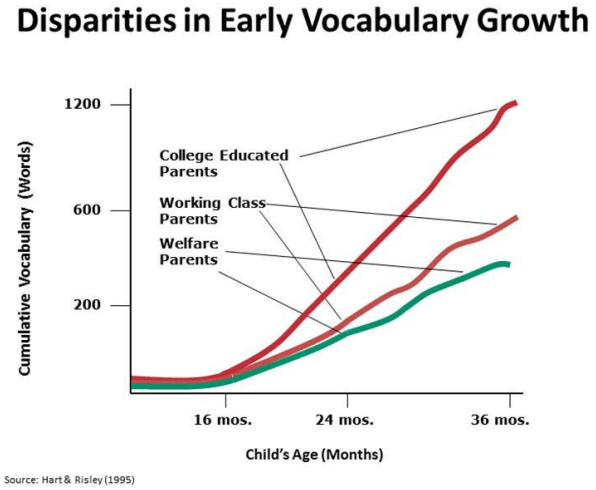
The Best Beginnings STARS to Quality Program is "a voluntary quality rating improvement system that aligns excellence with support and incentives for early childhood programs and early childhood professionals." [76] The research-based program provides program assessment tools to make quality improvements to child care facilities. In Missoula, Child Care Resources is the point of entry for providers who wish to enter the STARS program.[75]

School Readiness

"Language proficiency is a key predictor of school success. Early literacy skills (size of vocabulary, recognizing letters, understanding letter and sound relationships) at kindergarten entry are good predictors of children's reading abilities throughout their educational careers. Language and literacy skills enable children to develop cognitive skills and knowledge and to interact effectively with peers and adults." [24, p.1]

Language enriched environments during early childhood enhance a child's early literacy. Researchers have found a significant relationship between children at risk and poverty (Carol Ewen, personal communication, September 2012) and parental education level (Hart and Rosley, 1995).

Education and Poverty Effect on Early Childhood Vocabulary



According to Carol Ewen, Missoula County Public Schools (MCPS), Response to Interventions (RTI) Specialist and Psychologist, the size of a child's vocabulary at the age of four predicts 11th grade reading level. Reading is a "gateway skill" with 75% of the variance in academic achievement attributable to how well a student can read (National Assessment of Educational Progress, 2008). As each child enters kindergarten at MCPS they are given a one minute Letter Naming Fluency (LNF) screening test that represents the number one indicator of reading readiness. The LNF is a part of a set of procedures and measures (the Dynamic Indicators of Basic Early Literacy Skills or DIBELS) used to assess the acquisition of early literacy skills from kindergarten through sixth grade" (DIBELS website, 2012). The measures are designed for use by teachers to regularly monitor (three times per year) literacy and early reading skills.

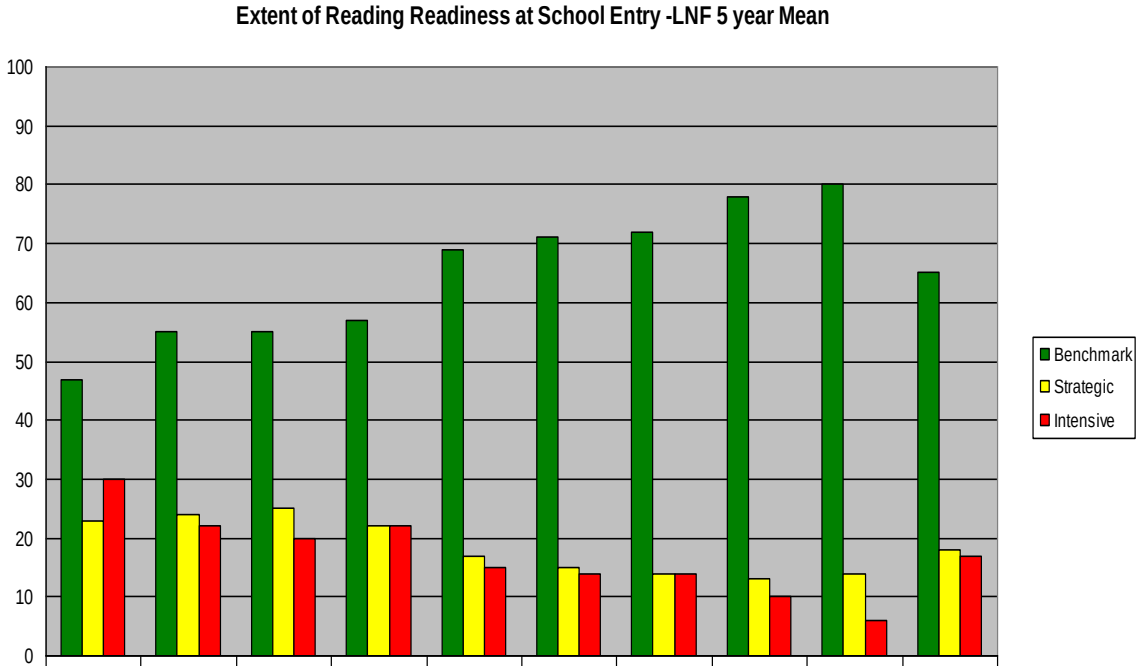
The exhibit below documents the history of incoming kindergarten students in the MCPS system from 2006-2011. Children who are at "benchmark" are at low risk; "strategic" indicates a child is at some risk; and, "intensive" signals a child is at risk. The 2010-2011 results (N=632), indicate 55% of children were at low risk (benchmark), 28% were at some risk (strategic) and 17% (approximately 107 children) were at risk.

Letter Naming Fluency MCPS Kindergarteners 2006-2011

	2006	2007	2008	2009	2010	2011
Benchmark	56	62	70	63	73	55
Strategic	20	22	17	20	15	28
Intensive	26	18	16	19	15	17

Source: Carol Ewen, MCPS

The graph below identifies the DIBELS Letter Naming Fluency (LNF) kindergarten screening results and reading readiness for nine MCPS elementary schools.



	Lowell	Franklin	Russell	Hawthorne	Lewis & Clark	Chief Charlo	Rattlesnake	Paxson	Cold Springs	District Mean
Benchmark	47	55	55	57	69	71	72	78	80	65
Strategic	23	24	25	22	17	15	14	13	14	18
Intensive	30	22	20	22	15	14	14	10	6	17

School Age Children

Schools: Missoula County has 13 school districts. The largest is District 1 Missoula County Public Schools (MCPS), which includes nine elementary schools. In October 2011, MCPS had 650 students enrolled in kindergarten. The other school districts include Hellgate, Lolo, Potomac, Bonner, Woodman, DeSmet, Target Range, Sunset, Clinton, Swan Valley, Seeley Lake, and Frenchtown. Hellgate is the largest district after MCPS with 175 kindergarten students enrolled in October 2011, followed by Frenchtown (83), Lolo (69), and Target Range (58). In line with population projections forecasted in 2009, the number of enrolled kindergarten-age children increased for the 2012-2013 school year (Missoulian, 9-14-2012).

Some private elementary schools also provide early education. The 2011-2012 list includes Clark Fork School (PreK-5), Garden City Montessori (PreK-3), Kinderhaus Montessori (PreK-1), Lighthouse Baptist Academy (K-12), Mission Christian School (K-8), Missoula Community School (PreK-3), Missoula International School (PreK-8), Missoula Valley Montessori, Mountain View Elementary (K-8), Saint Joseph Elementary (K-8), Sussex (K-8), and Valley Christian (PreK-12).

During 2011-2012, District 1 engaged 1,034 at risk children from 3-18 years-old in special education services.

Missoula County School Enrollment[78-80]
October 2011

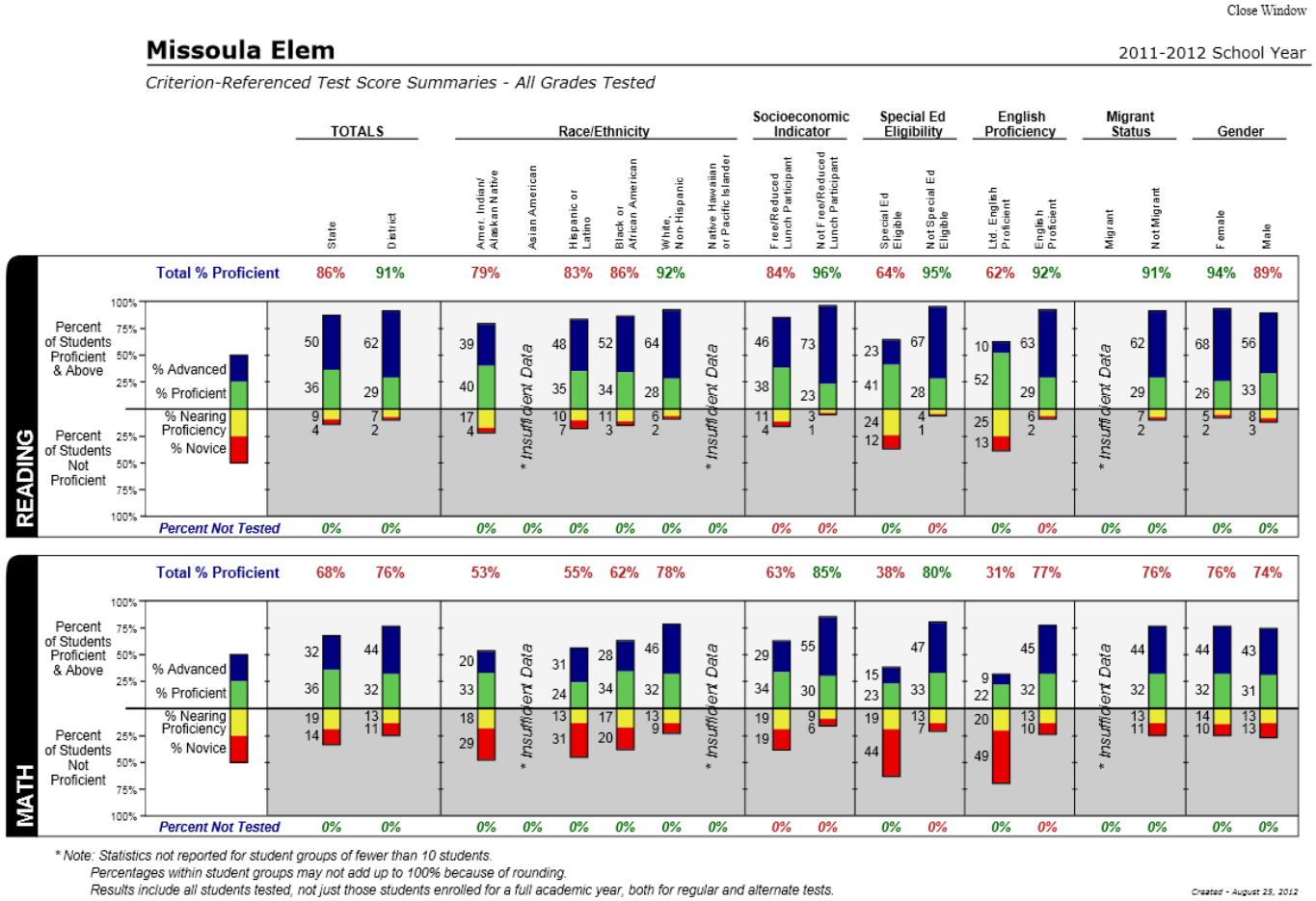
School District	K	1	2	3	4	5	6	7	8	Total
Elementary										
1 City										
Chief Charlo	81	46	72	74	69	81				423
Cold Springs	82	66	80	81	72	82				463
Franklin	54	39	58	40	43	45				279
Hawthorne	58	63	60	46	45	53				325
Lewis & Clark	99	79	75	85	77	81				496
Lowell	55	55	54	55	45	32				296
Meadow Hill							162	168	135	465
Paxson	59	57	66	54	52	56				344
C.S. Porter							160	158	139	457
Rattlesnake	85	66	84	71	63	63				432
Russell	77	53	60	51	40	56				337
Washington							169	204	211	584
CITY TOTAL	650	524	609	557	506	549	491	530	485	4901

4 Hellgate	175	154	152	143	134	150	137	139	133	1317
7 Lolo	69	79	69	72	65	89	60	63	63	629
11 Potomac	8	9	13	9	12	7	15	8	10	91
14 Bonner	38	44	37	32	37	43	31	46	39	347
18 Woodman	8	5	3	2	8	3	6	5	5	45
20 DeSmet	15	13	16	6	18	11	18	18	15	130
23 Target Range	58	51	60	54	41	55	58	44	60	481
30 Sunset							1			1
32 Clinton	23	19	29	19	31	31	25	16	26	219
33 Swan Valley	2	4	3	3	2	7	1	5	4	31
34 Seeley Lake	15	28	15	14	19	20	27	25	25	188
40 Frenchtown	83	82	77	78	78	82	107	91	95	773
Elementary Total	1144	1012	1083	989	951	1047	977	990	960	9153

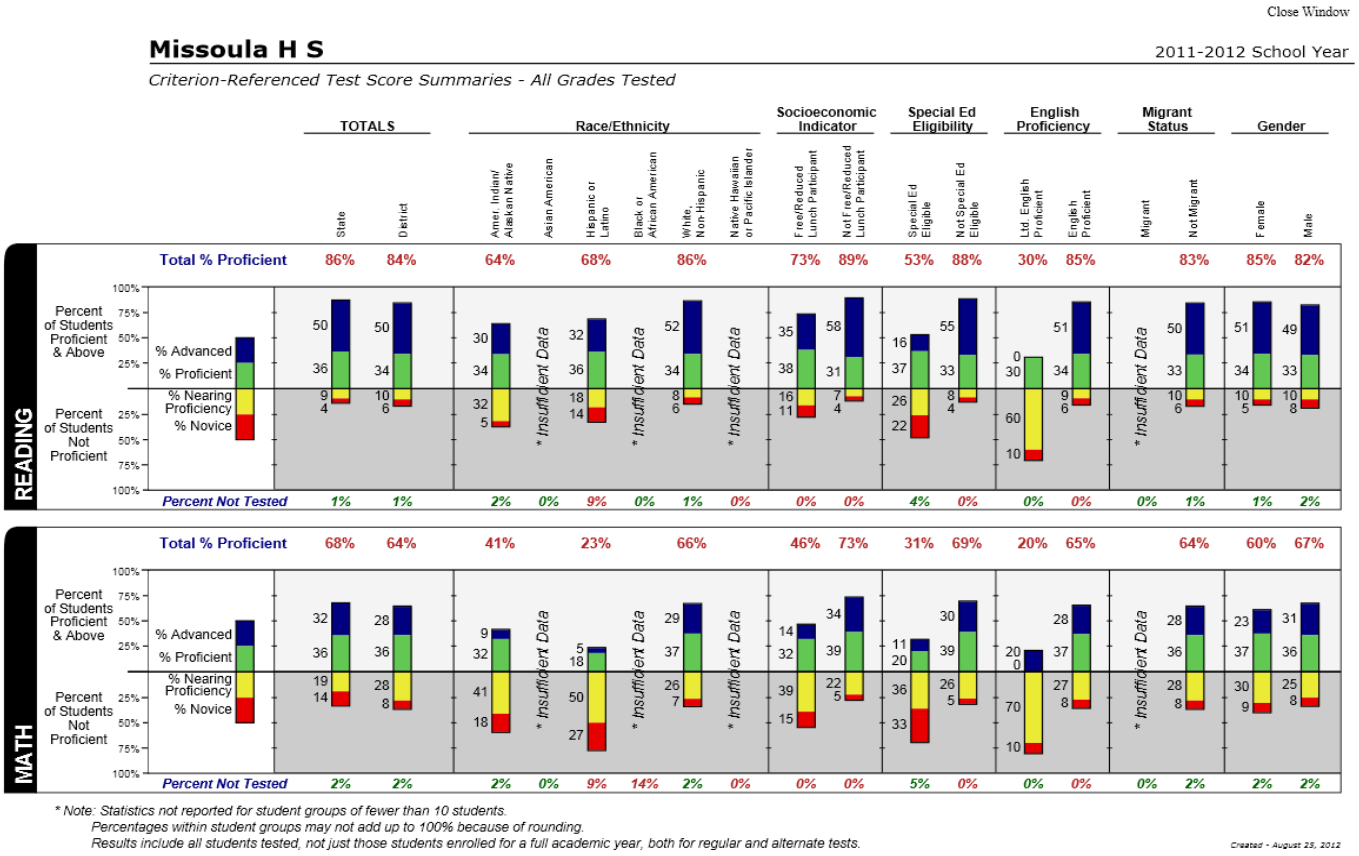
School District	9	10	11	12	Total
High School					
1 City	245	275	266	268	1054
Big Sky					
Hellgate	331	360	289	313	1293
Seeley Swan	26	32	30	22	110
Sentinel	306	302	289	311	1208
City HS Total	908	969	874	914	3665
40 Frenchtown	97	103	102	91	393
High School Total	1005	1072	976	1005	4058
TOTAL PUBLIC SCHOOL ENROLLMENT				13211	

Risk Factors and School Achievement. The purpose of this needs assessment was to determine the current status of the early childhood system in Missoula County through an examination of health and education indicators, a survey of parents, and a conversation with providers serving children and families in various capacities throughout the community. For at risk children, including children living in poverty, Native American or Hispanic/Latino children, and special needs children, the trajectory of decline is witnessed in a sample of reading and math proficiency test scores for Missoula Elementary and High School.[81,82] Although the rate of decline for all students appears more dramatic between elementary school and high school on math scores, the exhibits below from the OPI website confirm projections nationally and in the literature. The impact of poverty, as measured by free or reduced lunch finds a decline from elementary to high school (based on % of students advanced or proficient in reading) from 84% to 73%. The percentage of elementary school Native American children advanced or proficient in reading (79%) is less than their White counterparts (92%) and in high school the percentage continues to deteriorate (64%) compared to White adolescents (86%). If we accept that the effects of race, poverty, and special needs are inevitable and cannot be reversed through interventions such as evidence-based home visiting or high quality early education programs (0-3 and 3-5), then we stand defeated. There is in fact strong evidence that children-at-risk when supported early and consistently can excel despite hardship and adversity. The exhibits below identify areas of concentration and data collection necessary for measuring progress toward an "all children ready for school" goal.

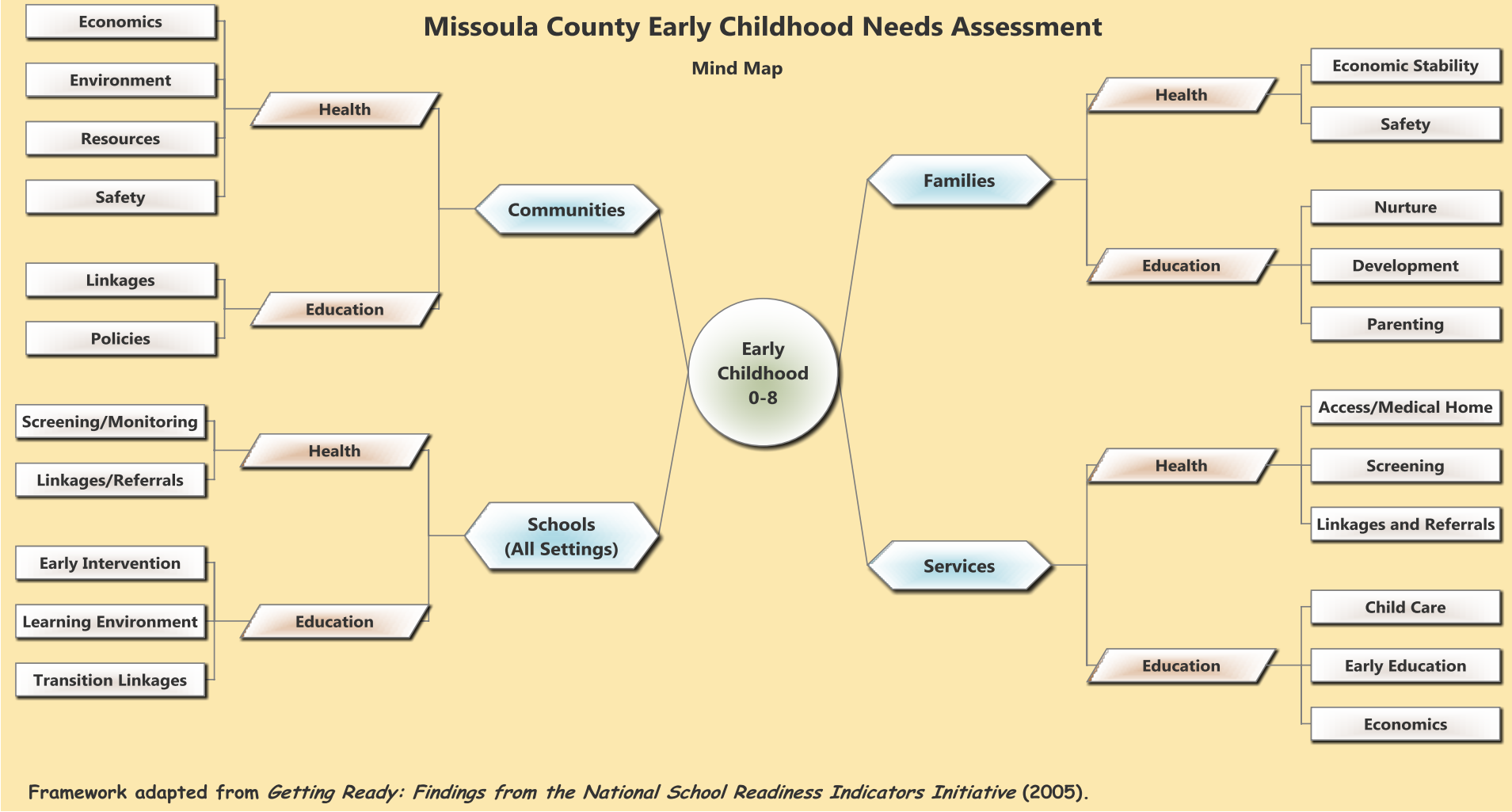
Missoula Elementary Reading and Math Proficiency



Missoula High School Math and Reading Proficiency (2011-2012)



Proposed Missoula County Partnership Improvement Indicators



Ages Preconception-5: Child Readiness for School

Child Readiness Domains	Potential Indicator	MT/Missoula Measure
Physical Well-Being and Motor Development	% of children with age-appropriate fine motor skills	
Social and Emotional Development	% of children who often or very often exhibit positive social behaviors when interacting with their peers	
Approaches to Learning	% of kindergarten students with moderate to serious difficulty following directions	
Language Development	% of children almost always recognizing the relationships between letters and sounds at kindergarten entry	
Cognition and General Knowledge	% of children recognizing basic shapes at kindergarten entry	
Families	**Indicator**	
Mother's Education Level	% of births to mothers with less than a 12th grade education	
Births to Teens	# of births to teens ages 15-17 per 1,000 girls	
Child Abuse and Neglect	Rate of substantiated child abuse and neglect among children birth to age 6	
Children in Foster Care	% of children birth to age 6 in out-of-home placement (foster care) who have no more than two placements in a 24-month period	
Communities	**Indicator**	
Young Children in Poverty	% of children under age 6 living in families with income below the federal poverty threshold	
Supports for Families with Infants and Toddlers	% of infants and toddlers in poverty who are enrolled in Early Head Start	
Lead Poisoning	% of children under age 6 with blood lead levels at or above 10 micrograms per deciliter	

Services – Health	**Indicator**	
Health Insurance	% of children under age 6 without health insurance	
Low Birthweight Infants	% of infants born weighing under 2,500 grams (5.5 pounds)	
Access to Prenatal Care	% of births to women who receive late or no prenatal care	
Immunizations	% of children ages 19-35 months who have been fully immunized	
Services – Early Care and Education	**Indicators**	
Children Enrolled in an Early Education Program	% of 3- and 4-year-olds enrolled in a center-based early childhood care and education program (including child care centers, nursery schools, preschool programs, Head Start programs, and pre-kindergarten programs)	
Early Education Teacher Credentials	% of early childhood teachers with a bachelor's degree and specialized training in early childhood	
Accredited Child Care Centers	% of child care centers accredited by the National Association for the Education of Young Children (NAEYC)	
Accredited Family Child Care Homes	% of family child care homes accredited by the National Association for Family Child Care (NAFCC)	

Source: National School Readiness Indicators Initiative (2005)
http://www.gettingready.org/matriarch/d.asp?PageID=303&PageName2=pdfhold&p=&PageName=Getting+Ready+%2D+Full+Report%2Epdf

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PART IV

Joint Council Focus Group Summary Points

(Meetings held 5/24/12; 6/7/12; 6/29/12; 7/24/12; 7/31/12; 8/23/12 & Email)

1) Need for increased communication, coordination and collaboration among agencies and services (5-24, 6-7, 6-29, e-mail input)
   - 1.1 Team approach to serving families
   - 1.2 Shared resource tracking
     - 1.2.1 Determine how many agencies serve same families, what services offered, consolidate, and share updated information
   - 1.3 Collaboration may reduce duplication, increase efficiency, and improve services.
   - 1.4 Inter-documentation among agencies, sharing assessments of commonly-shared clients and willingness to embrace on tool across agencies to assess families
   - 1.5 Combined home visits would provide feedback, identify practices other agencies may benefit from, and help staff gain a more comprehensive picture of families' situations
   - 1.6 Need standardized (although modifiable to agency needs) way to evaluate child care and home visiting that can be used across the community, may help with efficiency, may give status
   - 1.7 Agencies should be willing to refer outside established partnerships
   - 1.8 Bring health care providers to the table to educate about family services, early childhood
   - 1.9 Need to address sustainability of system collaboration efforts; program funding often limits the ability to support additional administrative structures; reductions in program funding also affect sustainability
     - 1.9.1 Day-to-day program operations, administrative structures and program enhancements are generally all integrated. Extra funds are not available for additional administrative structures or program enhancements, such as additional home visits, or the agencies would already be utilizing funds for those purposes.
   - 1.10 Although agencies generally complement each other rather than competing, there is still some overlap. Individual agency self-interest and competition for funding occurs.
   - 1.11 Each child should have only one case manager. When programs compete, treatment plans are less effective and more difficult for the families.

2) Need for increased and improved communication with families (5-24, 6-7, 7-24)
   - 2.1 Need a directory of services website as a reference to families
     - 2.1.1 Is underutilized and can be a great source of information and referrals
   - 2.2 Need for agencies to communicate with families what they do and don't do
   - 2.3 Need for including parents in the entire process, finding a balance between recognizing parents' expertise and informing them of early childhood education/ services.
   - 2.4 Need to better support/educate/empower families
     - 2.4.1 Better system of asking and understanding parents wants/needs, and helping families address their needs
     - 2.4.2 Need to do a better job engaging and involving parents, recognizing it can be challenging to secure parental involvement; need to ask for parent input about programs
     - 2.4.3 Reframe client assessment: include positive wording and identify parents' strengths, not only risks
   - 2.5 Need to match home visiting education messages with families' education levels; health messages may not always be getting to families
   - 2.6 Electronic data collection could serve to give parents a visual representation of their child's developmental progress.

3) Need for increased and improved communication with the community and outlying areas (5-24, 6-7, 6-29, 7-31, 8-23)
   3.1 Need for agencies/service providers to create a coordinated, unified, and shared message/collaborative mission for the public; need to give key messages to the community; messaging can increase buy-in from additional community sectors
      3.1.1 Community needs to understand and embrace prevention; a unified message needs to be crafted that focuses on primary prevention, the importance of early childhood, and the need for social supports
      3.1.2 Community needs to understand generally the importance of early childhood
      3.1.3 Community needs to understand the costs of being exposed to violence and "unreadiness" for school
      3.1.4 Specific health messages and targeted supportive services, such as home visiting, should be provided to the population at the appropriate time in their lives, using the life course prospective
      3.1.5 Need to move from deficit model to all-encompassing approach by normalizing and removing stigma from accessing services, showing that all populations are vulnerable and all children are at-risk, changing language (e.g., from "intervention" to "enrichment" for every child; framing seeking help as "trendy"; using words like "resilience"), and reducing fear that agencies "are out to get them" by emphasizing community health and resources
      3.1.6 Every child should be screened and screened early
      3.1.7 Need to make home visiting more understandable and explain why it is good for the community; need to have home visiting as a community-wide value; benefits of home visiting, such as crime reduction, should be emphasized; increasing capacity of home visiting services would increase buy-in; need to make home visiting as accepted in outlying areas as it is in Missoula where many people participate
      3.1.8 Support can be provided by paraprofessionals, family, friends, and the community as well
      3.1.9 Need to define and promote "family friendly workplaces"
      3.1.10 Need to increase awareness of importance of early care and education
      3.1.11 Need to better inform rural areas of County about services available
   3.2 Need to define what a healthy community is and how we can get there
   3.3 Need to strengthen buy-in for home visiting and early childhood services and utilize existing buy-in
      3.3.1 Strong support, including "in-kind", from service organizations, churches, private sector, businesses and associations, some obstetricians and dentists, police and government agencies
      3.3.2 Strengthen community buy-in by utilizing physicians, parents, and peer support group leaders as advocates for home visiting and early childhood services

4) Need to address gaps identified in the early childhood system (5-24, 6-7, 6-29, 8-23)
   4.1 Need to develop transition system for childhood services in community
      4.1.1 Need to implement transition meetings with families to clarify who will be providing what services
      4.1.2 Both parents and children need transition support
      4.1.3 When a family moves from one program/agency to another, the application requirements/processes may be different and the family may not follow through
   4.2 Need to address insufficient level of community mental health services, for all socioeconomic levels, and for parents as well as children.
      4.2.1 Need for consistent access to mental health services. Services are not affordable and there are a limited number of practitioners within the system to provide services.
      4.2.2 Need to decrease high level of stigma associated with mental health services

4.3 Need to address middle income gap in services; families may not qualify for services based on income but do not have insurance or cannot afford paying for services or quality child care. The "working poor" fall through the cracks.
4.4 Dental health in early childhood and prenatally has been identified as a need.
4.5 Although there is adequate child care capacity in Missoula, there are limited quality care facilities and limited access to those facilities because of the high cost of quality care.
4.6 Outlying areas of the County have limited capacity and limited quality child care.
4.7 Need to make developmental screenings more accessible.
4.8 Affordable housing needs are not met. Families in shared housing are embarrassed to be receiving services and may drop out of programs.
4.9 The cost of living is high in Missoula County and families' basic essential needs may not be met, resulting in fear of being judged.
4.10 Families who birth at home or at the Birthing Center are not being reached by service providers.
4.11 Agency budget restrictions may impede joint messaging.
4.12 Need to build relationships with college advisors so that there is follow-up about the quality of the students' work and more communication between the agencies and the advisors.
4.13 Need for easy access to services.
4.13.1 Even State 211 may not have answers for families
4.13.2 Difficult for families to apply without help from agencies since applications are complicated and much paperwork is required
4.13.3 Need for common intake form or single point of access
4.13.4 Time frame for being approved and receiving services can be difficult or preclude certain services

5) Need to increase awareness of needs related to child care (5-24, 6-7, 8-23)
5.1 Developmental screenings and appropriate interventions are not the norm in child care
5.2 Training in cultural diversity, health, development, high risk, and maternal and child health are not required unless the child care is accredited
5.3 Various factors affect the stability and quality of relationships children have with child care providers
5.3.1 Factors include the instability of at-risk families' lives, staff changeover at child care facilities due to low-paying jobs, families having more than one child care provider as their schedules change, the fact that caring for 0-3 year olds is not cost effective for providers, use of family members or friends for care (the degree of stability depends on the provider), and the inability of providers to "cope" with some special needs children.

6) Need to address training needs of service providers (6-7, 6-29, 7-24, e-mail input)
6.1 Most agencies do not have training in evidence-based models or practice, which could improve professionalism, but are interested in such training
6.2 Improved cultural sensitivity is a need
6.3 Agency funding is used for day-to-day operations with limited funds for training; some agencies have a portion of their budget that is dedicated to training but generally that training is not open to professionals outside the agency
6.4 Some funding defines and requires the use of "billable units"; sharing expertise with other agency staff is not billable
6.5 Agencies sometimes collaborate to provide shared trainings, with different agencies offering space, speaker, etc. This is often arranged through Healthy Start and the Forum.
6.6 Some State agencies ensure that supervisors get needed support.

7) Need to evaluate services (5-24, 6-7, 7-24)
   7.1 Data collection must be done to measure effects of services
   7.2 Agencies input collected data into their own datasets.
   7.3 Some data are required by funding sources and may not be good measures of developmental outcomes, making it difficult to show effectiveness of programs.
   7.4 Measuring outcomes for ages 0-3 is difficult; ages 3-5 are easier. It's also difficult to measure family outcomes.
   7.5 In the health realm, data can only be shared and compared on the County level.
   7.6 Program data collection could be enhanced by: finding shared tools; adding data fields; enhancing client assessments to better measure outcomes; using technology to input data, reduce error, and increase efficiency.
   7.7 Data "defends" what we do and helps generate funds but anecdotal or unimportant data that will not serve agency needs should not be collected.
   7.8 Internal review is useful for making program improvements; external review emphasizes compliance or accountability, although it may point to deficiencies in your program.

8) Need to be conscious of service costs and level of services needed (6-29, 7-24, 7-31)
   8.1 Paraprofessionals, family, friends and the community can all provide family support, and then in turn, can be supported by the professional community
   8.2 Services can be provided to groups (e.g., free parenting classes)
   8.3 Utilize in-kind resources, such as parents (at child care facilities), nursing students, UM undergraduates, and social work graduate students. Access goods, services, and grants from service organizations, nonprofits, churches, businesses.
   8.4 Sharing in-kind resources can be difficult since funding sources often have different accountability measures
   8.5 Need a systems way to streamline the system so that costs could be cut. For example, savings could perhaps be made on supplies, food, insurance, and accounting.

9) Need to celebrate early childhood system strengths (6-29)
   8.1 Nutrition services are a strength; can refer to SNAP, WIC, the Food Bank, EFNEP; agencies model good nutrition through local community events.

SECTION V
Parent Survey

1. What is the size of your household, by age?

Answer Options	Response Total	Response Count
Less than 1 year	8	8
1 year old	7	7
2 year old	16	14
3 year old	21	20
4 year old	48	45
5 year old	14	14
6 year old	13	13
7 year old	7	7
8 year old	14	11
9-12 years old	15	14
13-17 years old	12	11
Adult (18+ years)	173	67
	answered question	**84**
	skipped question	**0**

2. I have children for whom I am currently caring. I am a:

Answer Options	Response Percent	Response Count
Parent	97.5%	79
Grandparent	3.7%	3
Family Member	0.0%	0
Foster Parent	1.2%	1
Step Parent	4.9%	4
Other (please specify)		0
	answered question	**81**
	skipped question	**3**

3. Do you reside at, or near, one of the following cities/towns?

Answer Options	Response Percent	Response Count
Bonner	4.9%	4
Condon	0.0%	0
Frenchtown	2.5%	2
Huson	0.0%	0
Lolo	3.7%	3
Milltown	1.2%	1
Missoula	91.4%	74
Seeley Lake	0.0%	0
Other (please specify)		2
	answered question	**81**
	skipped question	**3**

OTHER
Potomac
Arlee

4. What is the racial/ethnic identification within your household?

Answer Options	Response Percent	Response Count
Black or African-American	2.4%	2
American Indian or Alaskan Native	12.0%	10
Asian/Pacific	3.6%	3
Hispanic/Latino	4.8%	4
Caucasian	86.7%	72
From multiple races	2.4%	2
Some other race (please specify)		0
	answered question	**83**
	skipped question	**1**

5. What is the primary language spoken in your home?

Answer Options	Response Percent	Response Count
English	100.0%	82
Spanish	1.2%	1
Other (please specify)		1
	answered question	**82**
	skipped question	**2**

OTHER
both

6. Select the employment status of the primary adult(s) in your home?

Answer Options	1st Adult	2nd Adult	Response Count
Employed, working 1-39 hours per week	41	19	60
Employed, working 40 or more hours per week	25	14	39
Not employed, looking for work	6	5	11
Not employed, NOT looking for work	3	12	15
Retired	1	1	2
Disabled, not able to work	1	1	2
		answered question	**82**
		skipped question	**2**

7. Please select your household income bracket.

Answer Options	Response Percent	Response Count
under $15,000	31.3%	26
$15,001 - $30,000	32.5%	27
$30,001 - $45,000	8.4%	7
$45,001 - $60,000	8.4%	7
$60,001 - $75,000	7.2%	6
$75,001 - $90,000	9.6%	8
over $90,000	1.2%	1
Information withheld	1.2%	1
	answered question	**83**
	skipped question	**1**

8. How do you feel your family is doing financially?

Answer Options	Response Percent	Response Count
Not making ends meet	7.2%	6
Struggling	20.5%	17
Just getting by - No extra funds	38.6%	32
Just getting by - Can afford a few "perks"	26.5%	22
Doing well	7.2%	6
answered question		**83**
skipped question		**1**

9. What is the highest level of education you have completed?

Answer Options	Response Percent	Response Count
Did not attend school	0.0%	0
Did not complete high school	7.4%	6
Graduated from high school/GED	24.7%	20
Some College	24.7%	20
Associates degree	7.4%	6
Bachelor's degree	23.5%	19
Graduate school or Professional school	12.3%	10
answered question		**81**
skipped question		**3**

10. Where do you currently get information about community services/programs for children & families?

Answer Options	Response Percent	Response Count
TV	24.1%	20
Radio	33.7%	28
Newspaper	38.6%	32
Internet	56.6%	47
Posters, flyers, etc.	36.1%	30
Preschool/childcare provider	33.7%	28
Home visits	10.8%	9
Friends/family	72.3%	60
Medical provider	13.3%	11
School district	26.5%	22
Social media/Facebook	42.2%	35
Libraries	6.0%	5
I find it hard to get information	9.6%	8
Other (please specify)		5
answered question		**83**
skipped question		**1**

OTHER

1. Other services and experience
2. Health department - WIC
3. My child is disabled and is on 4 CDC services
5. Mamalode Online
6. WIC

11. How do you prefer to get information about community services/programs for children and families?

Answer Options	Response Percent	Response Count
From my Doctor's/Specialist's office	19.3%	16
From agencies I already visit	22.9%	19
Newspaper	20.5%	17
Internet	49.4%	41
E-mail	32.5%	27
Personal referral	26.5%	22
Home visits	9.6%	8
Word of mouth	33.7%	28
Family/Friends	56.6%	47
Social Media/Facebook	38.6%	32
Preschool/childcare providers	31.3%	26
Other (please specify)		4
	answered question	**83**
	skipped question	**1**

OTHER
1. School
2. School
3. Schools
4. School District

12. What concerns you the most about raising children birth to 8 years of age?

Answer Options	1st	2nd	3rd
Access to services	5	3	2
Childcare and early education (Preschool, Pre-K, Head Start, etc.)	8	8	14
Child's health and/or development	17	8	7
Healthcare system and/or health insurance	5	15	6
Finances	22	14	16
Planning for the future	5	11	15
Child's safety/violence and/or unsafe communities	11	7	9
Parenting education skills	6	1	3
Social supports/sense of community	7	6	13
Mental health	2	2	8
		answered question	**81**
		skipped question	**3**

13. Do you currently receive home visiting services? If yes, from whom? (Check all that apply)

Answer Options	Response Percent	Response Count
Child Development Center	21.7%	5
Missoula City-County Health Department	30.4%	7
Child Start, Inc. (Head Start)	47.8%	11
Missoula Early Head Start	13.0%	3
Parenting Place	0.0%	0
Mountain Home Montana	0.0%	0
Word (Futures)	8.7%	2
Other (please specify)		12
answered question		**23**
skipped question		**61**

* (N=22) *There was no option for "No current home visiting services"*

OTHER

1. Winds of Change
2. Have received from CDC & MCCHD but not currently
3. PD Waiver
4. HCBS, in home PT
5. None
6. Home visits from WORD (parents as teachers) but have quit that program
7. Winds of Change, mental health center
8. Full Circle
9. Early Head Start
10. NA
11. Full Circle
12. Haven't had any home visits

14. Have you been the recipient of home visiting in the past?

Answer Options	Response Percent	Response Count
Yes	49.4%	41
No	50.6%	42
answered question		**83**
skipped question		**1**

15. What was the result of the home visiting experience?

Answer Options	Response Count
	42
answered question	**42**
skipped question	**42**

OTHER

1. I love all my home visits! It not only gives me advice and ideas from different people and perspectives, but also as a single mom gives me a chance to have adult conversations and I don't feel like I'm talking to a wall. :-)
2. Good
3. Visit after birth of first baby. Nurse helped me with breastfeeding and linking to community services.

4. CDC. Our son was dx with a developmental delay at 15 months. Graduated from CDC services at age 3, but still needed OT and other outside assistance.
5. For our particular household, I felt the visits were unnecessary. I did not follow up with or continue with the agency or programs.
6. Good
7. My daughter was born prematurely & at the time the mother of a good friend was a nurse working at the Health Dept. She set up some visits for me when we first got out of the NICU. It wasn't "official" but she brought me lots of information on newborns & helped with nursing. It made the transition from hospital to home smooth.
8. Our home visits I really enjoyed and so did my daughter. In our environment and very helpful!
9. Lactation consultant from the health department. Learned about and how to breastfeed.
10. They helped us as we were struggling with behavioral and health issues with my sons.
11. We have home visits for one of my children with a serious heart condition. I think these services have been very professional and helpful.
12. Child Development Center-home visits for over a year. Caseworker missed my son's autism completely. No help at all. Extremely disappointed in CDC!
13. Our home visiting nurse was amazing and so supportive and helpful. We were very grateful for the help and the peace of mind - not having to worry so much about our child struggling with health concerns.
14. Our home visit is next week
15. Head Start teacher visit. It was wonderful. My son had a lot of fun talking and showing off his Spiderman room and game
16. Need more time for visit
17. It going well. Working on Brookelyn's diet and right food to eat.
18. Great we get along great with are teachers
19. WIC and Futures
20. It told us a lot how Jordin was doing.
21. It was good, public health nurse visited about breastfeeding & everything through WIC
22. It is a wonderful experience and a great help to me, my husband, and my children. We receive the help and care that we can't afford outside our home.
23. I liked it as far as it helping me to teach my children while they were at such a young age and every week we would get a new book.
24. I have been very pleased with nearly every home visiting services I have had. I have had one bad experience with a past head start advocate, and I think other than that I LOVE having home visits. It lets me be in the comfort of my own home, and lets my children be in their regular environment; therefor I don't have to worry about spending the visit making sure they aren't destroying offices! Ha!
25. It was very helpful in a lot of ways helping us learn and grow as a family thank you so much for all that you have done
26. It was nice everything went alright
27. Head Start visits are always fun and informative. We were able to learn new activities to try with our kids and different and helpful parenting strategies.
28. I find the social worker that I meet with to be very helpful.
29. Public Health Nurse while I was pregnant with Mya
30. Kitty was a great help for Jonathan and Mahje about what services that could help them
31. I absolutely love it! I have had it for all three of my boys and it has been so wonderful to get them excited and ready for school. I also love how it helps me to be a better parent. I really appreciate the services and woman who have come to my home and helped me and my family from both Head Start and Early Head Start.
32. They were a good time to hear about results, problems, concerns, progress, what more we

could do at home, and getting to know teachers better.
33. Just to talk. We never had any specific problems.
34. It was good; the home visits were for my two girls who were in preschool last year. The person that came to the house gave me information about my children that helped me know how they were doing in school.
35. My children were very comfortable
36. Having the opportunity to discuss current issues with children's needs and making sure we are all on the same page working as a team.
37. Great and learn new things all the time.
38. I had home visits through the parents as teachers at word. They helped me make sure my child was developing where he should and taught me games that I could play with him that would help him learn.
39. Just head start. Went fine.
40. Not any
41. It was great 3 of my children went to head start and we really enjoyed the home visit.
42. good

16. Would you recommend the home visiting experience to other parents of infants and young children? If no, please explain.

Answer Options	Response Percent	Response Count
Yes	90.6%	48
No	9.4%	5
Other (please specify)		6
answered question		**53**
skipped question		**31**

OTHER

1. It made a huge difference in my confidence. She helped me recognize postpartum depression.
2. If there are special needs of the child or parent.
3. Have not had a visit yet
4. Especially young parents and parents with younger children
5. Definitely!
6. Some people have a hard time getting out of the home. House visits are nice for that reason. It also gives an outside look into a child's situation and help where there is a need

17. What individuals, groups or organizations do you look to for support and assistance?

Answer Options	Response Percent	Response Count
Family/friends	87.7%	71
Other parents	44.4%	36
Neighbors	27.2%	22
Church or religious organizations	22.2%	18
Other non-profit organizations	21.0%	17
Neighborhood councils	1.2%	1
City, County or State Agencies	37.0%	30
Other (please specify)		7
answered question		**81**
skipped question		**3**

OTHER

1. Futures/word, Winds of Change
2. Without family in the area, and not currently enrolled in any non-profits/churches/agencies, I find it difficult to seek out support for my family, advice, childcare referrals that I can trust, etc.
3. Child Development Center
4. In 2011, my husband was finishing his Associate's Degree and being home with the children while I worked more than 50 hours per week at 3 different jobs. At that time we turned to SNAP for public assistance with food and energy costs.
5. Families First have been great for parenting advice. Our kids are on Healthy MT Kids program. They are wonderful, organized and supportive.
6. Winds of Change, mental health center
7. I also have a teenager; I look for support for him.

18. What services offered in your community have you, as a parent or guardian, participated in?

Answer Options	Response Percent	Response Count
Prenatal care	47.6%	39
Breastfeeding/Lactation Nurse	45.1%	37
Nutrition/WIC	68.3%	56
Child development classes or screenings	32.9%	27
Child care scholarships	17.1%	14
Academic assistance/learning needs	9.8%	8
Parent education	23.2%	19
Managing Child's behavior	15.9%	13
Getting ready for school	18.3%	15
Activities for children	42.7%	35
Physical wellness/health	35.4%	29
Special Needs	12.2%	10
Mental or emotional issues	14.6%	12
Assistance with domestic/child abuse	4.9%	4
Financial assistance	25.6%	21
Housing assistance	29.3%	24
Food assistance	52.4%	43
Health insurance	42.7%	35
Day care	45.1%	37
Preschool or Head Start	64.6%	53
Medical care	36.6%	30
Transportation	11.0%	9
I do not know what services are in my community	2.4%	2
Other (please specify)		4
	answered question	**82**
	skipped question	**2**

OTHER

1. Health fairs, community family events
2. Insurance just for son. Just starting preschool
3. YMCA Financial Assistance & Child Watch Center
4. Celebrate recover

19. What needs does your family have that are not being met?

Answer Options	Response Count
	49
answered question	**49**
skipped question	**35**

1. "Financial help after the age of 22. Help with adult medical and medication co-pays
Adult interaction - it is hard to find people that want to and have time to come around."
2. "Good paying job Gap in assistance for those trying to become self-sufficient"
3. Getting out of TV habit, family meals
4. Mostly financial. Property taxes are killing us. We make a very decent income, have one car, live in a modest house, but have daycare and pre-college costs that make us barely squeak by.
5. A more affordable healthcare option. Our monthly premiums cut deeply into our budget and the extremely high deductible is nearly impossible to meet.
6. Lacking health insurance for both parents.
7. We are fairly reliant on the SNAP program and appreciate the service greatly, but the system has been fairly unreliable, and the office difficult to work with.
8. Social opportunities for my child and for us. Socially isolated due to her special needs. Educating others about special needs to ensure inclusion not isolation
9. None
10. Most of the needs we have are being met. We do have issues with blending our family & parenting classes for how to do that would be nice. I am not sure if there are such things in our income bracket. Our blending issues stem mostly from my step-children's mother...if only there was a class we could get HER to take. Something that would teach her how detrimental it is to constantly talk negatively about the kid's father, how detrimental it is to have them in the middle of every child-support payment....
11. Daycare or preschool close to home (Potomac)
12. In-home childcare/respite care.
13. Affordable childcare with someone we can trust in a home based setting. Parents do not have access to medical insurance through work so pay a ridiculous amount of money each month for a basic major medical plan-baby at least has Healthy MT Kids. Struggle to afford healthy food, do not qualify for assistance due to assets and we refuse to eat junk like overly processed cheap food.
14. We don't really have someone now that we can go to about current behavioral and emotional issues. We used to have CCR and then Full Circle to help us with that stuff, but lately some things have come up and I'm not sure who to talk with...
15. "Ability to develop year-round sustainable work-family balance (husband works seasonally, I work full-time plus, much of the ""plus"" during the academic year).
Slow housing market (our home in Alberton has been on the market for 4 years while we have been living in Missoula (and paying rent) during that time- family budget is tight."
16. I wish I had found out about the autism services available through the Child Dev. Center sooner. My son is 6 now. We are just getting started with those services.
17. I wish that we had a free pre-K for all program in Montana. We have two preschool age kids and the cost of having them both in preschool is very difficult for us. We have a two income household, so I know we are quite fortunate in that regard- and yet it is still a huge challenge.
18. I would love to get all of my children braces, I feel as though the healthy development of their teeth and mouth is very important, but it is very hard to obtain a referral.
19. Financial--hard to keep up with mortgage, bills, extra-curricular activities.
20. At this moment none
21. Play Groups for social interaction during summer
22. I wish we owned or were in the process of owning our own home.

23. Lack of transportation from one place to another
24. None
25. Everything being met. Need a raise at work.
26. Just money it's never enough to catch up
27. Would like to live without having to rely on the government. (i.e. food stamps and subsidized housing)
28. Diapers, and clothing
29. Riley needs new fall clothing for school and we don't have the extra funds at this time.
30. None
31. For our family of four, we are doing really well. We wish the economy was better, so my husband can find a job that better supports our family, but other than that we are really comfortable.
32. Job availability
33. Help paying rent and utilities, I am on the Missoula Housing waiting list for a year and 3 months now. Wondering if there are any resources out there that may help with that.
34. Help and donations of materials to finish remodeling new mobile home ASAP!, financial needs-so behind on bills I can't catch up, if I can get a little help getting on track I can stay on track, clothing for kids and me.
35. We are doing very well looking to brighten our future and our family and grow
36. Transportation
37. We could really use full day child care
38. The school system seems they have failed my children and with hope they will not with my grandchildren
39. Honestly we have already sought out help where needed and now it is just a waiting game to move forward. :)
40. Employment: re-training, job search, daycare
41. No work. Low economy and lack of training to obtain jobs we would like without paying an arm and a leg. i.e. it costs to take training classes such as CNA, dental assistant, etc. but then it is hard to get a job without training
42. Eye exams
43. Finding childcare or a school that will fit with my school schedule, my classes are between 10 to 2 and my daughter classes ends at noon so it will be hard for myself to pick her up when I am in class.
44. Housing
45. Transportation for special equipment.
46. None at this time
47. I am not really too sure what exactly needs are not being met. Probably going to school to get a better paying job, so that I can support my son without needing assistance would be something I would hope for.
48. I need to find more activities for my children ages 4,5,15. Hard to do with such a range of age.
49. We are making ends meet. Doing ok.

20. What services in your community have you applied for or were referred to, but did not use?

Answer Options	Response Percent	Response Count
Prenatal Care	0.0%	0
Breastfeeding/Lactation Nurse	3.0%	1
Nutrition/WIC	24.2%	8
Child development classes or screenings	6.1%	2
Child care scholarships	30.3%	10
Academic assistance/learning needs	12.1%	4
Parent education	6.1%	2
Managing child's behavior	9.1%	3
Getting ready for school	9.1%	3
Activities for children	9.1%	3
Physical wellness/health	6.1%	2
Special needs	6.1%	2
Mental or emotional issues	6.1%	2

Financial assistance	12.1%	4
Housing assistance	15.2%	5
Food assistance	12.1%	4
Health insurance	9.1%	3
Day care	15.2%	5
Preschool or Head Start	12.1%	4
Medical care	9.1%	3
Transportation	3.0%	1
I do not know what services are in my community	9.1%	3
Other (please specify)		7
	answered question	**33**
	skipped question	**51**

OTHER

1. Well child clinics when kids were little
2. If I didn't apply I could not get denied.
3. None
4. None
5. None
6. None
7. I have used everything I have been offered

21. Are there services offered by your community for which you or your child has been placed on a "wait list, weren't eligible, or there wasn't enough of the service available?

Answer Options	**Response Percent**	**Response Count**
Prenatal care	0.0%	0
Breastfeeding/Lactation Nurse	0.0%	0
Nutrition/WIC	2.6%	1
Child development classes or screenings	0.0%	0
Child care scholarships	10.5%	4
Academic assistance/learning needs	0.0%	0
Parent education	0.0%	0
Managing child's behavior	0.0%	0
Getting ready for school	2.6%	1
Activities for children	0.0%	0
Physical wellness/health	5.3%	2
Special needs	7.9%	3
Mental or emotional issues	0.0%	0
Financial assistance	21.1%	8
Housing assistance	39.5%	15
Food assistance	7.9%	3
Health insurance	18.4%	7
Day care	18.4%	7
Preschool or Head Start	36.8%	14
Medical care	10.5%	4
Transportation	0.0%	0
	answered question	**38**
	skipped question	**46**

22. What has been difficult about services/programs you have used in your community?

Answer Options	Response Percent	Response Count
Location of service/program	15.3%	9
Cost of service/program	47.5%	28
Knowledge of service/program	39.0%	23
Quality of service/program	25.4%	15
Available space for service/program	28.8%	17
Service/program I need is not available	8.5%	5
Schedule of service	20.3%	12
Other (please specify)		5
answered question		**59**
skipped question		**25**

OTHER

1. We make too much money to qualify for many types of assistance. We're in the gap.
2. I'm considering HMK health insurance in Helena to be a part of this community. Once you have the coverage, it's great. But to get it is a HASSLE!
3. None
4. None
5. Money for fuel to get to program

23. If you applied for services/programs and did not use them, what was the reason they were not used?

Answer Options	Response Percent	Response Count
Do not want	17.5%	7
Do not qualify	35.0%	14
On wait list or cannot get a spot	22.5%	9
Do not know how to ask for/apply for what I need	25.0%	10
Cannot get to the service - distance or transportation barrier	7.5%	3
Cannot get to the service - hours do not work for me	12.5%	5
Friend or relative had a bad experience with the service	7.5%	3
I had a bad experience	17.5%	7
Please explain		14
answered question		**40**
skipped question		**44**

OTHER

1. Early Head Start ends at 3. How do all of these parents get off at 3?
2. The food available via WIC is unhealthy. I prefer debt to feeding my family with low quality foods.
3. The WIC checks were constantly changing and I was always sent out of line to get the appropriate food item. Once my grapes weighed too much and they broke off a section and threw them in the garbage. (Would not let me pay the difference.)
4. Too many assets (vehicles) but they are needed for self-employment so cannot sell them
5. Some child care - we have been on waiting lists but had poor impressions of the facilities/programs during tours or previously.

6. Offered WIC but chose to opt-out. Doing fine w/food and didn't want to take away from those who do need it.
7. Not at this time
8. I have no transportation and work 6 days a week
9. Tanf was a nightmare!
10. I use all my services if available.
11. Child care-I don't allow many people to watch my children, it's hard finding a sitter I trust
12. Expensive and/or scheduling issues.
13. The lady that had my case had a very poor attitude. She was very rude and short with me when I would ask questions.
14. How to get housing assistance

24. Are there services that are not available that you would like your community to offer?

Answer Options	Response Count
	29
answered question	**29**
skipped question	**55**

1. "Transportation assistance - other than bus Emergency housing immediately!"
2. "More child care assistance more jobs all day preschool assistance"
3. More support for parents with respect to helping navigate the school system. Even though my child received early childhood services and has documented special needs, getting any kind of accommodation has taken FOREVER. It took 3 years to get a 504 and even then the district reluctantly granted it (only after threat of legal action). There has to be a better way to work together for the benefit of children.
4. Free state mandated preschool for children that are not special needs.
5. Healthy Montana Adults! Health coverage for parents who stay at home.
6. As above...how about camps for developmentally disabled kids, special swim lessons and times. Anything that spec kids and their families could be involved in to meet other families like ours and not be so isolated within a community that is known for being "kid friendly"...I guess that means typically developing kids.
7. More activities/sports programs in Lolo. We shouldn't have to drive to Missoula for all our activities.
8. No
9. A directory or agency to assist parents of special needs children who need in-home care or "nanny" services. I had no idea how to find a person to come into my home when attending another care facility was not an option due to medical issues.
10. Childcare co-op, affordable healthcare for adults (similar to Healthy MT kids but for adults)
11. "A park for special needs kids...
More information for the general public about special needs/autistic kids
more family restrooms"
12. We were very fortunate to get a HCBS Medicaid Waiver slot for my son. These slots should be available to every child that qualifies. I don't know what we would do without this program. I am not aware of any, but it might be helpful to have meetings for parents specific to their children's disability.
13. N/A
14. None
15. No
16. No
17. Not that I can think of
18. Job placement programs for parents
19. No
20. No, the community offers a huge variety of services.
21. Nanny services

22. I strongly believe there should be an emergency TEMPORARY housing facility for families, as of now, women and children go to one place and men go to another, so in their time of support needs, families are divided, making the situation harder. But I believe that there should be a limit and strong rules on how long families can stay. They should be required to show applications for jobs, and what they are working on to better their lives to get back out on their own
23. I would like to see if my husband and I could get some health insurance
24. Building neighborhood networks--taking ownership of our community.
25. Job training to help families get on their feet.
26. Emergency funds for bills
27. No
28. Parent play groups for children out of school district.
29. I very rarely hear about services.

25. What trainings would help you as a parent?

Answer Options	Response Percent	Response Count
Understanding my child's health and development	33.3%	19
Locating and receiving information and resources	28.1%	16
Becoming involved in your childcare center or preschool	21.1%	12
GED/Adult education	8.8%	5
Literacy/Helping my child read	21.1%	12
Behavioral/Discipline	54.4%	31
Nutrition	15.8%	9
Mental health	12.3%	7
Physical activity	26.3%	15
Getting ready for kindergarten	33.3%	19
Financial education	43.9%	25
Other (please specify)		2
answered question		**57**
skipped question		**27**

OTHER

1. Vaccination literacy. Non-biased.
2. None

26. What preschool/childcare options do you currently have your child/children in?

Answer Options	Response Percent	Response Count
Nanny/Babysitter	7.8%	6
Home care (someone else's home)	7.8%	6
Home care (in my own home)	5.2%	4
Day care	19.5%	15
Preschool	26.0%	20
Montessori School	7.8%	6
Family member care	15.6%	12
Head Start	29.9%	23
Private K-1 preschool	1.3%	1

A parent is at home	32.5%	25
Neighbor (or friend) care	3.9%	3
Other (please specify)		8
	answered question	**77**
	skipped question	**7**

OTHER
1. Public school K-5
2. 1st grade
3. YMCA after school care
4. respite care worker (PD waiver)
5. I work an average of 3 days/month.
6. After school campfire program
7. Parenting Place respite care
8. Kindergarten

27. What preschool/childcare options have you used in the past?

Answer Options	Response Percent	Response Count
Nanny/Babysitter	27.5%	22
Home care (someone else's home)	21.3%	17
Home care (in my own home)	8.8%	7
Day care	55.0%	44
Preschool	35.0%	28
Montessori School	10.0%	8
Family member care	33.8%	27
Head Start	21.3%	17
Private K-1 preschool	5.0%	4
A parent is at home	40.0%	32
Neighbor (or friend) care	16.3%	13
Other (please specify)		2
	answered question	**80**
	skipped question	**4**

OTHER
1. Early head start - home visits
2. Summer camp

28. When selecting a preschool/childcare provider (referred to as "provider" below) how important are the following qualities?

Answer Options	Not important	Important	Very Important	N/A	Response Count
Provider's environment/cleanliness & safety	0	6	76	0	82
Provider's curriculum/philosophy	0	31	51	0	82
Researching provider's local reputation	3	20	59	0	82
Distance to provider from home	12	37	30	2	81
Observing a day at the provider's facility	4	39	37	2	82
Meals (vs. snacks) are provided	11	24	45	2	82
Provider or teacher/child ratio	0	18	63	1	82
Cost for child to attend provider's facility	2	22	58	0	82

Services for special needs children	13	18	25	25	81
Volunteer opportunities at provider's facility	27	28	23	4	82
Parent education support	23	30	27	1	81
Licensed or registered with the State of Montana	7	16	58	1	82
Provider-to-home communication	2	17	61	1	81
Provider training and education backgrounds	1	20	58	0	79
				answered question	**82**
				skipped question	**2**

29. What was good about preschool/childcare providers you have tried? What was difficult?

Answer Options	**Response Count**
	55
answered question	**55**
skipped question	**29**

1. "Good - knowing my children are safe, fed and taken care of in all aspects of parenting/childcare Difficult - finding the ""as perfect"" as perfect can be sitter for my children. Sitters quitting or refusing the job because of the low pay from the state."
2. "Difficult affordability complications surrounding assistance school aged children getting to daycare while parents work Good: communication"
3. "Friendly provider, close to home. Kids liked being there.
difficulty was the husband of provider smoked in the presence of my children, TV was on most of the day, and place smelled like cat urine"
4. Open and willing to compromise and adapt to my son's special needs, although this was not always smooth. Young, undertrained, underpaid staff not understanding developmental levels.
5. The teachers are great; qualified, knowledgeable and caring. I wish the service was free and provided by the local school district instead of having to pay for it. I also wish we could afford a preschool that offered more flexible scheduling, i.e. more than three mornings/week for 2 1/4 hours/day.
6. Affordable, clean, and near my home.
7. The only preschool (Northern Rockies Learning Center) we have ever used has been amazing, but the search for a preschool that we really liked was a difficult one.
8. Preschool experience not good for either me or my child. Provider not knowledgeable re: spec needs. Kindergarten and first grade better but my child not getting the kind of education she needs...which is functional, not academic.
9. Nothing was difficult. Communication was great. The kids love the care providers. Price was reasonable. Safe and clean.
10. "I took my daughter to Tot-Town from the time she was two until she started kindergarten. In the beginning I loved it & so did she. It was a place that both her father & I agreed on & that was nice to have a constant in her life even though we split custody. The summer before she started school there were lots of staff changes that made me uncomfortable so I found an alternative to their after-school program. My daughter goes to St. Joseph for school now & since my mother is a teacher there both before & after-school care has been with my parents. In the summers she has been doing the Y day camps. The most difficult thing for us is finding a place we can all agree on (my daughter, her father & me) that is affordable & has space for her."
11. The primary difficulty is their distance from my home.
12. Location, cost, and benefits are not as important as the physical and emotional safety of my child. The childcare situations that worked the best were situations where the caregiver genuinely cared about my child and

parents and child were comfortable and happy. This included opportunities to be in the home/facility to see what my child is doing and what the environment was like.
13. Just started Head Start, not sure yet!
14. Had someone come to our home to watch baby while we worked, felt safe/trustworthy leaving baby at home with someone rather than taking a tiny baby to a large daycare center. Difficulty: the cost! We knew paying for someone to come to our house was more expensive than a daycare but the 1:1 care was worth it. Now I'm a work from home mom and we have no childcare so we never get a break, we can't afford it and don't know any babysitters that don't charge $10+ per hour.
15. "They have worked while there was a strong personal connection between at least one provider and the child- they have fallen apart once that provider left.
Our youngest is at Northern Rockies Learning center- it works because of that personal connection. She's extremely happy there, which makes the high cost, long commute, and additional stress on my life while husband is out of town for the most part worth it."
16. We have had excellent providers. I wish I could afford to send my twins to the same Montessori preschool my daughter attended.
17. The people, kind, well-educated, attentive staff with TONS of patience and compassion.
18. We have been happy with the two daycares we used. Both were small in home providers, under 12 kids, and licensed. We have been very happy with our preschool, but the additional expenses beyond the 9am to 3pm classical school day add a lot to the cost, which is frustrating.
19. "We have only had good experiences, but we have been very choosy, and have sacrificed as a family to prioritize excellent care for our son. I stayed home for a year, until he was 1. Then we had a friend watch him about 2 days a week until he was 2, then a small excellent group home day care 3 - 4 days a week until he was 3, then a wonderful preschool 5 days a week when he was 5. We have flexed our schedules as much as possible (and are fortunate to be in jobs where this is allowed) to keep his time in care to a minimum (no more than 6 -7 hours a day). However, his child care/school is on a par with our mortgage as our single largest expense monthly. We often debate whether we should just have one of us to stay at home, so we could qualify for services! SNAP, Healthy Kids MT, and so on. We don't qualify for any of those because we're doing what we are ""supposed to"" -- work!!"
20. I was involved with the Head Start Program with all three of my children. It gave them a great boost into the school environment and was helpful to all three of them socially. My husband and I adored all of the teachers and appreciated the readiness it instilled in our children for being in an academic environment.
21. Highly qualified teachers, child-centered, community oriented. Communication on my child's day can be sparse.
22. We have only used private day care or private pre-school and the experiences have been amazing except the cost.
23. The communication between the provider and parent.
24. "Good: Clear communication, provider has eye contact and greets parent and child at drop off/pick up, clean environment, educational plan to day. Bad: Unclean environments, lack of engagement by providers with children/parents, no communication at drop off/pick up."
25. I love the Montessori method. I dislike all the birthday parties that have treats as I have a diabetic child.
26. "Good - at home feel for child, great transition Bad- ""family"" of the provider was always around"
27. Caring, connected
28. I liked how the fed and kept my daughter on a schedule but did not like picking my child up and have her come out sobbing because she was in a separate room from other kids.
29. worked with my schedule but it was all mostly bad experience.
30. Family watches Brookelyn for me. This is first time she going to school.
31. Great for social activity
32. Very good. She learned A LOT.
33. The thing that was good was the education that they gave my child to this point in his life. They thing that is difficult is trying to realize that no matter the environment accidents always happen and I can't always be there to watch him.

34. Hours fit my hours. Location was close. Small and personal. Difficult was finding openings in the ones I wanted and getting childcare scholarship paperwork filled out.
35. My sons preschool in Idaho was amazing
36. I have only used head start and I liked it a lot.
37. That the children are well taken care of. That there is a good ratio between children and providers.
38. There is a structure there and you know what you child will be doing and the educational background
39. They were always very reliable. Some providers can be very unfriendly, you can't trust just anyone.
40. Everything is always a challenge that is the way life is all you have to do is work on things together and try the best way to get through it
41. They teach my son a lot of things that i cant
42. The communication we have had with our providers has been the best. They got to know us and our kids.
43. I had a very good experience with Iddy Biddies until I called to see if my daughters Grandpa had picked her up and the owner's older child answered the phone and told me she was not there and neither was his mother. I went to Grandpas house and he had Not picked her up yet and she was still at Daycare.
44. It was a good start for my children
45. I have only used Head Start in both Utah and Montana. I have loved them both. Teachers know what they are doing and are kind. The facility/People are clean. There is open communication.
46. They were people I knew and trusted, had good reports about them prior to using them.
47. Other kids are bullies. Knowing they are safe and being watched closely
48. They always communicated with me about my children's progress in school. This was helpful because I like knowing how my children are doing in school.
49. my children refuse to go
50. Missoula Early Head Start and the Head Start program have both been extremely great at informing our family about needs for our twins.
51. Child Start wonderful program and Playschool daycare great and experience
52. I haven't really put him in daycare before maybe a couple of times. He enjoyed it once he got used to it. The hardest thing though would be his separation anxiety he has a hard time actually wanting to go to the daycare.
53. Good communication about child's day. Difficult-daycare being closed on non-holiday days, sense that my children didn't like being there.
54. The teaching process they show the children
55. it's just hard for me to leave her

30. What problems made it so you wouldn't or couldn't use particular services?

Answer Options	Response Count
	38
answered question	**38**
skipped question	**46**

1. "Feeling in the ""gut"" when interviewing a provider. Providers back ground Providers ""ways"" of teaching or discipline Daycares - hearing bad experiences from friends or knowing a not so great employee at the daycare. Daycare hours and fee/cost rules (not paying for 8 hours when my children are there for 3)"
2. Affordability
3. CDC lost funding when he turned 3 and couldn't continue. He could easily have used another year. We pieced it together as best we could, but our insurance had limits.
4. Took too much vacation, shared a common cup of water with all kids, and allowed kids to play out front along street and no fence. I shared my concern with Health Department 2x and nothing changed. Happy Kids Daycare
5. We removed our child from one home care situation due to safety concerns. My child was injured due to the tolerance of dangerous behavior by the caregiver. The second home care we removed our child from was not caring towards my child.

6. Live out of town and do not go to town everyday so access is sometimes an issue, especially for services across town
7. My son is high needs, Asperger's, and has epilepsy. Many providers that we tried could not handle him. We ended up at Jefferson preschool and LOVED it!
8. Cost!
9. Lack of communication internally and with families. High staff turn-over.
10. Cost
11. We don't qualify for most kinds of benefits because we make too much money. How 45-50K is "too much money" for a family of three I don't understand, but it must be that others are far worse off and need the help more.
12. Our income level changed over the years that we were involved with Head Start and in order to continue working with the program, we began to pay according to their financial assessment of our circumstances. We really struggled to pay and were often late, which made us feel terrible, but not terrible enough to pull our kids out of the program.
13. Poor staff, ratio or high turnover in caregivers.
14. Increase in child's repertory illnesses seemed to correlate to environment of day care.
15. None
16. transportation
17. Didn't qualify, made too much money at DirecTV so I had to get different jot to get the help I needed.
18. None
19. Mostly if i don't like the feeling i get from the start
20. Nothing.
21. Education, Cleanliness, waiting lists
22. A lot of paperwork. Unavailability.
23. cost
24. Finances
25. Just that we didn't qualify
26. My child kept coming home with bruises and he was only 3 months old and his diaper wasn't being changed all day. we had applied for section 8 over 2 years ago and are still waiting with a family of 6
27. No room had to be on the waiting list.
28. gas money, schedule, child care
29. We are not eligible for medal insurance we would like to get insurance
30. See above
31. Waiting list or little services
32. Here in Montana it has been wonderful, the only suggestion is the time. The elementary where my 6 year old goes is at the same time as the drop off for Head Start. I obviously can't be in two places at once, so it is stressful to decide how to handle the situation. I wish there was a 15 minute difference so I could drop both of my kids off each day. In Utah the 1/2 day preschool was about 20 minutes one way. With having to drive back and forth twice a day it was impossible to have my son go.
33. Unfamiliarity
34. I won't use services where I feel my child isn't attended to closely, and where the staff is unclean. If other children are bullies and staff doesn't fix it I will pull them out of care
35. The problems I came across are the schedule.
36. My children would have night terrors
37. When I went with my friend to take her son to busy hands. Upon picking him up they hadn't tried to feed him only some crackers. When they were told he had not eaten this morning. I think the lack of responsability that they showed made me not want to take my child there.
38. Haven't had problems

31. How satisfied are you with services/programs in your community? (Mark level of satisfaction for all that apply)

Answer Options	Not Satisfied	Satisfied	Very Satisfied	Response Count
Amount of information about local services and supports available to parents/caregivers	13	52	14	79
Hours of available services and supports	13	53	12	78
Quality of services	5	55	18	78
Personalized services	12	51	13	76
Positive relationships	7	50	19	76
Outcomes for child	5	52	20	77
Location of services and supports	7	56	13	76
Ease of receiving supports or services	18	46	12	76
Other (please specify)				5
			answered question	**79**
			skipped question	**5**

OTHER

1. OPA is ridiculous - nothing done in timely manner, things lost, and workers unfriendly even when you are friendly to them.
2. I haven't used any services except a licensed daycare
3. I am very satisfied with all services we receive, however I feel that it was a luck and persistence on my part that got us into these programs. I don't know if I would have had access if I had been a parent who could not navigate "the system", had cognitive challenges, or any other limitations.
4. I think that making parents aware of resources is very important. In Missoula, I feel that there are a lot of people who are proactive about their own situation and take advantage of programs and opportunities that exist in our community. People are passionate about advocating and helping others. There seems to be more funding available for establishing services. I feel that is not the case in some of the smaller, more rural MT towns who cannot afford to offer such resources. I have met many low-income people who have moved to Missoula and cannot even imagine the resources existing, much less know how to access them.
5. Just very grateful for the program.

32. Recently in a national data report by The Annie E. Casey Foundation 2012 kidsCount, (http://datacenter.kidscount.org/DataBook/2012/), the State of Montana ranked 50th nationally in overall health. Would you consider partnering with local agencies to help improve Montana's health outcomes?

Answer Options	Response Percent	Response Count
Yes	75.3%	58
No	24.7%	19
	answered question	**77**
	skipped question	**7**

33. Have you ever participated on a board to represent the "parent voice" for any agency?

Answer Options	Response Percent	Response Count
Yes	12.7%	10
No	87.3%	69
answered question		**79**
skipped question		**5**

34. What would make it possible for you to participate or what would prevent you from participating?

Answer Options	Response Count
	54
answered question	**54**
skipped question	**30**

OTHER

1. Prevent - lack of information about group, time and childcare
2. Hours
3. INFORMATION ABOUT OPPORTUNITY
4. Time constraints.
5. My own personal lack of knowledge would prevent me from participating.
6. Timing.
7. Time. Parents are busy people! Not sure that my voice would make a difference.
8. The notion of just being there but not being heard, or, probably, understood
9. My schedule prevents me from participating. I have two young children who spend half their time with me and half with their dad, so I won't give up the time that I do have with them. The rest of my time is spent on school and a part-time job.
10. Flexible hours-maybe on-line attendance/forums to read and contribute.
11. Finding extra time would make it hard to participate. Participation would depend on where and when and how long!
12. It would be difficult to participate with a baby and no childcare
13. Time and energy
14. Time constraints
15. I am willing to participate. I have not heard of any opportunities, but would follow up if they were presented to me. I would like to be more involved. I'm sure you understand that as a parent with three small children, it is sometimes hard to find time to find out all the programs and opportunities available.
16. I already volunteer at my sons' school; I would have to feel VERY strongly about a new volunteer opportunity in order to sacrifice time for it.
17. Time
18. The idea of participating on such a board as someone that works 36 hours/week, while my husband works over 45/week, is unrealistic. We barely have enough time to talk to each other some days, let alone pursue volunteer opportunities like this. I think you would, by default, end up getting a stay at home parent (most likely) which is only one type of voice in the community.
19. I work in the early childhood field and that may present a conflict or confusion?
20. Scheduling
21. Time commitment. Already involved with other non-profits and my children's schools. Hard to make any more time.
22. Time is always an issue - I should be home with my kids
23. Flexibility and childcare.
24. Participation would depend on ability to balance work and family commitments with volunteer opportunities.

25. I'm honestly not sure.
26. Busy Schedule
27. Days off at work
28. Has to work w/college schedule
29. No
30. Just knowing when and where
31. Nothing.
32. Having time prevents me from doing this
33. More information
34. I have a very rigid schedule right now so finding the time would be difficult. i would participate if i could do some of it from home.
35. I work a varied schedule so it is hard for me to participate on a regular basis
36. n/a
37. Time
38. I need more information about them, no one has told me about it yet.
39. s schedule,
40. Someone needs to call me and remind when the events are so I can make arrangements to be there
41. Lack of transportation
42. New baby on the way presently but would be nice in the future.
43. Just knowing about it
44. I have zero extra time
45. If someone actually listened
46. I have three kids, so child care is helpful. Transportation reimbursement if the location is out of town (i.e. Hamilton from Missoula).
47. Knowing who needed help. Personal situations--travel costs would possibly make it harder to participate.
48. Finances would make it hard. Time would make it possible
49. Knowing about the programs and more understanding of it.
50. My current work schedule is very difficult to work around.
51. knowledge
52. It would probably be being able to have the time to participate I work around 40 hours a week and don't have much down time to really participate in groups.
53. I'm a single mom, and my time is spent right now with children so young, making it from day to day and staying a float
54. Letting me know what I have to do to participate

35. Please share any additional comments or ideas.

Answer Options	Response Count
	13
answered question	**13**
skipped question	**71**

1. This is a great city to raise kids. Still, I worry that low income folks don't have access to quality child care or the luxury of time to pursue better options.
2. Frenchtown needs sidewalks!
3. Our beautiful state of MT should rank much higher than 50! Let's improve our health!
4. Thank You
5. Thank you
6. N/A
7. N/A

8. I am thankful for Missoula Head Start and I hope my child get a good start on her future and is ready for grade school when the time comes.
9. Parents should get more invitations to come to school with their children. Information on other groups, community events, classes, etc. should be better advertised. Children should be more welcome to come with parents to appointments, groups, etc.
10. I am so thankful that Head Start is here they have helped us with allot of enjoying things to help our family grow
11. I have recently moved to Missoula, from Utah so I am not too familiar with all of the programs and community options available. I feel like the things that i know about are fairly easy to find or find someone to direct you to the correct place if you are willing to ask for help. A lot of the programs have a lot of paper work and verification, BUT i am totally okay with that! So many people complain about how hard it is to get government and community assistance. Well you are getting help, be grateful and be willing to work to earn that help. I am SO grateful for all of the help that my family and I have received. I only hope that someday I can repay it :)
12. "It would be helpful if Head start could help parents receive training in some way. To get on our feet financially is hard enough but it is even harder when appropriate training isn't available at a decent cost. Also the food classes offered by the state is a good program to help struggling families"
13. The programs I have been involved with have been very helpful. The people I have come across are very nice and professional, they try to help me in any way they can.