

**Maternal and Child
Health Services Title V
Block Grant**

North Dakota

**FY 2017 Application/
FY 2015 Annual Report**

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I. General Requirements

I.A. Letter of Transmittal



NORTH DAKOTA
DEPARTMENT of HEALTH

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July 13, 2016

Director
Health Resources and Services Administration
Maternal and Child Health Bureau
Division of State and Community Health
5600 Fishers Lane, Room 18-31
Rockville, MD 20857

To Whom It May Concern:

Enclosed are North Dakota's FY 2017 Title V MCH Grant Application and FY 2015 Title V MCH Annual Report.

The North Dakota Department of Health serves as the grantee for the Title V MCH Grant. The Title V Program is administered by two divisions within the Health Department, the Division of Family Health, which administers programs for mothers, infants, children and adolescents, and the Division of Children's Special Health Services (CSHS), which administers programs for children with special health care needs and their families. Staff from both divisions worked closely together in preparing the application and annual report.

Questions pertaining to maternal, infant and child populations of the enclosed application may be directed to Ms. Kim Mertz, Director, Division of Family Health, North Dakota Department of Health, 600 East Boulevard Avenue Dept. 301, Bismarck, ND 58505-0200. Ms. Mertz's telephone number is 701.328.2493. Questions pertaining to children with special health care needs should be directed to Ms. Tamara Gallup Lelm, Director, Division of Children's Special Health Services, North Dakota Department of Health, 600 East Boulevard Avenue Dept. 301, Bismarck, ND 58505-0200. Ms. Lelm's telephone number is 701.328.2436.

Sincerely,

Kim Mertz, RN, BNSc, Director
Division of Family Health
N.D. Department of Health

Tamara Gallup Lelm, RN, MPA, Director
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Enclosure

c: Terry L. Dwelle, M.D., State Health Officer, DoH
Laura Olson, Accounting Division, DoH

Cancer Prevention and Control 701.328.2306 800.280.5512 (N.D.) 701.328.2036 (Fax)	Children's Special Health Services 701.328.2436 800.755.2714 701.328.1545 (Fax)	Chronic Disease 701.328.2367 800.280.5512 (N.D.) 701.328.2036 (Fax)	Family Health 701.328.2493 800.472.2286 (N.D.) 701.328.1412 (Fax)	Injury Prevention and Control 701.328.4636 800.472.2286 (N.D.) 701.328.1412 (Fax)	Nutrition and Physical Activity 701.328.2496 800.472.2286 (N.D.) 701.328.1412 (Fax)
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I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

Every five years, North Dakota (ND) is required to develop a comprehensive statewide needs assessment. This needs assessment requires ongoing analysis of sources of information about maternal and child health (MCH) status, risk factors, access, capacity, and outcomes. Needs assessment of the MCH population in an ongoing collaborative process, one this is critical to program planning and development and enables the state to target services and monitor the effectiveness on interventions that support improvements in the health, safety, and well-being of the MCH population. MCH population domains include women's/maternal health, perinatal/infant health, child health, adolescent health, children with special health care needs (CSHCN), and crosscutting/life course.

Through the initial 2016-2020 five-year needs assessment process, the Title V/MCH Leadership Team, partners and stakeholders identified the 10 highest priority needs for ND that aligned with National Performance Measures (NPM) and outcome measures. Of the ten priority areas identified, eight priorities were selected to be addressed by the ND Title V/MCH Program over the next five-year period as National Performance Measures (NPM):

- Reduce tobacco use in pregnant women
- Increase the rate of breastfeeding at 6 months
- Reduce disparities in infant mortality
- Reduce overweight and obesity in children
- Reduce fatal motor vehicle crash deaths to adolescents
- Increase the utilization of medical home
- Increase the number of children with special health care needs receiving transition support
- Increase preventive dental services to children

The remaining two priority areas were selected as the State Performance Measures (SPM), along with an additional measure on existing state mandates as part on ND's ongoing needs assessment process:

- Decrease depressive symptoms in adolescents
- Increase adequate insurance coverage to the MCH population
- Implement North Dakota state mandates delegated to the North Dakota Department of Health Title V / Maternal and Child Health Program

A State Outcome Measure (SOM) was also developed: Decrease the disparity of mortality among American Indian (AI) infants. This SOM was developed based on the overwhelming disparity in infant mortality among AI, in which the AI infant death rate is about 3 times greater than that of the White infant death rate. For calendar year 2014, the three year average mortality rate of AI infants was 13 per 1,000, compared to White infants at 4.1 per 1,000.

Based on ND's needs assessment process, the following 11 priorities across the six population domains and their alignment with the NPMs are shown in the table below:

North Dakota MCH Priorities 2016-2020



North Dakota Priorities	National Priority Areas	MCH Population Groups
Reduce tobacco use in pregnant women.	Well Woman Care	Women's/Maternal Health
Increase the rate of breastfeeding at 6 months.	Breastfeeding	Perinatal/Infant Health
Reduce disparities in infant mortality.	Safe Sleep	Perinatal/Infant Health
Reduce overweight and obesity in children.	Physical Activity	Child Health
Reduce fatal motor vehicle crash deaths to adolescents.	Injury	Adolescent Health
Decrease depressive symptoms in adolescents.	Bullying	Adolescent Health
Increase the utilization of medical home.	Medical Home (a family-centered approach to providing comprehensive care)	Children with Special Health Care Needs
Increase the number of children with special health care needs receiving transition support.	Transition (a planned movement from teenage years to adulthood)	Children with Special Health Care Needs
Increase preventive dental services to children.	Oral Health	Cross-cutting/Life Course
Increase adequate insurance coverage to the MCH population.	Adequate insurance coverage	Cross-cutting/Life Course
Implement North Dakota state mandates delegated to North Dakota Department of Health Title V / Maternal and Child Health Program.	N/A	Cross-cutting/Life Course

Five-year action plans containing evidence-based evidence-informed and/or promising practice strategies have been developed and organized around the six population domains for all 11 priorities. Significant accomplishments on “moving the needle” around ND’s priority areas and national and state performance measures include:

Women’s/Maternal Health:

- *Reduce tobacco use in pregnant women:* Collaboration with the American Indian Public Health Resource Center (AIPHRC) on ND’s Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) initiative that focuses on tribal outreach, engagement, and interventions that can increase rates of prenatal care, reduce tobacco use in pregnant women, encourage safe sleep practices, and improve birth outcomes.

Perinatal/Infant Health:

- *Increase breastfeeding rates at six months:* A new MCH grant process that targeted funding to increase breastfeeding rates; and two statewide breastfeeding designations that support breastfeeding mothers and infants – the Infant-Friendly business designation and the ND Breastfeeding-Friendly hospital designation. There are currently 71 businesses designated “Infant-Friendly” and four out of the twelve birthing hospitals have initiated the process of becoming “Breastfeeding-Friendly.”
- *Reduce disparities in infant mortality:* Through ND’s Infant Mortality CoIIN initiative, a project has been developed to work with hospitals on safe sleep policies that will include safe sleep messaging on crib sheets with a newly designed safe sleep ND logo; and mini-grants to promote safe sleep environments for infants that require integration of other risk reduction education training including breastfeeding, smoking cessation, and second hand smoke exposure.

Child Health:

- *Reduce overweight and obesity in children:* The MCH Nutritionist is taking the lead on a Pediatric Obesity COLLN mini-grant to enhance efforts related to nutrition and physical activity in children ages 2-5; and new MCH grant process that targeted funding has been awarded to three entities to work on evidence-based strategies to reduce overweight and obesity in children in schools, child care facilities and communities.

Adolescent Health:

- *Reduce fatal motor vehicle crash deaths to adolescents:* New infographic fact sheets have been developed from the 2015 ND Child Passenger Safety Observation Survey data and have been shared statewide with stakeholders; and efforts are moving forward to implement Impact Teen Drivers throughout ND communities.

Children with Special Health Care Needs (CSHCN):

- *Increase the utilization of medical home:* Sharing of best practice care coordination resources, (e.g., toolkits, training curriculums, strategies, etc.) and information from national surveys with partners; and enhancement of family engagement through care coordination trainings, mailings, and other educational opportunities.
- *Increase the number of children with special health care needs (CSHCN) receiving transition support:* Enhancement of an Information Resource Center in which various information on transition is mailed to individuals ages 14 to 21 that are utilizing services; and alignment of work efforts with family support organizations, committees, and other partners to provide family-centered information regarding youth transition.

Cross-cutting/Life Course:

- *Increase preventive dental services to children:* Implementation of Seal!ND, a school-based fluoride varnish and sealant program that increases access to preventive dental care to underserved populations; and a strong, broad-based Oral Health Coalition.

Overarching challenges consistent across all priority areas include competing priorities and workloads that stress staff resources and limited funding.

Annual Report Summary:

In 2010, ND completed the needs assessment process and identified the following 10 priorities and performance measures to focus on for 2011 through 2015. Major accomplishments and significant challenges related to each of the priorities/performance measures per population health domain are included below for the period of October 1, 2014 through September 30, 2015. This is the final time these priorities will be reported on, as strategies and activities addressing the new 2016-2020 priorities started October 1, 2015.

Women's/Maternal Health:

- **Promote healthy eating and physical activity within the MCH population.**
- Performance Measure: The percent of healthy weight among adults ages 18 through 44.

Major accomplishments: Title V staff coordinated a sustainability training for 12 local Healthy Communities Coalitions; the Women, Infants and Children (WIC) Program final food rule was implemented that required only low-fat milks be provided for all women participants and children over two years.

Significant challenges: Changing social norms and personal habits.

Perinatal/Infant Health:

- **Increase access to available, appropriate and quality health care for the MCH population.**
- Performance Measure: Increase the number of children birth to age 2 served by an evidence-based home visiting program.

Major accomplishments: Prevent Child Abuse North Dakota (PCAND) is the state's Maternal, Infant and Early Childhood Home Visiting (MIECHV) grantee – they have become a partner site with the Cribs for Kids Program; the State Title V Director serves on PCAND's MIECHV Advisory Committee – through this role, the Title V Director has been able to facilitate increased collaboration between Title V programs and home visiting programs.

Significant challenge: PCAND's targeted service areas of Turtle Mountain and Spirit Lake reservations transitioned from Healthy Families America to Parents as Teachers; thereby resulting in a slight decline in the number of children served.

Child Health and Children with Special Health Care Needs (CSHCN):

- **Form and strengthen a comprehensive system of age-appropriate screening, assessment and treatment for the MCH population.**
- Performance Measure: The percent of ND Medicaid enrollees receiving Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening services.

Major accomplishments: CSHS staff participated on various committees with the ND Medicaid Program; partnership with ND's Early Childhood Comprehensive System Program aimed to expand developmental screening with a focus on mental health; collaboration between the Suicide, Family Planning and the Optional Pregnancy Outcome Programs screened clients for depression.

Significant challenge: The ND Medicaid Management Information System (MMIS) project, which began in 2004 and went live in October 2015, has taken priority for ND Medicaid staff; thereby limiting collaboration opportunities.

- **Support quality health care through medical homes.**
- Performance Measure: The percent of children birth through 17 receiving health care that meets the American Academy of Pediatrics (AAP) definition of medical home.

Major accomplishments: Funding through CSHS to the ND Chapter of the AAP for a Medical Home Project; funding provided to Minot State University for a medical home online course; discussions occurred with one major health system that has been attempting to move medical home forward and is interested in the concept of a statewide medical home coalition; and medical home identified as a priority area for CSHCN based upon the 2015-2020 Title V MCH Needs Assessment.

Significant challenges: Limited providers and lack of a statewide coalition; the curriculum, as well as the Medical Home Project through the ND Chapter of the AAP, has had limited participation; a care coordination program funded by CSHS was discontinued on September 30, 2015 due to resource limitations; and competing workload demands.

- **Increase the number of child care health consultants and school nurses who provide nursing health services to licensed child care providers and schools.**
- Performance Measure: The ratio of students per school to nursing full-time equivalent (FTE).

Major accomplishments: More schools are recognizing the need for school nurses. In 2012, there was one nurse to every 2,057 students, in 2014; there was approximately one nurse for every 1,478 students; the State School Nurse Consultant (SNC) participated in the Johnson and Johnson School Health Leadership Program with the goals of training school staff and nurses on medication administration, developing a standardized health history form, and developing a virtual school nurse model.

Significant challenges: No state mandate for school nursing services; the SNC has other MCH responsibilities and is only able to dedicate about 30 percent of her time to school nursing advocacy.

- **Increase participation and utilization of family support services and parent education programs.**
- Performance Measure: The percent of parents who reported that they usually or always got the specific information they needed from their child's doctor and other health care providers during the past 12 months.

Major accomplishment: CSHS provided funding to two family-led organizations, Family Voices of ND and ND Hands and Voices, to provide information, training and support services for children with special health care needs and their families.

Significant challenges: Because of ND's population growth, family support agencies that provide care coordination to families have needed to provide more services, despite a decrease in resources.

Adolescent Health:

- **Promote optimal mental health and social-emotional development of the MCH population.**
- Performance Measure: Decrease the percentage of students who reported feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.

Major accomplishments: The State Suicide Prevention Program (SPP) launched a media campaign to promote mental health; with support from the SPP, Turtle Mountain Indian Reservation and Bismarck School District have implemented suicide prevention programming in the majority of their high schools.

Significant challenges: While the 2015 Youth Behavior Risk Survey showed a hopeful decrease of high school students reporting feeling so sad or hopeless that they stopped doing some usual activities during the 12 months before the survey (19.6 % in 2015 compared to 25.4 % in 2013), this number is still a concern; including funding and personnel resources.

- **Reduce violent behavior committed by or against children, youth and women.**
- Performance Measure: Reduce the number of students who were bullied on school property during the past 12 months.

Major accomplishments: State law that requires every school district to develop and implement a bullying policy; creation of an online toolkit with primary prevention resources.

Significant challenges: Limited funding; lack of staff to coordinate efforts.

- **Reduce the rate of deaths resulting from intentional and unintentional injuries among children and adolescents.**
- Performance Measure: The rate of deaths to individuals ages 1 through 24 caused by intentional and unintentional injuries per 100,000 individuals.

Major accomplishments: Primary seat belt law for children through age 17; strong partnership with the Department of Transportation; successful ND Conference on Injury Prevention and Control with 125 participants attending.

Significant challenges: Obtaining hospital discharge data to monitor and access intentional and unintentional injury rates; limited funding.

Cross-cutting/Life Course:

- **Form and strengthen partnerships with families, American Indians (AI) and underrepresented populations.**
- Performance Measure: The degree to which families and American Indians participate in Title V program and policy activities.

Major accomplishments: CSHS supported a ten-member Family Advisory Council and provided funding for a multidisciplinary developmental assessment clinic at Fort Totten and Turtle Mountain American Indian reservations; a contract with the AIPHRC to work with the AI tribal programs to determine available resources and data related to infant mortality.

Significant challenges: The goal of the AIPHRC was to work with all ND tribes; however, they have only been able to engage two tribal reservations.

II. Components of the Application/Annual Report

II.A. Overview of the State

Principle characters important to addressing the health status and needs of the states MCH population, and the extent to which poverty, racial and ethnic disparities in health status, geography, urbanization and the private sector create unique challenges of the delivery of Title V services:

North Dakota (ND) is a beautiful state located in the geographic center of the United States between Montana and Minnesota, adjacent to the Canadian provinces of Saskatchewan and Manitoba. It encompasses significant landmass (68,976 square miles) divided into 53 counties and spread over four distinct regions; the southwestern Great Plains (badlands), northwest Missouri Coteau (plateau), central Glaciated Plains, and eastern border Red River Valley. ND is the 19th largest state by geographic size. ND's health status is confronted by a variety of challenges including the unique geography and climate, socioeconomic factors and demographics of the state.

ND has traditionally been one of the leading agricultural producers in the United States (U.S.). In the last U.S. Department of Agriculture (USDA) Census of Agriculture in 2012, ND ranked sixth in the nation for the value of crops sold. Energy development also plays a large role in ND's economy. In 2004, oil and gas activity represented about 2 percent of the state's economy; by 2014, it was almost 16 percent. Other top industries in ND include finance, insurance, real estate (14%); agriculture (13%); government (10%); and wholesale trade (8%).

Over the last decade, ND has had one of the fastest growing economies in the nation as measured by Gross Domestic Product (GDP). The 2003-2013 compound annual growth rate for ND's real GDP of 6.6 percent, was over four times greater than the national average (1.5%) for this period. In 2008, ND doubled its previous annual level of oil production to rank sixth among the oil producing states with annual production of 63 million barrels. Today, ND's daily oil production makes it the second largest oil producing state in the nation behind Texas. Recently however, ND's economy has been dealing with the dramatic drop in oil prices. Taxes on oil production account for only about 5 percent of state general fund revenue. Income generated from sales tax revenue makes up the majority of where the revenue comes from, which is derived from the sale of equipment and services related to fracking. With prices down, roughly 1,000 wells that have been drilled but not fracked are sitting idle, waiting for the market to recover. As a result, the state's sales tax revenue fell by a fourth during the third quarter of 2015 from the same period in 2014. As a result of decreased revenue forecasts (down \$700 million from the original forecast), Governor Jack Dalrymple ordered 73 state agencies to make 4 percent across-the-board cuts on February 1, 2016. In May 2016, Governor Dalrymple issued his budget guidelines for the 2017-19 biennium to state government agencies, directing them to develop general fund base budgets equal to 90 percent of their 2015-17 appropriations. Fortunately, the state match for the Maternal and Child Health (MCH) Block Grant will not be affected by these reductions.

A particular area of concern that has been highlighted since the increase in oil activity is prostitution. In addition, sex trafficking – including the trafficking of children – has emerged as a critical issue. To help combat this problem, a statewide anti-trafficking coalition has been formed called FUSE (Force to end Human Sexual Exploitation). Staff from the ND Department of Health's (NDDoH) Division of Injury Prevention and Control – Domestic Violence Program, participates in this coalition.

Despite these challenges, ND has many positive attributes. In December 2015, Governor Dalrymple highlighted the following facts in a press release:

- In 2015, ND's population reached an all-time high of 756,927, an increase of 16,887 residents since the 2014 U.S. Census Bureau count. This population growth by 2.5 percent since last year is the largest percent increase among all states.
- The in-migration of adults of childbearing age is playing a major role in the state's current population trend. In just the past 10 years, the number of births in ND has steadily increased from about 8,380 to 11,352.
- ND's economy continues to be among the nation's strongest. In the past five years, the state's economy has averaged an annual growth rate of nearly 12 percent, four times that of the national economy.
- ND's unemployment rate of 2.7 percent is the nation's lowest. The state has created more than 123,000 net jobs since 2000, and employers currently report having nearly 16,000 open positions. Note: ND's current employment rate as of May 2016 is 3.2 percent.
- Personal incomes in ND have also improved in the past 10 years. In 2004, the state's per-capita personal

income was below the national average and ranked 38th among all states. Last year, North Dakota's per-capita personal income (\$55,579) ranked fourth highest among all states at 121 percent of the national average.

The population growth in the state, especially among young adults, has strengthened ND's workforce and revitalized the state's natural increase through more births. According to the U.S. Census Bureau, ND is the fourth youngest state in the nation with a median age of 34.6 and is the only state that continued to grow younger in 2015. The dynamic nature of this change creates a variety of opportunities and challenges for ND communities. One important consequence will be a growing demand for housing. From 2010 through mid-2014, ND's housing units grew by 10.4 percent, far exceeding second-place Texas' 4.5 percent. The greatly expanding number of births will increase the number of children and youth in the state, thereby creating increased demand for childcare and educational facilities. On the other end of the age spectrum, the leading edge of the baby boom cohort moved into the 65-year-old bracket, which has long-term implications for health systems and providers.

Age distribution data from 2013 estimates that approximately 6.7 percent of the ND population is less than five years of age, 22.5 percent is under 18 years of age and 14.2 percent of the population is elderly (65 years of age or older). From 2010 to 2025, residents ages 65 and older are projected to expand by 52 percent (50,583 residents) while the cohort they are aging out of, those ages 45 to 64, will expand by only 5 percent statewide (7,972 residents). In 2025, residents ages 65 and older are projected to be 18 percent of the total population (up from 14 percent in 2010), and residents ages 45 to 64 will represent 22 percent of the population (down from 27 percent). The age group under 25 years is expected to grow by 18 percent (41,395 residents) in the next 15 years after declining by 1 percent from 2000 to 2010. ND has not seen a balanced influx distribution of men and women. From 2010 to 2013, the number of men in ND increased by 9 percent compared to a 6 percent increase of women. Hence, unlike the rest of the country, ND has more males than females (51% vs 49%).

Currently, 71 percent of ND residents reside within the largest nine urban counties. However, the majority of ND counties possess a population base below 5,000 residents, including 36 counties considered "frontier," defined as having a population density of six or fewer residents per square mile. In 1930, approximately 85 percent of the population lived in a rural environment such as "on a farm, in the countryside, or in a community with less than 2,500 people." Urbanization followed throughout the 1950s and into the 1960s, depopulating many smaller ND towns. This trend continued into the 1970s and through the 1990s, when the majority of North Dakotans living in an urban environment exceeded those living in a rural environment. From 1990 to 2000, the population grew by just 0.5 percent: the smallest relative growth of any state at that time. Early within the new millennium, the population actually declined. Predictions of the state's increased population growth come with a further reduction in those living in rural areas, by as much as one-third.

For decades, the state experienced out-migration of its young adult population, leaving it an older state with about three-fifths of its population in the eastern half, closest to Minnesota. With the in-migration of workers, the state has seen a surge in the population of young adults shifting the center of the state's population westward. ND has quickly gone from being an older than average state to one of the youngest. As of 2013, ND is estimated to have the highest percentage of residents between the age of 20 and 24, nearly 10 percent of the state's total population. This in-migration of young adults has also made the state more racially and ethnically diverse than it was a few short years ago.

Although racial and ethnic minorities continue to represent a relatively small proportion of the state's overall population, ND is becoming more diverse. The White, non-Hispanic population comprised 87 percent of all residents statewide in 2013, which is down from 89 percent in 2010 and 92 percent in 2000. From 2010 to 2013, the population of Persons of color (i.e., non-White) in ND grew 23.8 percent, compared to 6.2 percent nationally. During the same time period, when comparing racial/ethnic groups, the Black population experienced the fastest growth (59% increase), followed closely by the Hispanic population (54% increase). Members of the group that comprise the highest proportion of non-White residents in the state are American Indians (AI), which make up 5.4 percent of the population.

There are five federally recognized Tribes and one Indian community located at least partially within ND. These include the Mandan, Hidatsa and Arikara Nation (Three Affiliated Tribes), the Spirit Lake Nation, the Standing Rock

Sioux Tribe, the Turtle Mountain Band of Chippewa Indians, the Sisseton-Wahpeton Oyate Nation, and the Trenton Indian Service Area. Approximately 64 percent of American Indians live on reservations and over forty percent are under the age of 20. As of 2014, the median age of ND's American Indians was 26.9, a full eight years younger than ND's overall median age of 35.1. Specifically, the median age for males is 25.4, while for females it is 28.6. Infants born to AI mothers in ND are at much higher risk of experiencing poor birth outcomes than infants born to White mothers including being born preterm, being born at a low birth weight and to die in the first year of life. Additional disparities facing the AI population include higher rates of diabetes, cancer, addiction, heart disease, and other public health issues, including unintentional injuries. The average age at death for American Indians is 54.7 years, compared to 75.7 years for the White population. All 10 of the ND counties identified as "least healthy," according to County Health Rankings, are either within a tribal reservation, or designated as rural or frontier areas. Additionally, five of these counties are also ranked "most poor" in health behavior factors that include measures of smoking, diet and exercise, alcohol use and risky sexual behaviors.

Differences in median household income exist by race/ethnicity. White households in the state have a median income more than \$25,000 higher than those of AI households. Although the state has seen economic prosperity and has the lowest unemployment rate in the nation at 2.7 percent (as of December 2015), the proportion of people who live below the federal poverty level saw no significant change from 1999 to 2014 (12% and 11.8, respectively). In AI reservation areas, one in four residents lives in poverty (25.2%).

There is a direct correlation between the rate of poverty for a given area and the percentage of households receiving public assistance. From 2009-2013, the percentage of ND households receiving Supplemental Security Income (SSI), cash assistance such as Temporary Assistance for Needy Families (TANF) or **Supplemental Nutrition Assistance Program** (SNAP) benefits, ranged from over 57 percent in Sioux County (American Indian reservation area) to 0 percent in Billings County (an oil producing county). Counties with the highest rates of public assistance all had a high American Indian population. These same counties had the highest rates of poverty in the state.

The health care delivery system in ND consists of 50 hospitals – 36 smaller critical access hospitals with 25 or fewer acute-care beds, six larger general acute-care hospitals located in the four largest cities, three psychiatric hospitals, two long-term acute-care hospitals, two Indian Health Service hospitals, and one rehabilitation hospital – and about 300 ambulatory care clinics. Outpatient care is augmented by 57 federally certified rural health clinics and five federally qualified health centers. There are 43 trauma centers across the state, with each of the "Big Six" hospitals home to a Level II trauma center. Most emergency medical service support in the state is ground-based and provides basic services; which is under duress because of its dependence on volunteers and funding challenges. There has been an expansion across the state in the deployment and use of electronic health records, but financial and other barriers to full implementation remain.

Local public health units also provide valuable health care in ND. The public health system is made up of 28 single- and multi-county local public health units; all are autonomous and not part of the Department of Health. Services offered by each health unit vary, but all provide services in the areas of maternal and child health.

Like the rest of the country, ND is facing a major health care delivery challenge – how to meet a burgeoning need for health care services now and in the future with a supply of health care professionals that is not keeping pace with the growing demand, thereby impacting the health status and needs of the maternal and child health (MCH) population. If the population increases to 800,000 by 2040 as predicted, 500 additional physicians will be needed in the state. Part of the challenge in ND is an inadequate number of providers; however, a larger portion of the challenge is a maldistribution of providers who are disproportionately located in the larger urbanized areas of the state. People in rural areas of the state are older, poorer, have less or no insurance coverage than people in non-rural areas, all of which are challenges to providing adequate health care. Frontier areas of the state face even greater difficulties than rural areas in maintaining their health care workforce. These thinly populated regions cannot easily compete with the wages and amenities offered to health care providers by hospitals and clinics in urbanized areas. Even communities that do have adequate staffing are often one doctor or nurse away from a shortage.

Census Bureau Health Insurance statistics break the population into major age cohorts: children under age 18, workforce age (18 through 64) and those age 65 and above. In 2014, an estimated 93 percent of children in the state

had health insurance, very similar to the national rates. ND children who are White have insurance at a rate higher than the state's average (94%), while AI children are insured at rates substantially lower than the state's average, at 86 percent – although this rate has increased from 80 percent in 2012.

In 2014, 9 percent of residents under age 65 in ND lacked health insurance coverage (91 percent had some form of health coverage). This rate is lower than the national average of 14 percent and has decreased since 2013. White residents under age 65 were the highest of the insured at 91.2 percent, while AI's reported the lowest rates of insurance at only 66.2 percent. Adults least likely to be covered tend to be in younger age groups. ND residents in the age range of 25 through 34 tended to have the lowest coverage at 87.3 percent. Males tended to have lower rates of coverage than females in this age range regardless of race or ethnicity. Due to Medicare coverage, nearly 100 percent of residents age 65 and over were estimated to have health insurance.

Approximately one-sixth (18%) of ND adults have a disability. North Dakotans with disabilities, compared to those without disabilities were more likely to be female, older, of AI descent, possess lower levels of education, have lower incomes, and unable to work. In addition, ND adults with disabilities were more likely than those without disabilities to be overweight/obese, smoke cigarettes, be less physically active and more likely to binge drink or be heavy drinkers. Among ND adolescents, 27.5 percent of middle school students and 27.9 percent high school students had a disability. According to the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), ND provided slightly more coordinated and comprehensive care services within a medical home to children with special health care needs (48%) compared to the national average (43%). The 2009 study indicated that a majority (68%) of families of children with special needs agreed that ND services were easy to utilize. However, in 2009, only 60 percent of families with children with special health care needs ages zero through 17 reported to have adequate funding to pay for private health care, indicating the dynamic need for these services.

How health care reform efforts and the Affordable Care Act (ACA) implementation are impacting the health status of the maternal and child health (MCH) and children with special health care needs (CSHCN) population, and delivery of Title V supported programs:

ND is one of 36 states that make up the Federally Facilitated Marketplace (FFM) for the Affordable Care Act (ACA). During the 2016 open enrollment period, 21,604 people enrolled in private plans through the ND exchange; a 19 percent increase over 2015, when 18,171 people selected private plans through the exchange. Of the people who enrolled in private plans through the exchange for 2016, 86 percent are receiving premium subsidies to offset the cost of their coverage. The average premium subsidy in ND is \$262 per month, and the average after-subsidy premium is \$142 per month.

Three organizations in ND received a total of nearly \$637,000 in navigator grants in 2015 that are used for outreach and enrollment efforts. The grants were awarded to the Family HealthCare Center, Great Plains Tribal Chairmen's Health Board (GPTCHB), and Minot State University's North Dakota Center for Persons with Disabilities (NDCPD).

Family HealthCare is partnering with Southeast Community Action Agency and Valley Community Health Centers to reduce the number of uninsured in ND and provide outreach and education to seven northeastern and southeastern ND counties with focus on new citizens/refugees, pregnant women/new mothers, AIs, disabled, college students, and ND Medicaid-eligible individuals. GPTCHB served as a 2013 and 2014 Navigator grantee and will provide enrollment assistance to AI's residing on and near the eight reservations in South Dakota and the four reservations and one Indian Service Area in ND, as well as those residing in major urban areas served by Urban Indian Health Centers in these two states. NDCPD served as a 2013 and 2014 Navigator grantee and will continue to work with their collaborative network of regional Navigators targeting those most at risk of being uninsured in ND, including people with mild disabilities, people with mental health disorders, farmers, young adults, AIs, small business persons, people who are unemployed, and people who are drug or alcohol addicted.

The knowledge and awareness of children with special health care needs has been an asset in supporting access to affordable care for families. Several navigators are employees of organizations that already have an understanding of programs that can assist families of children with special health care needs. When they are approached by a family for health care options, they can intelligently respond with the best course of action and link the family to additional resources.

There are still gaps that exist with the ACA in that some children need services that are not available through current benefit plans. Service limits may also pose a challenge. Lower income families may not be able to afford a plan that covers the needs of their children or the associated co-payments for services.

In addition to private plan enrollments, nearly 9,000 low-income ND residents had enrolled in the state's expanded Medicaid program by early June 2014. ND has followed a unique public-private partnership model of Medicaid expansion, allowing private health insurance carriers to bid for the opportunity to provide health insurance coverage to the state's newly-eligible Medicaid population using federal Medicaid funds; Sanford Health Plan is ND's carrier. By October 2015, total enrollment in ND's Medicaid program had increased by 19,263 people, representing a growth of 28 percent.

Healthy Steps and ND Medicaid have been effective public programs in reducing the number of uninsured, low-income children in the state. Healthy Steps provides premium-free, comprehensive health, dental and vision coverage to uninsured children up to 19 years old who do not qualify for ND Medicaid. The income eligibility limit is at 175 percent of the federal poverty level (FPL). Modest co-payments apply for certain services, which are waived for AI children. ND Medicaid covers children ages 0 to 6 (thru the month they attain age 6) at 152 percent of the FPL and children ages 6 to 18 (thru the month they attain age 18) at 138 percent of the FPL. ND Medicaid has some limitations or restrictions for some covered services. For State Fiscal Year (SFY) 2015, there were a total of 116,366 ND Medicaid recipients compared to 105,539 in SFY 2014.

1-877-KIDS-NOW is a toll-free resource line that helps uninsured families learn about low-cost and free health coverage programs in ND. A seamless eligibility process for health coverage programs has helped to assure coverage for ND's children. In March 2016, the monthly child enrollment in Medicaid and CHIP in ND was 46 percent compared to 51 percent in the U.S. The total monthly Medicaid and CHIP enrollment in ND was 21 percent compared to 27 percent in the U.S. during the same period.

The state health agency's current priorities and the resulting Title V program roles and responsibilities: In December 2005, the NDDoH started a strategic planning process. As a result of this effort, Strategic and Business Plans were developed that identify the department's mission, strategic initiatives, key objectives and indicators: (<http://www.ndhealth.gov/DoH/Overview/DeptStrategicPlan.pdf?v=2> <http://www.ndhealth.gov/DoH/Overview/DeptBusinessPlan.pdf?v=2>).

These plans are reviewed and revised annually and assist the department in communicating with partners, setting direction, motivating employees, making decisions, determining priorities and budgets, and monitoring progress and impact. Both the Title V and Children's Special Health Services (CSHS) directors are members of the Strategic Planning Committee. All department programs have been linked to the strategic plan goals and objectives. Data indicators consisting of baseline data, targets and benchmarks have been developed for each objective.

After tracking several years of data, the department published the indicators on its website with accompanying text describing the indicator results and what those results mean. This allows the general public to track the state's health status. The format used to display the indicators is called the Dashboard which presents a graphical depiction of the data indicators and facilitates tracking of performance. The Dashboard can be viewed at: <http://www.ndhealth.gov/StrategicPlanning/>.

Title V programs align with the following NDDoH goals and objectives:

Goal: Improve the health status of the people of ND

- Decrease vaccine-preventable disease
- Achieve healthy weights throughout the lifespan
- Prevent and reduce chronic diseases and their complications
- Prevent and reduce intentional and unintentional injury
- Prevent and reduce tobacco use and support other substance abuse prevention
- Reduce infectious and toxic disease rates

Goal: Improve access to and delivery of quality health care and wellness services

- Enhance the quality of health care

- Improve access to and utilization of health and wellness services
- Improve health equity

The NDDoH recognizes the importance of public health accreditation and the alignment of accreditation efforts throughout the public health system in order to strengthen performance across the state. The NDDoH submitted a notification and applied to participate in the Public Health Accreditation Board's (PHAB) accreditation process in 2015. On April 19-20, 2016, an Accreditation Site Visit Team was on-site at the NDDoH. The Accreditation Site Report has been received and the department is awaiting a decision from the PHAB **Accreditation Committee on the accreditation status of the department.**

To increase the effectiveness of strategic planning and accreditation, the NDDoH has developed and implemented a performance management system and continuous quality improvement (CQI). These efforts assist to systematically monitor and improve the quality of programs, processes and services in order to achieve high levels of efficiency, effectiveness, and both internal and external customer satisfaction.

Title V program staff have varying roles and responsibilities within the department's priorities and initiatives. The Title V and CSHS directors hold senior management positions within the NDDoH and are actively involved in strategic planning and accreditation activities. As a result, Title V issues are included in department discussions, planning and decision-making processes. In addition, the Title V and CSHS directors provide regular updates to staff to seek input and feedback on department issues.

Process used to determine the importance, magnitude, value and priority of competing factors, along with current and emerging issues:

ND's Title V statewide needs assessment process for FY's 2016-2020 began in early 2014 and continued through May 2015. The Title V and CSHS directors use this process in part to determine what the current and emerging issues are and to assist with the prioritization of the many competing factors that impact MCH health services in the state. A description of ongoing needs assessment activities can be found in Section II.B. Five Year Needs Assessment Summary.

In addition, initiatives set at the federal level drive work priorities such as the Infant Mortality Collaborative for Improvement and Innovation Network (IM CoIIN). ND's IM CoIIN team has identified four strategies: 1) safe sleep, 2) smoking cessation before, during and after pregnancy, 3) prevention of preterm and early elective deliveries; and, 4) social determinates of health. While the Title V director serves as ND's IM CoIIN lead, other Title V and NDDoH staff have been actively involved in strategy actions and outcomes. The Infant and Child Death Services Program Director is leading efforts in safe sleep. The State Systems Development Initiative Grant Coordinator serves as the lead for social determinants of health and is also the state data lead. The NDDoH's Tobacco Prevention and Control Program Director, along with the Optimal Pregnancy Outcome Program Director, are leading efforts for smoking cessation before, during and after pregnancy. Strong partnerships with entities such as the March of Dimes ND Chapter (lead for prevention of preterm and early elective deliveries), Prevent Child Abuse ND, Sanford Health-Bismarck (Nursery and Pediatrics Units), and the American Indian Public Health Resource Center at ND State University assist the state to carry out activities and accomplish outcomes. IM CoIIN strategies and activities have also been incorporated into the Five-Year State Action Plan Tables, as appropriate.

Legislative activity also serves to determine priorities and to identify current and emerging issues. Title V staff monitored over 100 bills during the 2015 Legislative Session. During the legislative interim, Title V staff have been involved in monitoring and/or providing information for legislative studies, including a study of dental services in the state (the effectiveness of case management services and the state infrastructure necessary to cost-effectively use mid-level providers to improve access to services and address dental service provider shortages in underserved areas of the state). Title V staff have also monitored interim activities of the Political Subdivision Taxation Committee and the County Social Services Finance Working Group. A transition plan to transfer costs of operating social service programs from county property tax levies to general fund appropriations has been proposed. This type of change has financial implications for CSHS as county social service staff assist with implementation of the division's programs at the local level.

State Specific Statues:

Priority setting also is determined by state mandates; see Supporting Document #02 – Title V-MCH State Mandates. A State Performance Measure has been developed to address the Title V responsibilities related to these mandates titled “Implement North Dakota State Mandates Delegated to the North Dakota Department of Health Title V/Maternal and Child Health Program.” Information regarding these mandates is discussed in Section II.F.1. State Action Plan and Strategies – State Action Plan Narratives.

II.B. Five Year Needs Assessment Summary

2016 Five-Year Needs Assessment Summary

II.B.1 Process:

During the past year, North Dakota's (ND) ongoing Title V/Maternal and Child Health (MCH) Needs Assessment focused on two main objectives: 1) the development of the three State Performance Measures (SPM), and 2) continued efforts to identify local needs in alignment with the MCH 3.0 Block Grant Transformation.

Development of State Performance Measures

The Title V/MCH Leadership Team (Title V Director, Children's Special Health Services (CSHS) Director, State Systems Development Initiative Coordinator, MCH Epidemiologist) met between November 2015 and May 2016 to determine the process of selecting SPMs. Initially, the team reviewed both qualitative and quantitative data from the five-year needs assessment. Given that adolescent depressive symptoms and adequate health insurance had risen to the top in both quantitative need and the qualitative consensus of stakeholders, the team determined that these two measures would be developed into SPMs. Additionally, the leadership team evaluated three other measures that were brought forth from the needs assessment data: developmental screening; social determinants of health in the MCH population; and the implementation of relevant state mandates. Assessing MCH program capacity and resource availability, the team determined that the third SPM would be implementation of state mandates delegated to the Title V/MCH Program. State action plans have been developed for each of these SPMs. A grid highlighting ND's priorities and SPMs and how they align to the national priority areas and MCH population domains is located in I.E. Application /Annual Report Executive Summary.

A State Outcome Measure (SOM) was also developed: Decrease the disparity of mortality among American Indian (AI) infants. In ND, the AI infant death rate is about 3 times greater than that of the White infant death rate. For calendar year 2014, the three average mortality rate of AI infants was 13 per 1,000, compared to White infants at 4.1 per 1,000. Many action plan strategies and activities have been developed to address this concerning issue.

As a result of the new needs assessment findings and of MCH Transformation 3.0, the State Title V Director revised the mechanism for allocating local MCH funds to ensure local grantee activities aligned with the state selected priorities and National Performance Measures (NPM). In the past, MCH funds were allocated to all local public health units on a funding formula. A new, competitive grant application targeting four ND MCH priorities was sent out in September 2015 with applications due January 15, 2016. The targeted priorities included: increasing breastfeeding rates at 6 months (perinatal/infant health domain); reducing disparities in infant mortality specifically related to safe sleep (perinatal/infant health domain); reducing overweight and obesity in children (child health domain); and reducing fatal motor vehicle crash deaths to adolescents (adolescent health domain). Applicants were required to describe the need for the proposed program/project using current and relevant data, and to define the geographic area and the target population to be served. These narratives served as additional needs assessment data supporting the state priorities at a local level. Four grantees were selected to implement strategies and activities relating to increasing breastfeeding rates and reducing overweight and obesity in children. Funds were awarded April 1, 2016; grantees will be funded through September 30, 2021. Grant applications relating to the remaining two priorities – reducing disparities in infant mortality specifically related to safe sleep and reducing fatal motor vehicle crash deaths to adolescents – were not funded due to grant applications not meeting standards. Strategies to award funding for these two targeted areas are currently being developed.

The CSHS Director utilizes a similar MCH granting process that requires applicants to describe service area needs of children with special healthcare needs (CSHCN) in their communities using current and relevant data, and to

define the geographic area and the target population to be served. These narratives provide needs assessment data from a local perspective, which complement and enrich the state's overall assessment effort. Grantees were funded to enhance systems of care for CSHCN and their families. Strategies and activities in programs and projects that were funded in the CSHCN domain focused on the following outcomes: 1) increased medical home infrastructure, including care coordination, 2) increased coordinated care through multidisciplinary clinics, and 3) increased family information, support and education. Grants funded by CSHS in the current biennium align with several of the state's identified priorities.

II.B.2. Findings:

See Supporting Document #01 – Ongoing Needs Assessment Findings for a summary of MCH and CSHCN grantee needs assessment and activities.

Additionally, the Title V/MCH Leadership Team continued to assess new data sources as they became available to inform programmatic activities. New data sources that have become available in the past year include:

- [2015 Division of Vital Records Data](#)
- [2015 Behavioral Risk Factor Surveillance System](#)
- [2015 Youth Risk Behavior Survey \(YRBS\)](#)
- Title V/MCH Federally Available Data (FAD)
- 2014-2015 Oral Health Third Grade Basic Screening Survey
- [2016 KIDS COUNT Data Book](#) (the Title V Director did an interview with the media when this data was released)
- Local community data

II.B.2.a. MCH Population Needs

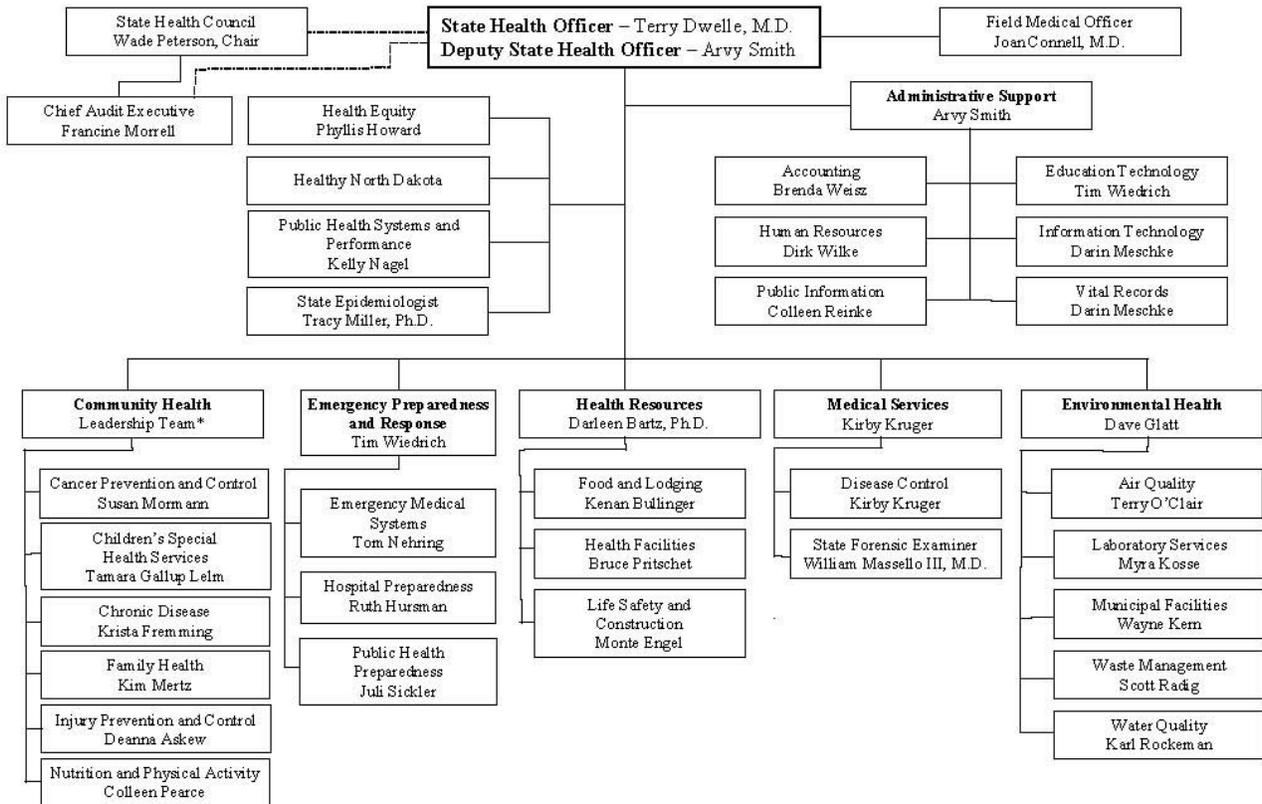
The health status of ND's MCH population is discussed in II.A. Overview of the State. Additional data/information related to the selection of ND's three SPM's include:

- Decrease depressive symptoms in adolescents (adolescent health domain): According to the 2015 YRBS, 16.2 percent of ND students in grades nine through twelve seriously considered attempting suicide during the 12 months before the survey (16.1 in 2013).
- Increase adequate insurance coverage to the MCH population (cross cutting/life course): Overall, 9 percent of ND residents lack health insurance. ND children who are White have insurance at a rate higher than the state's average (94%), while AI children are insured at rates substantially lower than the state's average, at 86 percent.
- Implement North Dakota state mandates delegated to North Dakota Department of Health Title V/MCH Program (cross cutting/life course): Title V staff have responsibility for several state mandates. See II.F.1. State Action Plan and Strategies, SPM Implement North Dakota state mandates delegated to the North Dakota Department of Health Title V/Maternal and Child Health Program. Also see Supporting Document #02 – Title V-MCH State Mandates.

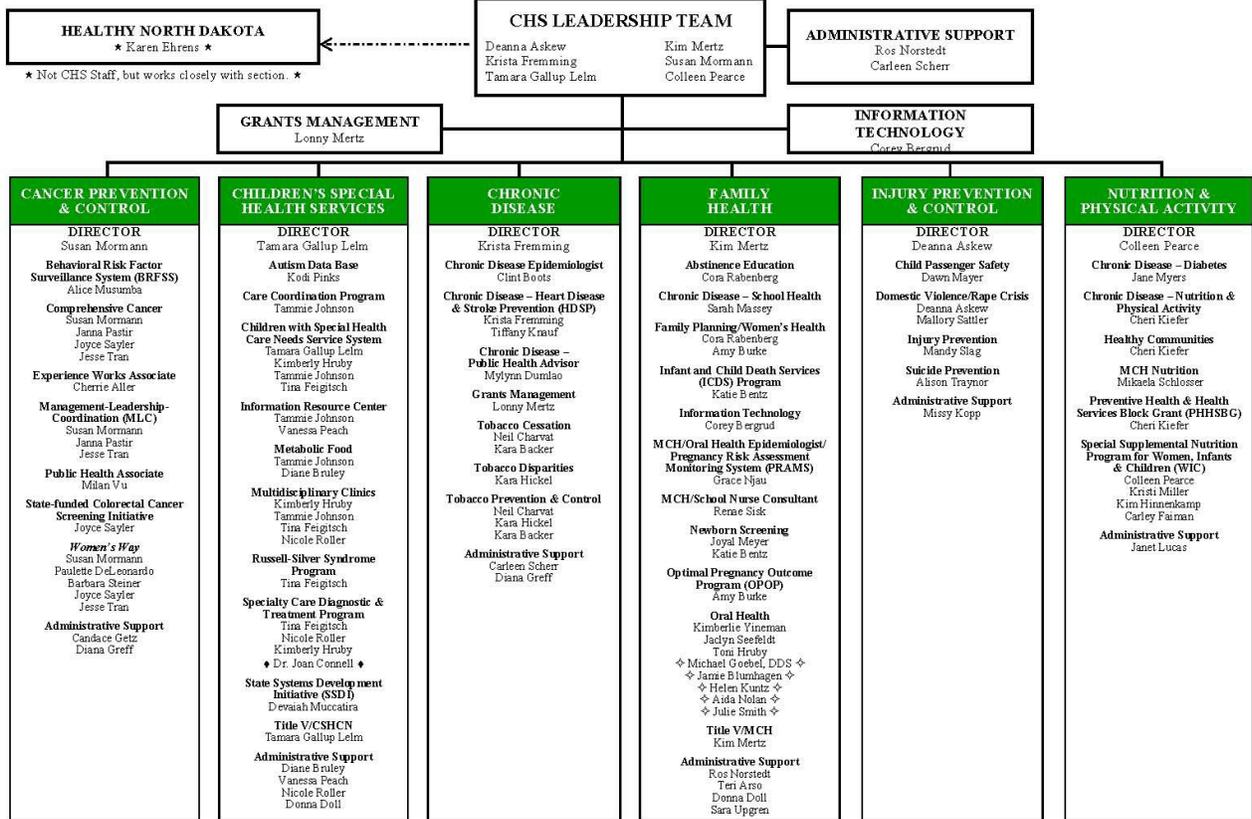
II.B.2.b. Title V Program Capacity Organizational Structure

Description:

The North Dakota Department of Health's (NDDoH) organizational charts are located below.



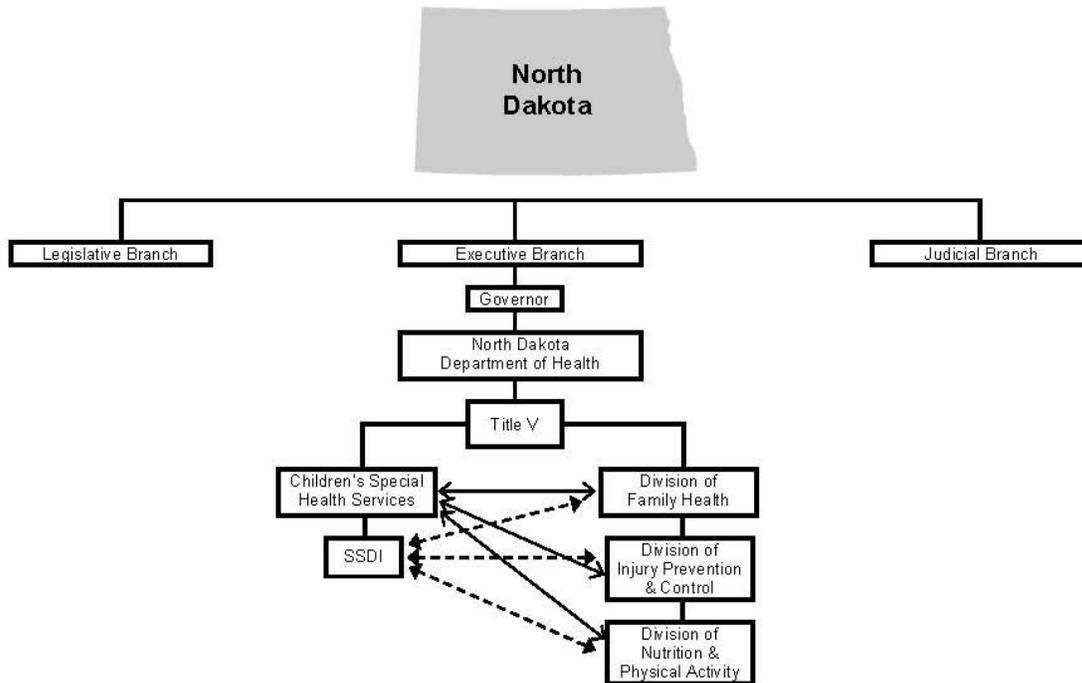
*The six division directors share responsibility for management of the Community Health Section.



◆ Medical Director ◆ / ◆ Non-Permanent Positions ◆

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STATE OF NORTH DAKOTA ORGANIZATIONAL CHART



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Last Revised 7-11-2007 / Reviewed-No Changes 7-2016

The Divisions of Family Health and Children’s Special Health Services (CSHS), within the Community Health Section (CHS) are the lead divisions for administration of the Title V funds. The organizational structure of the CHS lends itself strong collaborative efforts between programs, an important asset for many MCH activities, including the needs assessment process.

Agency Capacity

Agency’s Capacity to Promote and Protect the Health of all Mothers and Children, including CSHCN: Title V staff actively participate on a variety of committees and coalitions that impact the health of mothers and children, including CSHCN. These collaborative partners help identify common strategies to address priority needs identified through the needs assessment process within each of the six population health domains and strengthen Title V efforts to promote and protect the health of the MCH population.

Statewide System of Services: ND Title V has many strong collaborative partnerships with other state agencies and private organizations that participate in needs assessment activities, such as the ND Department of Human Services (DHS), ND Department of Public Instruction (DPI), Family Voices of ND, Prevent Child Abuse ND, March of Dimes ND Chapter, ND Center for Persons with Disabilities at Minot State University (NDCPD), etc.

MCH Workforce Development and Capacity

A summary of MCH and CSHCN workforce, including those serving in leadership roles, tenure of staff, and projected shifts in the workforce over the next five years is included as Supporting Document #03 – MCH Workforce.

Culturally Competent Approaches: As part of the initial needs assessment process, data was collected, reported and analyzed according to race and ethnicity. This process assisted in the selection of state priority needs and was

used to inform program development and service delivery when completing the Five-Year State Action Plan tables.

II.B.2.c. Partnerships, Collaboration, and Coordination

Title V staff actively participate on a variety of committees and coalitions that impact the health of mothers and children, including those with special health care needs. Communication and collaboration between many of these groups is assured through Healthy North Dakota (HND); a dynamic, statewide partnership that brings together stakeholders to identify common strategies to address health issues. Both the Title V and CSHCN Directors attend this meeting. Updates on the initial MCH need assessment process, as well as ongoing needs assessment activities, are shared at these meetings. Information about HND can be found at: <http://home.healthynd.org/>.

Other MCH Investments

Essential to data infrastructure of ND's Title V Program is the SSDI grant, which helps to develop, enhance and expand state data capacity. The SSDI Coordinator is a member of the Title V/MCH Leadership Team and is essential to providing and analyzing data for ND's ongoing needs assessment process.

Other Federal Investments

Title V staff collaborate with other federally funded programs, such as Women, Infants and Children (WIC) and family planning. Data from these programs is used to assist with program planning and evaluation (e.g., WIC data is used for program planning/reporting in the reducing overweight and obesity in childhood action plan).

Other HRSA Programs

The Title V and CSHCN Directors participate in quarterly HRSA Partnership calls. The purpose of the calls are to increase knowledge and facilitate collaboration with ND's other HRSA funded partners. Updates on the initial MCH need assessment process, as well as ongoing needs assessment activities, are shared at these meetings.

State and Local MCH Programs

State and local support for MCH programs is described in the Process part of the section.

Other Programs within the NDDoH

Additional partnerships within the NDDoH, not previously mentioned, that address the priority needs of the MCH population, but are not funded by the state Title V program include: autism database, cancer, chronic disease, tobacco, oral health, suicide, domestic violence/rape crisis, healthy communities, and worksite wellness. Partners from these programs and of those previously mentioned, participated in the ongoing needs assessment process and with the state's action plan development.

Other Governmental Agencies

Title V and the NDDPI have a strong partnership and work collaboratively on many projects, such as administration of the YRBS and the Youth Tobacco Survey. These surveys are important components to ND's ongoing needs assessment process.

Tribes, Tribal Organizations and Urban Indian Organizations

NDDoH staff utilize the American Indian Public Health Resource Center (AIPHRC) at North Dakota State University (NDSU), and the ND Indian Affairs Commission for tribal communications, epidemiologic needs, technical assistance and mentoring. A contract with the AIPHRC that focuses on tribal assessments has been an important part of ND's ongoing needs assessment process.

Public Health and Health Professional Educational Programs and Universities

NDSU and the University of North Dakota (UND) collaboratively offer a Masters of Public Health (MPH) program. MPH students are available to the NDDoH to assist with data projects.

The NDDoH also utilizes graduate students from other universities. In early 2016, a graduate nursing student completed a timeliness study for the Newborn Screening (NBS) Program. This data is currently being used by the NBS Program to apply for grant funds to focus on education and timeliness of newborn screening.

Family/Consumer Partnerships and Leadership Programs

There are several family-led organizations in ND that provide leadership and support to families. Three prominent organizations include Family Voices (health information, training and parent-to-parent support for CSHCN), Pathfinder Family Center (education) and the Federation of Families (mental health). These entities are critical partners in all MCH related needs assessment activities.

Other State and Local Public and Private Organizations

Additional entities not previously mentioned include the DHS Behavioral Health Division; Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT); Designer Genes of ND; Great Plains Tribal Chairman's Health Board; ND Center for Tobacco Prevention and Control Policy; ND Hospital Association; ND Medical Association; ND Chapter of the American Academy of Pediatrics; ND Long Term Care Association; ND Public Health Association; ND Dental Association; ND Board of Nursing; ND Office of the Attorney General; Fetal Alcohol Syndrome Center at UND; Child Care Aware; childcare facilities; hospitals, and clinics.

A copy of the current cooperative agreement to assure care and improve health status is in place between DHS, NDDoH, the Primary Care Office, and the Primary Care Association can be found in Section IV. Medicaid IAA/MOU. Title V leadership acknowledges it needs to be updated; processes are currently in place to update the agreement.

Qualitative and Quantitative Information on Established Family/Consumer Partnerships:

On-going collaboration with family/community partnerships is an important aspect to ND's ongoing needs assessment process, which has been described throughout this section.

Five-Year Needs Assessment Summary (Submitted on July 15, 2015)

II.B.1. Process

North Dakota's (ND) needs assessment process followed the conceptual framework outlined in the Title V Maternal and Child Health (MCH) Block Grant Guidance, which, when followed, is expected to serve as the driver in determining state MCH program priority needs and in developing five-year action plans to strategize and address the prioritized needs.

Framework:

The 10 steps in the needs assessment process framework include:

1. Engaging stakeholders
2. Assessing needs and identifying desired outcomes and mandates
3. Examining strength and capacity
4. Selecting priorities
5. Setting performance objectives
6. Developing an action plan
7. Seeking and allocating resources
8. Monitoring progress for impact on outcomes
9. Reporting back to stakeholders
10. Reporting in the interim years of application and annual reports

Early in 2014, ND began planning the five-year needs assessment to select priorities for 2016-2020. The first step involved the MCH leadership team reviewing the draft Title V MCH Block Grant Guidance. The MCH leadership team included the director of the Division of Family Health/Title V, the director of the Division of Children's Special Health Services (CSHS), the State Systems Development Initiative (SSDI) coordinator, and the MCH epidemiologist. These four individuals were responsible for the planning and oversight of the MCH needs assessment process. The leadership team created a mission statement and identified goals for the needs assessment process. The mission statement and goals were shared with state MCH staff for review and approval.

Mission:

To improve the health of ND's MCH population through a comprehensive assessment and planning process that is of value to the greater MCH community.

Goals:

- To build capacity of MCH staff and relevant partners for active participation in an ongoing needs assessment and planning process that drives change in MCH programs and systems.
- To assure accountability to stakeholders and partners involved in the ongoing MCH needs assessment and planning process.
- To enhance collection, analysis, synthesis, and dissemination of quantitative data needed for ongoing needs assessment efforts, including the comprehensive five-year MCH needs assessment and planning process.
- To incorporate qualitative approaches and strategies as part of the ongoing needs assessment and planning process.
- To select aligned priorities and determine relevant federal and state performance and evidence-based or -informed strategy measures.

- To integrate assessment and planning processes within the North Dakota Department of Health (NDDoH) and those conducted at the community level.
- To incorporate a culture of quality improvement and performance management into the five-year needs assessment and planning process.
- To have an executive summary as a product deliverable to partners and stakeholders.

In addition to creating a mission statement and goals, a logo and tag line were created to brand MCH in ND:



Methodology:

Both qualitative and quantitative data collection and review activities were completed to conduct the needs assessment. Qualitative activities consisted of surveying stakeholders to gain their input into perceived needs of their MCH communities; a kick-off meeting of MCH program staff and stakeholders; and a post-prioritization survey of stakeholders and presentations to a variety of entities to gather input on whether the areas prioritized reflected the needs of the MCH population. Quantitatively, an epidemiological review of all available MCH indicators and outcomes data at the state and national levels and a criteria-based ranking and weighting prioritization tool were utilized. A consensus-based approach was used to streamline the identified priorities and to align them with the Maternal and Child Health Bureau's set of national priority areas.

Stakeholder Involvement

MCH Survey of Perceived Needs:

In December 2013, a survey instrument was developed to obtain stakeholder input on MCH perceived needs; the survey was deployed January through March 2014. The 11 question survey was sent to a large number of MCH stakeholders, who were asked to forward the survey to others that may be interested in participating. Links to MCH resources and data (ND's MCH performance measures, outcome measures, health status indicators, and health system capacity indicators) were provided at the start of the survey to assist stakeholders in understanding MCH Block Grant requirements. The questions in the survey were open ended to capture qualitative information to gather: specific recommendations for strengthening and improving the health of the MCH population; specific programs or aspects of the service system that are, and are not, working well; and what MCH populations in the state need additional supports. In addition, the survey asked respondents to list their major or emerging health concerns and the biggest needs that are not being met for the MCH population.

There were a total of 149 respondents; the top three entity respondents were local public health (31.5%), state agency (12.6%) and hospitals (10.5%). The least responses were from family members (6.3%) and tribal entities (2.8%). Urban counties, specifically Burleigh (24.5%), Cass (14%), and Grand Forks (9.8%), had the highest number of responses, while eight rural counties had minimal to no responses. Smaller response rates included those from rural areas, tribal communities, policy makers, disability services, county social services, third-party payers, families, and schools. Although there were minimal responses from tribal entities, many respondents indicated that there was greater need for services among American Indian (AI) populations and communities.

Health education, access, and drug rehabilitation were the top recommendations for improving the health of ND's MCH population. Women, Infants and Children (WIC), car seats, and breastfeeding were listed as the top three specific programs or aspects of the service system that are working well; those not working well included transportation and education. Additional supports were indicated for AIs and those MCH populations living in the western energy producing counties in the state.

Health education, transportation, and access were identified as the main overall health concerns by the majority stakeholders. For pregnant women, mothers, and infants – drug rehabilitation, health education, and access were identified as the major health concerns. Major health needs for children and adolescents were identified as drug rehabilitation, nutrition, and parenting education. For children with special health care needs (CSHCN), the respondents identified access, insurance, and medical home.

North Dakota MCH Needs Assessment Kick-Off Meeting:

On June 16, 2014, a MCH needs assessment meeting was held to engage state and local stakeholders in the needs assessment process. Save-the-date fliers that included the purpose of the meeting were emailed to the same large group of stakeholders as for the MCH survey. Once again, the stakeholders were asked to forward the survey to others that may be interested in participating. Approximately 75 stakeholders attended the meeting in person or by video and/or audio conference. Meeting objectives included: a presentation on MCH history, information about the needs assessment process, information about MCH 3.0 transformation, and a review of the results from the MCH Survey of Perceived Needs. The meeting was successful in the fact that it increased stakeholders' knowledge and understanding of MCH and ND's needs assessment process; improved communication channels; generated new ideas; and built and sustained relationships and partnerships.

Another MCH Needs assessment meeting was held on July 10, 2015 for new state MCH staff. The purpose of this meeting was to provide an in-depth MCH orientation for new staff so that they could be actively engaged in the needs assessment process.

MCH Stakeholder Survey – Did we select the best MCH priorities for 2016-2020?:

In March 2015, another stakeholder survey was developed and distributed to obtain feedback on the selected state priorities. Information about the needs assessment process and rationale for why the priorities were selected were included in the survey. A total of 222 individuals completed the survey. Of those, 83 percent (184) agreed with the selected priorities. Additional detail regarding this survey is discussed under "Findings."

Family Voices Topical Call – Improving Health Services and Health Outcomes for ND Mothers and Children, including those with Special Health Care Needs:

On April 14, 2015, the Title V and CSHCN directors provided information on the MCH needs assessment and selected state priorities on a Family Voices of ND (FVND) topical call. FVND hosts topical calls every month to increase families and providers knowledge on topics relevant to children with special health care needs. The email sent by FVND to invite individuals to the call included the link to the MCH stakeholder survey – *Did we select the best MCH priorities for 2016-2020?*. Nineteen individuals participated in the call.

In May 2015, the results of the MCH Stakeholder Survey – *Did we select the best MCH priorities for 2016-2020?*, were shared with stakeholders, along with the finalized list of ND's 10 state MCH priorities. In this same email, stakeholders were informed that action plans would be developed for addressing the priorities and were invited to participate in the process.

In addition, MCH leadership team members individually presented information for feedback on the needs assessment process and state priorities to many entities including the ND State Association of City and County Health Officials (local public health), ND State Council on Developmental Disabilities, Pathfinder Services of ND, and Family and Medical Advisory Councils for CSHCN.

Quantitative and Qualitative Methods

The SSDI Coordinator compiled MCH data into a spreadsheet organized by federal and state performance and outcome measures, and by health status and health system capacity indicators. When possible, data was stratified by race, age, socioeconomic status, and geography for meaningful comparisons so that disparities could be identified. Relevant data sources were organized in the following categories: population and demographics; pregnant women, mothers and infants to age 1; children and adolescents; and CSHCN.

The MCH epidemiologist conducted an objective review of this data and developed a summary of needs for the ND MCH population. In this criteria based review, the MCH epidemiologist evaluated the MCH indicators and outcome measures through a problem-based framework as defined by the size of the population affected, trend of the data, comparison to national estimates, preventability of conditions, and the life-long effect of the various risk factors and outcomes considering the risk of mortality and morbidity of the MCH population. Eighteen pertinent needs were identified as potential priority areas based on the quantitative data. These results were then compared with the initial public input survey which had identified healthcare access, education, and drug rehabilitation as the top areas of perceived needs. Taking these recommendations and considering the 15 national priority areas, the MCH epidemiologist presented these findings to the MCH leadership team to facilitate the selection of ND's priorities for 2016-2020.

Following this quantitative and qualitative evaluation, the MCH leadership team utilized a criteria-based ranking and weighting prioritization tool that was adopted from Minnesota to select ND's priorities. On a scale of 1 to 5, with 1 being low priority and 5 being high priority, individual team members assigned a score to each of the 15 potential priority areas after an extensive discussion. Scores were pooled and then averaged to account for variations between the four team members. Criteria definitions included:

- Seriousness of the issue – what is the size of the problem, is trend data available, what are the short and long-term health impacts, do population subgroups have significantly worse illnesses or conditions when compared to another group?
- Evidence-based strategies – are there evidence-based strategies for improving the issue, how easily can the strategy be implemented, is there consistent data available for measuring the outcomes?
- Current resources – what is currently happening at the state and local levels to address the issue, what resources are currently being devoted to the issue, are these resources stable and likely to remain available?
- Momentum for change – is addressing this issue politically feasible, is there community awareness and acceptance of the issue, is the issue perceived to be preventable, is the environment supportive of choosing this issue and/or directing resources to improve outcomes?
- Return on investment – what is the expected payoff, will dollars invested make a difference in this measure, can something be done with relatively few resources or will it take extensive resources to affect the measures, what is the impact on downstream issues?
- Ease of measurement – are consistent data available, is there a measure that will tell us if we are successful?

Data Sources

A number of data sources were utilized to inform the needs assessment process, including:

- MCH data sources (National Performance Measures, State Performance Measures, National and State Outcome Measures, Health Status Indicators, Health System Capacity Indicators)
- U.S. Census Bureau data
- ND Vital statistics/vital records
- ND Department of Health program data (e.g., sexually transmitted infections)
- ND Department of Human Services, Medicaid Health Tracks Program
- National and state surveys (e.g., YRBS, BRFSS, National Survey of Children with Special Health Care Needs,

National Survey of Children's Health)

- Community health data (e.g., ND Early Hearing Detection and Intervention Program, WIC)
- Input of families and consumers through qualitative surveying (MCH Survey of Perceived Needs and MCH Stakeholder Survey – *Did we select the best MCH priorities for 2016-2020?*)
- Expertise from state MCH program staff

A complete list of data sources can be found in attachment – North Dakota Needs Assessment Data Sources - 2015.

Interface Between Data, Priority Needs and Development of Action Plans

As described above, both quantitative and qualitative data were utilized to make decisions on ND's MCH priorities by state level MCH staff. Following the selection of these priorities, stakeholders were asked – *Did we select the best MCH priorities for 2016-2020?* After a thorough review of responses, ND's 10 priorities were finalized and aligned with the national priority areas. An email was sent out to stakeholders announcing ND's priorities and inviting participation in action plan development.

Five-year action plans were developed and organized around the six population domains. State MCH staff took the lead in developing the action plans that pertained to their content area of expertise. While only four stakeholders responded to participate in action plan development, their input was extremely valuable. The Title V and CSHCN directors developed an action plan template and example for staff with specific instructions that followed MCH Block Grant Guidance on developing objectives, strategies and activities. Strategies were developed using best practices, evidence-based, evidence-informed or promising practice approaches.

II.B.2. Findings

Findings are included with II.B.2.a. MCH Population Needs.

II.B.2.a. MCH Population Needs

Initially, the MCH epidemiologist evaluated the state's MCH data based on the demographic factors that currently define ND, and later evaluated the socio-economic factors in order to identify disparities and needs. This was achieved first by reviewing ND census data to gather information on the current population and changes over time, racial distribution, and more specifically the proportion of the MCH population within the state. Several key findings on the general population stood out.

ND is the fastest growing state in the nation with an almost 10 percent population increase between the 2010 Census and the 2014 population estimate data, reaching a total of 739,482 residents. This has been primarily due to energy development activity, in addition to strong agricultural markets, and private sector growth.

Contrary to the national population shift towards an aging population as the youngest of the baby boom generation enters their fifties, ND's population is becoming younger. The median age in ND is currently 36.9 years old, slightly younger than the national median of 37.2.

Health disparities and poverty disproportionately persist in the reservation areas of the state. AI's represent the largest minority population in ND (5.4%). ND has five federally recognized tribes and one Indian community; approximately 64 percent of AI's in ND live on reservations.

ND's communities are becoming more racially diverse. The ND population of color (i.e., non-White) experienced a 24 percent increase from 2010 to 2013. During the same time period, when comparing racial/ethnic groups, the Black population experienced the fastest growth (59% increase), followed closely by the Hispanic population (54% increase).

This shift in population and racial diversity brings along both opportunities and challenges that affect the health of the

MCH population, the types of health-care services needed, and the financial viability of health-care systems.

Overview of the health status, strengths/successes and needs/challenges of the state's MCH population

The key issues facing the ND MCH population were assessed based on trends, program goals/objectives and publications, and comparison on the national platform – consequently identifying the strengths and weaknesses of the state's MCH population across the three legislatively-defined population groups.

Pregnant Women, Mothers and Infants up to Age 1

Women's/Maternal Health:

ND is doing well ensuring that high-risk pregnant women are delivering at appropriate facilities. The proportion of low-birth weight infants being delivered at facilities for high-risk deliveries has steadily increased from 45 percent in 2008 to 75 percent in 2013. Several key challenges have been identified to improve the health of ND women and mothers. With only 37 percent of ND women ages 18 through 44 being at a healthy weight, reducing overweight and obesity ranks high as a priority area for this population. The incidence of sexually transmitted infections in women ages 15-44 has steadily increased from 11.9 per 1,000 in 2008 to 17.4 per 1,000 in 2013 – a historical high. Smoking during pregnancy is another concern, with about 15 percent of pregnant women in the state smoking at any point during their pregnancy. Disparities exist in this population, especially in the AI population. In 2013, the mortality rate for all-causes for AI's birth through ages 44 was four times higher than the mortality rate for the White population. AI's overall have a higher prevalence of conditions such as diabetes, substance abuse, unintentional injuries, and smoking – especially those residing in reservations.

Perinatal and Infant Health:

ND mandates newborn screening, and as a result, 100 percent of infants screened that receive a positive result receive timely definitive diagnosis and clinical management. ND's involvement with the Infant Mortality Collaborative for Improvement and Innovation (ColIN) initiative has been successful in increasing partnerships and activities relating to safe sleep. While ND has been successful in decreasing neonatal mortality from a high of 4.2 per 1,000 live births to the current rate of 3.6 per 1,000 live births, AI infant mortality rates show significant disparities with an almost four-fold incidence of infant deaths as compared to that of the White infant population. ND ColIN has formed a strong partnership with the American Indian Public Health Resource Center at the University of North Dakota to address infant mortality on AI reservations. Other concerns include the percent of ND Medicaid enrollees less than one year of age who receive at least one periodic screen. In 2011, 88 percent of ND Medicaid enrollees received a screen, however, this dropped to 71 percent in 2013. Enrollees of Healthy Steps, the state's Children Health Insurance Program receiving at least one periodic screen also steadily declined from a high of about 81 percent in 2009 to a low of approximately 72 percent in 2013. Infants still breastfeeding at six months in 2011 was 45 percent, a proportion significantly below the national average of 50 percent, thereby making this another priority area.

Children

Child Health:

Among children, ND has been successful in steadily decreasing the death rate from unintentional injuries attributable to motor vehicle crashes from a peak of 3.4 per 100,000 to no deaths per 100,000 in 2013. Non-fatal injuries in the same age group from motor vehicle crashes have also steadily decreased from 366 per 100,000 in 2010 to 316 per 100,000 in 2013. Challenges in this population include declining oral health care services utilization in Early Periodic Screening Diagnostic and Treatment (EPSDT) eligible children, with this proportion dropping from approximately 50 percent in 2010 to about 42 percent in 2013. Obesity and overweight in the childhood and adolescent populations ages 10 through 17 is another pertinent issue that needs addressing – with approximately 36 percent of this population being overweight to obese. Bullying is also a concern for this population. According to the 2013 Your Risk

Behavior Survey (YRBS), more than half (52%) of students in grades seven and eight had ever been bullied on school property. Cyber bullying is also becoming an issue, with more than a quarter (28%) of these same students reporting ever been electronically bullied, with a significant difference between females (39%) and males (17%).

Adolescent Health:

Among the ND adolescent population, there has been a continued decrease in teenage pregnancies among female youth ages 15 through 17, from a high of about 13 pregnancies per 1,000 in 2010, down to a rate of about 10 pregnancies per 1,000 in 2013. While the percentages are lower for high school students, bullying is also a concern for this population, with 25 percent of students in grades 9-12 reporting being bullied on school property during the past 12 months according to the 2013 YRBS. Motor vehicle crashes are the number one killer of teenagers, and young drivers are twice as likely as adult drivers to be in a fatal crash. In ND in the past three years, unintentional injuries among youth ages 15 through 24 due to motor vehicle crashes ranged from 19 to 27 per 100,000. Disparities persist in this age group, with 2013 AI suicide rates for youth ages 15 to 19 at much higher rates (21 suicides per 100,000) than the national rate (12 suicides per 100,000).

Children with Special Healthcare Needs

In ND, approximately one in seven children (13.9%) has special health-care needs. Mandated services for certain conditions for CSHCN assists eligible families with medical costs and helps to provide gap filling services, such as state level care coordination and assisting with providing no cost medical food and low-protein modified food products for children with phenylketonuria (PKU) and maple syrup urine disease (MSUD). ND recognizes the importance of the medical home for all children, including CSHCN. In the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), it was reported that 47.8 percent of children, ages 0 to 18, received coordinated, ongoing and comprehensive care within a medical home. While ND is doing better than the nation (43%), this percentage represents a decrease from 2005/06 (55%). Transition into adulthood is cited as a challenge by families in the NS-CSHCN, with only about 47 percent of families in 2009/10 reporting having adequate resources for successful transition, down from about 51 percent in 2005/06.

Cross-cutting/Life Course:

Oral Health: ND has been successful in securing three oral health grants that have allowed the state ND Oral Health Program to function as the sustainable “backbone” organization in the state. These grants have strengthened the infrastructure and capacity to enable the Oral Health Program to carry out the core functions of public health. Despite this, challenges exist and the burden of oral disease is not uniformly distributed throughout ND. Access to oral health services is an ongoing concern and challenge. Vulnerable and underserved populations face a variety of barriers to oral health care including transportation issues; lack of insurance or ability to pay for care; inability to take time off work to go to the dentist or transport their children; limited availability of providers accepting Medicaid; and lack of understanding of the importance of good oral health and its impact on overall health. The limited oral public health infrastructure, particularly in rural counties and lower economically impacted state regions, provides limited options for families in need. The existing oral health safety-net facilities are overburdened and cannot take on more patients without expanding their infrastructure.

Adequate Health Instance Coverage: ND expanded Medicaid in the state, allowing all legal residents with incomes up to 133 percent of poverty to be eligible for ND Medicaid benefits. As of May 1, 2015, 17,500 consumers were enrolled. In December 2013, the ND Medicaid Office estimated Expanded Medicaid could benefit 20,500 consumers in ND. Current enrollment indicates 85 percent of those people have been covered. ND is one of 36 states that make up the Federally Facilitated Marketplace for the Affordable Care Act. Efforts in ND over the first two years of open enrollment indicate over 18,000 consumers have a Qualified Health Plan (QHP) through the Marketplace. To increase insurance coverage for ND’s children, a 1-877-KIDS-NOW toll-free resource line was developed that helps uninsured families learn about low-cost and free health coverage programs in ND. A seamless

eligibility process for health coverage programs has helped to assure coverage for ND's children. In 2013, 88.3 percent of the eligible children in the U.S. were enrolled in Medicaid and CHIP programs; ND's participation rate is 84.3 percent. Despite these successes, ND's uninsured rate has remained largely unchanged for all populations.

Based on this qualitative assessment of strengths/success and needs/challenges, along with utilizing the quantitative MCH survey data of perceived needs and the criteria-based ranking and weighting prioritization tool, 10 state priority needs were determined across the six population domains and aligned with the national priority areas.

With the 10 state priority needs identified and aligned with the national priority areas, the MCH leadership team sought public/stakeholder input in the form of a survey – *Did we select the best MCH priorities for 2016-2020?* The purpose of this survey was to evaluate whether the state priorities and national priority areas selected represented the public perception of the needs in ND; and if not, what they felt should be included.

The Title V and CSHCN directors sent out the survey via an email statewide to MCH partners and stakeholders. To further increase participation in the survey, state MCH staff distributed the survey to their partners and stakeholders, including committees, coalitions, and advisory groups. Collaboration with chronic disease programs assured that the survey was distributed to this group of critical partners and stakeholders as well. In addition, MCH leadership team members individually presented information for feedback on the needs assessment process and state priorities to many entities (e.g., FVND, local public health, ND State Council on Developmental Disabilities, Pathfinder Services of ND, and Family and Medical Advisory Councils for CSHCN). The link to the survey was included at each of these presentations.

The survey included the selected state priorities, linkage to the national priority areas and rationale for selection in a table format as presented below:

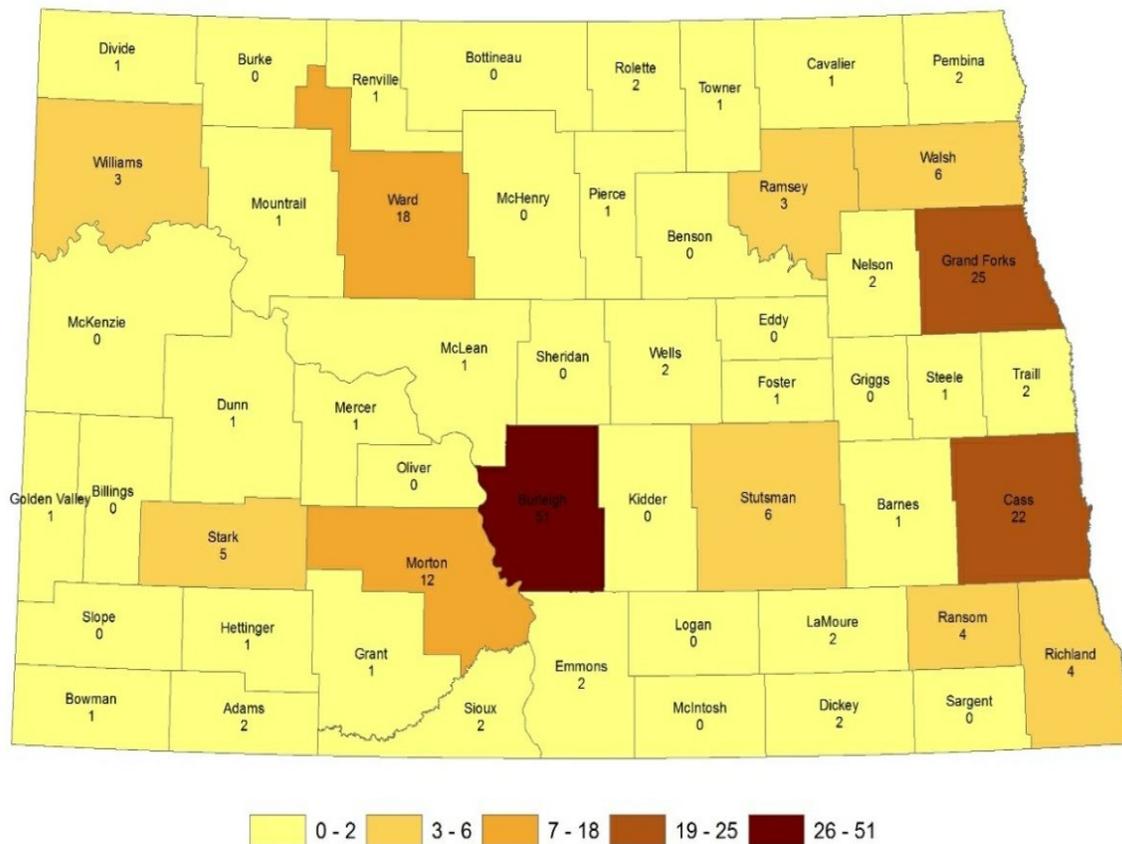
North Dakota Priority/ Linkage to National Priority Area	Rationale for Selection
Reduce tobacco use in pregnant women/ Well women care	In ND, about 18 percent of women (1 in 5) reported smoking at any point during their pregnancy, compared to about 11 percent nationally (1 in 10). Smoking during pregnancy can cause a baby to be born too early, have low birth weight, and increases the risk of Sudden Infant Death Syndrome (SIDS).
Increase the rate of breastfeeding at 6 months/ Breastfeeding	In ND, about 45 percent of women report having breastfed their infants at 6 months, compared to about 50 percent nationally. Breastfeeding is associated with a reduced risk of SIDS, reduces a child's risk of becoming overweight as a teen or adult, and has been linked to decreased risk of breast and ovarian cancer in women.
Reduce disparities in infant mortality/ Safe sleep	In ND, the American Indian infant death rate (15 per 1,000) is about 4 times greater than that of the White infant death rate (4 per 1,000). Significant differences exist in infant deaths between races. Infants born to American Indian mothers are at much higher risk for poor birth outcomes, including being born too early, being born at low birth weight, and to die in the first year of life.
Reduce fatal motor vehicle crash deaths to adolescents/	In ND in the past three years, unintentional injuries among youth ages 15 through 24 due to motor vehicle crashes ranged

Injury	from about 19 to 27 per 100,000. Motor vehicle crashes are the number one killer of teenagers; young drivers are twice as likely as adult drivers to be in a fatal crash. Motor vehicle crashes are preventable and proven strategies can improve the safety of young drivers on the road.
Reduce overweight and obesity in children/ Physical activity	In ND, about 36 percent of children and teenagers between the ages of 10 through 17 are considered overweight to obese, compared to 31 percent nationally. There are many reasons for childhood obesity including poor food choices and reduced physical activity. Children that are overweight have an increased risk for heart disease, diabetes, asthma, and low-self-esteem.
Decrease depressive symptoms in adolescents/ Bullying	In ND, about 25 percent adolescents (1 in 4) report having depressive symptoms (feeling sad and/or hopeless) and/or being bullied in the past 12 months. Mental/behavioral health conditions have been increasing among children. Bullying is a major public health problem that is linked to depression, antisocial behavior, suicidal thoughts, poor school performance, et cetera.
Increase the utilization of medical home/ Medical home	In ND, about 48 percent of families of children with special health care needs (less than half), ages 0 to 18, report having received coordinated, ongoing, comprehensive care within a medical home. A medical home means a child has a personal doctor or nurse as a usual source of care, gets needed referrals, receives effective care coordination, and assures families are actively involved in their child's care. Children with a medical home are more likely to receive preventive care, are less likely to be hospitalized, and are more likely to be diagnosed early for chronic or disabling conditions.
Increase the number of children with special health care needs receiving transition support/ Transition	In ND, about 47 percent of parents of children with special healthcare needs (less than half) report having adequate resources for their child's transition into adulthood. Transition to adulthood is a critical developmental period. Children who do not receive transition services are more likely to have unmet health needs as adults. Transition includes discussions about adult doctors, changing health needs, health insurance, and appropriate self-care and management.
Increase adequate insurance coverage to the MCH population/ Adequate insurance coverage	In ND, about 23 percent of all children did not have adequate health insurance to meet their complex needs, compared to about 28 percent of children with special healthcare needs. A benefit of health insurance is better access to care; however, individuals with continuous insurance coverage may still not be adequately insured. Inadequate insurance can lead to delayed or foregone care. Problems include cost-sharing requirements, benefit limitations, and inadequate coverage of

	needed services.
Increase preventative dental services to children/ Oral health	In ND, about 42 percent of Early Periodic Screening Diagnostic and Treatment-eligible children ages 6 through 9 (less than half) reported having received any dental services. Oral health is an important component of overall health throughout life and is a great unmet health need among certain population groups within the state. People with limited access to oral health care are at greater risk for chronic diseases.

A total of 222 respondents completed the survey. Survey respondents included state agency (28%), local public health (13%), health care provider (10%), county social services (8%), hospital (6%), family members (4%), and tribal entities (1%). There were no responses, or only one response, from legislators, judicial, law enforcement, health plan/insurance, and childcare/daycare providers. It should be noted that the survey was sent to partners in each of these categories. As shown in the map below, urban counties had the highest response rates, with no responses from 14 out of 53 (26%) counties.

Respondents to the Title V / MCH Survey by County



There were 222 respondents for the survey, out of which 195 were in-state respondents and one was from out of state.

Of those responding to the survey, 83 percent (184) of the participants agreed with the 10 selected priority areas; 17 percent (38) did not agree with the selected priorities. Of those not fully agreeing, 34 respondents provided an alternate priority area: 21 suggested developmental screening; four suggested perinatal regionalization; and adolescent well visit, smoking, and low-risk cesarean deliveries each received three votes. Rationale provided by 28 of the respondents emphasized the need for developmental screening, early detection, and early intervention. In the first qualitative MCH survey of perceived needs, developmental screening was also cited as a need to appropriately diagnose, refer, and treat children with special health-care needs.

Given that 17 percent of MCH stakeholders did not fully agree with the survey and that the majority of those respondents chose developmental screening as an alternate priority area, the MCH leadership team thoroughly re-evaluated this priority using the previously reference criteria-based ranking and weighting prioritization tool and also considered it under its relevant population domain. The final score put developmental screening below the other priority areas picked for this population domain; hence, developmental screening was not included as a state priority. The results of the survey and the final list of state priorities and national priority areas were shared with stakeholders via email. In this email, stakeholders were informed that additional data was analyzed relating to developmental screening and that the prioritization tool was once again utilized; however, after a thorough review and discussion of the data, it was determined not to include developmental screening. The email recognized the critical importance of developmental screening and assured continued partnerships on efforts to move this issue forward.

Of the ten selected state priorities, the MCH leadership team utilized their experience and expertise to determine which of the eight required national priority areas to develop five-year action plans around. Conclusively, the final ND MCH 2016-2020 eight national priority areas, state selected priorities and related population domain includes:

- Well woman care – Reduce tobacco use in pregnant women – Women’s/Maternal Health
- Breastfeeding – Increase the rate of breastfeeding at 6 months – Perinatal/Infant Health
- Safe sleep – Reduce disparities in infant mortality – Perinatal/Infant Health
- Physical activity – Reduce overweight and obesity in children – Child Health
- Injury – Reduce fatal motor vehicle crash deaths to adolescents – Adolescent Health
- Medical home – Increase the utilization of medical home – CSHCN
- Transition – Increase the number of CSHCN receiving transition services – CSHCN
- Oral health – Increase prevention dental services to children – Cross-cutting/Life Course

The remaining two state priorities – decrease depressive symptoms in adolescents, and increase adequate insurance coverage to the MCH population – will be addressed as state performance measures in 2016. Additional areas of need that were examined, but ultimately not included as state priorities included home visiting programs, suicide, youth and adult smoking rates, incidence of sexuality transmitted infections, obesity in adulthood, racial disparities, and American Indian mortality ages 0-44.

Programmatic Approaches

Analysis of specific programmatic approaches where current efforts are working well and areas in which new and/or enhanced strategies are needed, was completed during initial development of the five-year action plans by reviewing documents containing best practices, evidence-based, evidence-informed or promising practice approaches. Strategies were developed utilizing this assessment. This analysis will be on-going with further refinement of the action plans in the four interim year applications.

Adequacy and Limitations

ND’s five-year needs assessment process was successful in selecting state priorities and national priority areas; this success was due to several factors. First, having a core MCH leadership team leading the process increased the efficiency of moving the needs assessment process forward. In addition, having a large body of data to support the process, the design and implementation of the needs assessment was for the most part comprehensive and

representative of the needs of the MCH population. Finally, involving state MCH staff and stakeholders during all phases of the process assured that the findings of the needs assessment served as the “drivers” in determining MCH program priority needs and in developing the five-year action plans to address them.

Although the needs assessment process was successful, there were some limitations including: under-representation of rural counties and tribal populations in the qualitative portions of the process; lack of a thorough program capacity assessment; and time constraints in conducting needs assessment activities with competing priorities (e.g., CoIIN, MCH Transformation 3.0). While Infant Mortality CoIIN and MCH Transformation 3.0 involved significant work effort during the same time as needs assessment activities resulting in competing priorities, they also served as strengths in supporting data collection and development of action plan strategies.

Needs assessment is an on-going process and ND will continue to monitor and assess the successes and continuing needs of the MCH population.

II.B.2.b Title V Program Capacity

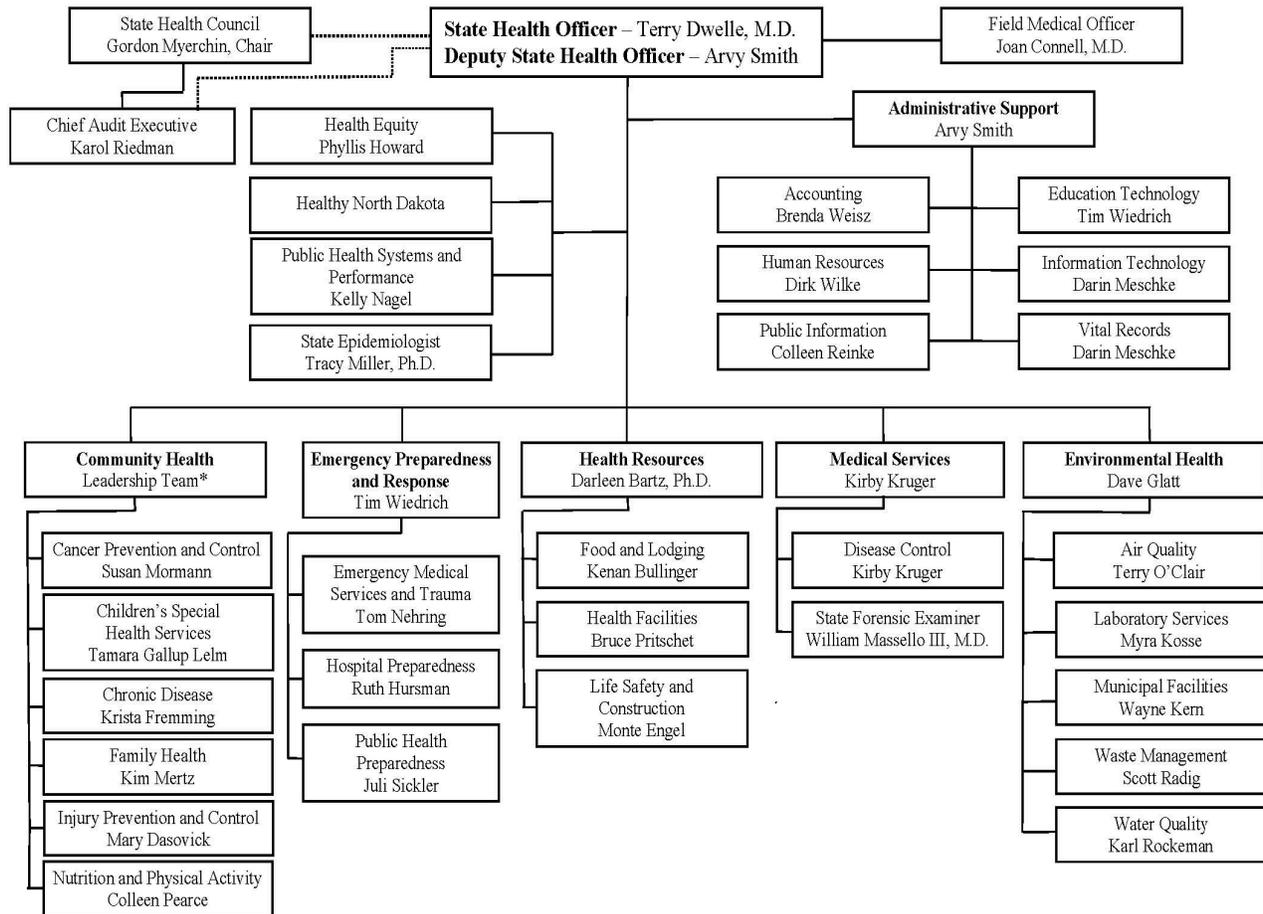
II.B.2.b.i. Organizational Structure

Description: The ND Department of Health (NDDoH) employs about 365 staff dedicated to making ND a healthier place to live. The mission of the NDDoH is to protect and enhance the health and safety of all North Dakotans and the environment in which we live. The six sections of the department include: 1) Administrative Support, 2) Community Health, 3) Emergency Preparedness and Response, 4) Environmental Health, 5) Health Resources, and 6) Medical Services.

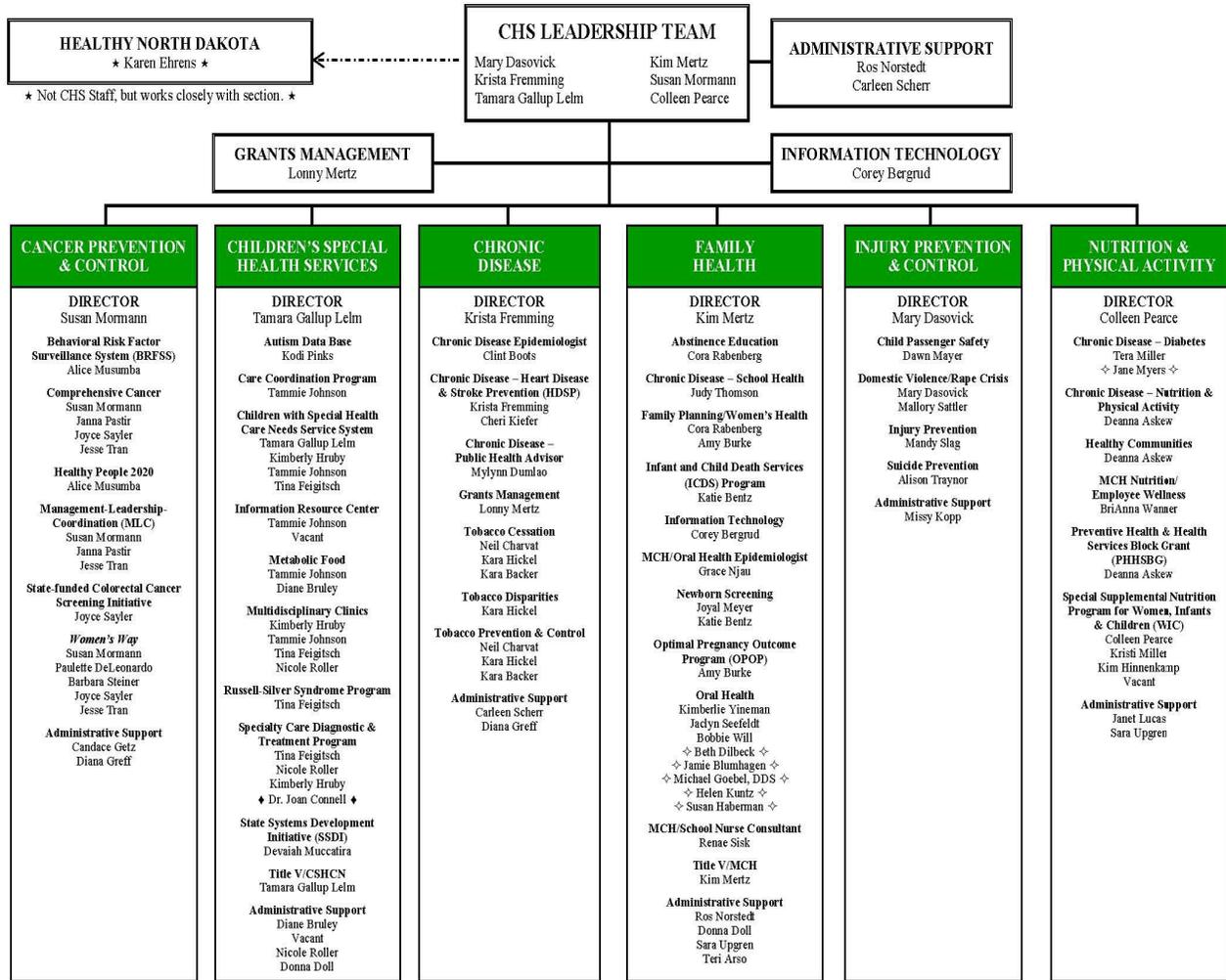
The Divisions of Family Health and Children’s Special Health Services (CSHS), within the Community Health Section (CHS) of the NDDoH, are the lead divisions for administration of the Title V funds. There are six divisions within the CHS: 1) Cancer Prevention and Control, 2) CSHS, 3) Chronic Disease, 4) Family Health, 5) Injury Prevention and Control (IPC), and 6) Nutrition and Physical Activity (NPA). The Divisions of Family Health, CSHS, IPC, and NPA have programs funded by the federal-state Title V Block Grant. The organizational structure of the CHS lends itself to strong collaborative efforts between programs, an important asset for many MCH activities, including the needs assessment process.

Responsibilities of the State Department of Health are addressed in ND Century Code (N.D.C.C.), Chapter 23-01. The State Health Officer (SHO) of the NDDoH is responsible for the administration of programs carried out with allotments made to the state by Title V. The NDDoH functions in compliance with Chapter 28-32, Administrative Agencies Practice Act; N.D.C.C. Programs funded by the federal-state Title V MCH Block Grant include: Children with Special Health Care Needs (CSHCN), child passenger safety, injury/violence prevention, newborn screening, MCH epidemiology, nutrition, breastfeeding, optimal pregnancy outcome, school nursing, and sudden infant death syndrome. Additional information regarding state mandates can be found in Section II.A. Overview of the State.

The NDDoH organizational charts are located below.



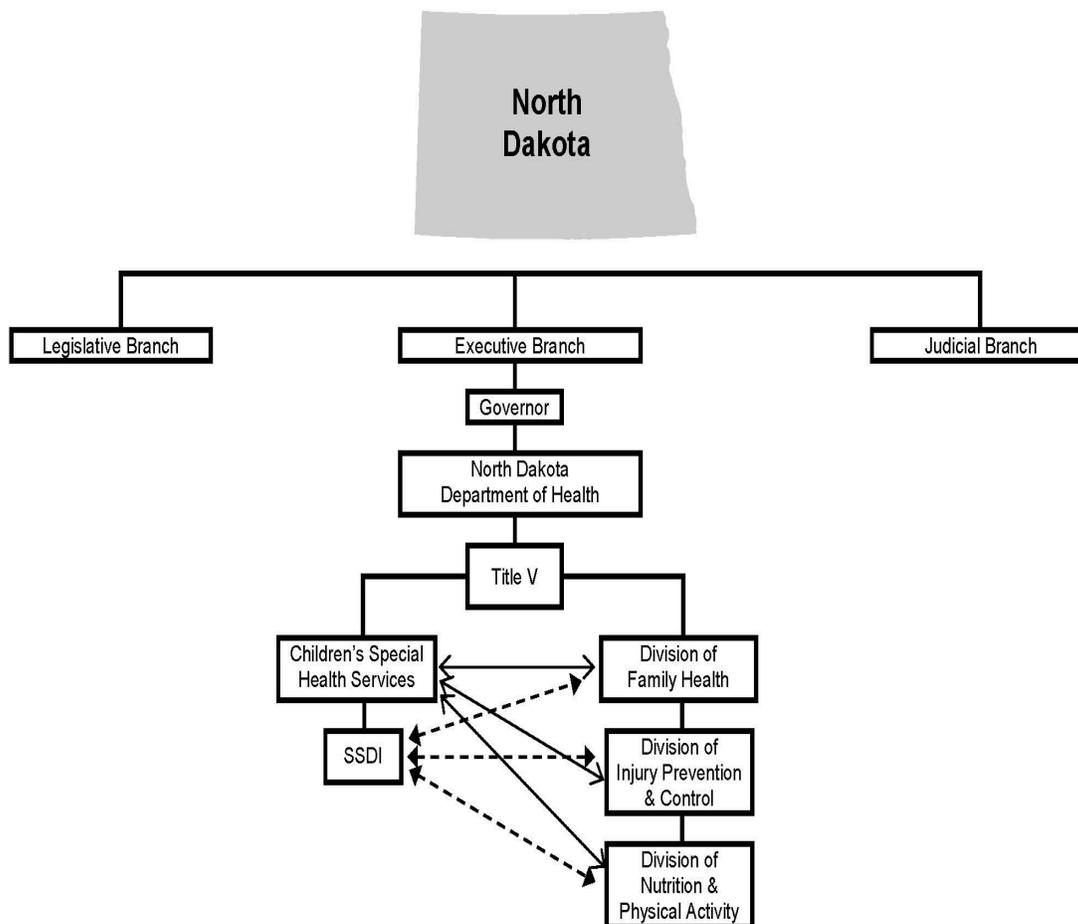
*The six division directors share responsibility for management of the Community Health Section.



♦ Contracted Medical Director ♦ / ♦ Temp Positions ♦

S:\COMMONCHS Div Dir Handbook\1. Overview\Organizational Chart CHS 7-2015

STATE OF NORTH DAKOTA ORGANIZATIONAL CHART



H:\MCH Grant\Current Organizational Charts\Org Chart State of ND 7-2015.docx
Last Revised 7-11-2007

II.B.2.b.ii. Agency Capacity

Agency's Capacity to Promote and Protect the Health of all Mothers and Children, including CSHCN: Title V promotes and protects the health of mothers and children, including CSHCN through a variety of programs and services. Descriptions of Title V supported efforts that address the six population health domains can be accessed at: <http://www.ndhealth.gov/CH/>

Title V staff actively participate on a variety of committees and coalitions that impact the health of mothers and children, including CSHCN. These collaborative partners help identify common strategies to address priority needs identified through the needs assessment process within each of the six population health domains and strengthen

Title V efforts to promote and protect the health of the MCH population.

ND is a 209(b) state, which means Supplemental Security Income (SSI) beneficiaries under 16 years of age are not automatically eligible for ND Medicaid. If assets are an issue affecting ND Medicaid eligibility, children eligible for SSI can be covered under the children and family coverage groups where asset testing is not required. The state CSHCN program pays for or provides rehabilitative services for eligible children that are served by Title V to the extent services are not provided by ND Medicaid.

State CSHCN program staff conduct outreach, information and referral activities targeted to the SSI population. On a monthly basis, Disability Determination Services provides referrals electronically to the state CSHCN program. In response, state CSHCN staff provide a direct mailing to families notifying them about potential programs that could be of assistance. This assures that children are consistently being referred to the Title V program and that families receive information about program benefits and needed services.

Statewide System of Services: ND Title V has many strong collaborative partnerships with other state agencies and private organizations, such as the ND Department of Human Services, ND Department of Public Instruction, Family Voices of ND, Prevent Child Abuse ND, March of Dimes ND Chapter, ND Center for Person's with Disabilities at Minot State University (NDCPD), etc. In addition, MCH and CSHCN staff participate on numerous committees, advisory boards and task forces and actively work on a variety of special projects to coordinate health services with other services at the local level. One example of a special project includes staff participation on ND's Early Hearing Detection and Intervention (EHDI) Program which is administered by the NDCPD. Over time, significant gains have been made in the percent of newborns in ND that have had their hearing screened before hospital discharge.

State MCH support for communities is addressed through contracts with local public health units, nonprofits, tribal entities and universities. The state CSHCN program supports cooperative administration of programs for CSHCN with 53 county social service boards. In addition, CSHCN support for communities is addressed through contracts with health systems, universities, foundations, and nonprofits that support multidisciplinary clinics, family support services, and CSHCN systems development initiatives.

II.B.2.b.iii. MCH Workforce Development and Capacity

MCH and CSHCN Workforce: ND Title V staff have many strengths including passion, dedication and knowledge to ensure families receive high quality services; strong interpersonal abilities required for partnership building, collaboration and integration; and the capability to manage multiple priorities – just to name a few. Almost 70 percent of Title V staff have less than five years' experience working in MCH programs at the state-level. Workforce needs include MCH leadership development, increasing understanding about health reform, adaptive skills to lead through change, skills to work effectively within integrated systems, and skills to measure the quality and return on investment of current programs.

Workforce development to advance the capacity of local staff is also important. For CSHCN, major functions of county social service staff include eligibility determination and care coordination services. Almost two-thirds of the 53 county social service assigned staff members have worked with CSHS less than five years. Although almost 80 percent of local staff are licensed social workers, most do not stay in their position long enough to gain needed expertise to best serve CSHCN and their families. With such high turnover (over 60% since November 2011), there is a significant need for ongoing technical assistance and training.

Senior level management who serve in lead MCH-related positions who contribute to the state's planning, evaluation, and data analysis capabilities include:

- Kim Mertz, RN, BNSc, Director for the Division of Family Health/Title V. Kim has over thirty years of experience in health care and has served as ND's Title V Director since 2004.
- Tamara Gallup Lelm, RN, MPA, Director for the Division of CSHS. Tamara has over 35 years of experience in

health care and has served as the CSHCN Director since 2001.

- Devaiah Muccatira, MS, State Systems Development Initiative (SSDI) Coordinator. Devaiah has had a variety of past work experiences as a research assistant and has served as the SSDI Coordinator since 2006.
- Grace Njau, MPH, MCH Epidemiologist. Grace has experience working in MCH-related programs and has served as the MCH epidemiologist since October 2014.

To help assure provision of quality care and services, CSHS supports a part-time Medical Director and a medical advisory council whose membership is appointed by the SHO. Parents or family members have not been hired by the state Title V program. However, CSHS supports a ten-member Family Advisory Council that meets quarterly. Members are reimbursed mileage, meals and lodging and are paid a \$75.00 consultation fee for each meeting they attend. The CSHS Family Advisory Council assures family involvement in policy, program development, professional education, and delivery of family-centered care for CSHCN and their families.

A summary of additional MCH and CSHCN workforce, including tenure and projected shifts in the workforce over the next five years is included as an attachment – MCH Workforce Development and Capacity.

Culturally Competent Approaches: As part of the needs assessment process, data was collected, reported and analyzed according to race and ethnicity. This process assisted in the selection of state priority needs and was used to inform program development and service delivery when completing the Five-Year State Action Plan table.

The NDDoH has developed policies and guidelines to support culturally competent approaches in its service delivery. In April 2015, the NDDoH revised the *Non-Discrimination to Applicants, Clients, and Other Beneficiaries* policy. The newly revised policy seeks to prevent and eliminate discrimination against individuals in employment and in the delivery of programs and services administered and supervised by the NDDoH and to make all programs and activities accessible to persons with disabilities. In addition, the NDDoH completed a *Cultural and Linguistic Competence Policy Assessment* in June 2015. Data from this assessment will be used: (1) to provide a summary of the strengths and areas for growth in training, policy development and administration, (2) for strategic planning, and (3) for quality improvement processes. A NDDoH *Workforce Development Plan* was also finalized in June 2015. This document will assist in identifying gaps in knowledge, skills, and abilities through the assessment of both organizational and individual needs, and address those gaps through targeted training and development opportunities. Cultural competency skills have been identified as one of the core competencies for the department. Annually, as part of the performance review process, all NDDoH employees will create an individualized professional development plan.

II.B.2.c. Partnerships, Collaboration, and Coordination

ND is committed to building, sustaining and expanding partnerships that contribute to, or expand, the capacity and reach of the state Title V MCH and CSHCN programs. Title V staff actively participate on a variety of committees and coalitions that impact the health of mothers and children, including those with special health care needs.

Communication and collaboration between many of these groups is assured through Healthy ND (HND). HND is a dynamic, statewide partnership that brings together stakeholders to identify common strategies to address health issues. The HND Coordinating Committee, which includes the chair/liaison from each of the groups, coalitions, etc., meets every other month with the goal to identify common strategies and strengthen collaborations to address priority health issues.

Other MCH Investments

Essential to data infrastructure of ND's Title V and Infant Mortality CoIN, is the State Systems Development Initiative (SSDI) grant. SSDI helps to develop, enhance, and expand state Title V MCH data capacity. Prevent Child Abuse ND (PCAND) administers the state's Maternal, Infant, and Early Child Home Visiting (MIECHV) and Early Childhood Comprehensive Systems (ECCS) grants. The State Title V Director is an active member of both grant advisory

committees. The CSHCN Director serves as the NDDoH's representative on the State Council on Developmental Disabilities and the Interagency Coordinating Council, both of which focus on systems that support individuals with disabilities and their families. Other CSHCN staff serve on the State Autism Task Force.

Other Federal Investments

Title V staff collaborate with other federally funded programs, such as Women, Infants and Children (WIC), family planning and immunizations. As a result of ND's Infant Mortality CollN initiative, safe sleep education is being provided in all WIC sites and a Cribs for Kids Program has been established at the Spirit Lake Tribal WIC site.

Other HRSA Programs

The Title V and CSHCN Directors participate in quarterly HRSA Partnership calls. These calls are organized and facilitated by the HRSA Deputy Regional Administrator. The purpose of the calls are to increase knowledge and facilitate collaboration with ND's other HRSA funded partners such as the Primary Care Association (Community Healthcare Association of the Dakotas), Primary Care Office (NDDoH subcontracts with the University of ND (UND) School of Medicine and Health Sciences to provide services for workforce development and shortage designation activities), State Office of Rural Health (UND Center for Rural Health), **Early Hearing Detection and Intervention** (NDCPD), Oral Health Workforce (NDDoH, Division of Family Health), and Ryan White/HIV AIDS (NDDoH, Division of Disease Control).

State and Local MCH Programs

Currently, state MCH support for communities is addressed through contracts with 27 local public health units, three nonprofits, one tribal entity and one university. The funds are used for services such as maternal care, well-baby clinics, newborn home visits, genetics, car seat safety programs, school health/wellness, nutrition and physical activity education, injury prevention, immunizations and oral health care. Starting January 1, 2016, the method of funding local MCH programs will be revised to align with MCH Transformation 3.0 and the 2016-2020 ND state priorities and aligning national performance measures.

The state CSHCN program supports cooperative administration of programs for children with special health care needs with 53 county social service boards. County agencies receive reimbursement based on a Random Moment Time Study method of cost allocation. In addition, CSHCN support for communities is addressed through contracts with health systems, universities, foundations, and nonprofits that provide multidisciplinary clinics, family support services, and CSHCN systems development initiatives.

Other Programs within the NDDoH

Additional partnerships within the NDDoH, not previously mentioned, that address the priority needs of the MCH population, but are not funded by the state Title V program include: autism database, cancer, chronic disease (e.g., Diabetes, Heart Disease, Obesity and School Health), tobacco, oral health, suicide, domestic violence/rape crisis, healthy communities, and worksite wellness. Partners from these programs and of those previously mentioned, participated in the needs assessment process and with the state's action plan development.

Other Governmental Agencies

The state Medicaid program is co-located with the State Children's Health Insurance Program (SCHIP), Healthy Steps, in the Medical Services Division within the ND Department of Human Services (DHS). The state CSHCN program has close ties within the Medical Services Division and participates in scheduled meetings to discuss policy, claims payment, and ND Medicaid Management Information System (MMIS) issues. Over the last several years, CSHS staff have contributed to the design and development of the ND Health Enterprise MMIS, a new ND Medicaid claims payment system. Training on the new system has been initiated for staff and providers in anticipation of the expected "go-live" date in October 2015.

Annually, the State CSHCN program convenes a meeting between the Disability Determination Services (DDS), the local Social Security Administration office, ND Medicaid and key family organizations in the state to assure communication about any new developments that have occurred or that are expected during the year that might affect SSI eligible children. Procedures are in place between DDS and CSHS to assure SSI recipients and cessations receive information about program benefits or services. DDS is located in the DHS, in the Vocational Rehabilitation Division.

Title V and the ND Department of Public Instruction (DPI) have a strong partnership and work collaboratively on many projects. The CSHCN Director is a member of the state Interagency Coordinating Council (ICC). Periodically, the ICC meets jointly with the DPI Individuals with Disabilities Education Act (IDEA) advisory group to better coordinate services for young children with disabilities. CSHCN staff are also involved with the Transition Community of Practice led by Special Education staff within DPI.

NDDoH and DPI work together to administer the Youth Risk Behavior Survey (YRBS), Youth Tobacco Survey (YTS) and Profiles. The NDDoH Oral Health Program works closely with DPI to select schools for the school-based dental sealant and fluoride varnish programs. The NDDoH State School Nurse consultant also works closely with DPI on issues such as infection control and medication administration.

Tribes, Tribal Organizations and Urban Indian Organizations

Recognizing the need to strengthen relationships between NDDoH programs and tribal reservations, Dr. Terry Dwelle, SHO, facilitated a meeting in May 2015 between the ND Indian Affairs Commission, staff from the AIPHRC, faculty from the NDSU School of Public Health and key NDDoH staff (Deputy State Health Officer, Title V Director, Health Equity Director). As a result of this meeting, a mutually agreed upon process is being developed for NDDoH staff to utilize the AIPHRC and School of Public Health for tribal communications, epidemiologic needs, technical assistance, and mentoring.

Public Health and Health Professional Educational Programs and Universities

NDSU and UND collaboratively offer a Masters of Public Health (MPH) program. NDSU offers the only MPH degree in the nation with specialization in American Indian public health.

The NDSU's Center for Social Research serves as an evaluator for several oral health grants/programs, including workforce capacity and infrastructure; the school-based dental sealant and fluoride varnish programs; and DentaQuest's long-term care project.

The state CSHCN program and several of the state's universities have developed a mutually beneficial relationship to support multidisciplinary clinic services for CSHCN. University personnel participate as team members in all CSHS cleft lip and palate clinic locations. CSHS multidisciplinary clinics are often used as a source of pre-service training experiences for various health disciplines (e.g., speech language pathology, nursing, social work, medicine, audiology, etc.). A collaborative relationship exists with the UND Communication Disorders Department for administrative support of cleft clinics in the northeast region of the state. In addition, a contract is in place with Minot State University to support autism diagnostic clinics that are held in two sites in western ND.

Family/Consumer Partnerships and Leadership Programs

There are several family-led organizations in ND that provide leadership and support to families. Three prominent organizations include Family Voices (health information, training, and parent-to-parent support for CSHCN), Pathfinder Family Center (education), and the Federation of Families (mental health). Other organizations in the state actively provide support to target populations such as families in the early intervention system and individuals with Down syndrome, autism, or hearing loss, etc.). The state CSHCN program contracts with two family-led organizations to provide emotional support, health information, and training for families. These include Family Voices of ND and ND Hands and Voices.

Other State and Local Public and Private Organizations

Additional entities not previously mentioned include the DHS Behavioral Health Division; Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT); Designer Genes of ND; Great Plains Tribal Chairman's Health Board; March of Dimes ND Chapter; ND Center for Tobacco Prevention and Control Policy; ND Hospital Association; ND Medical Association; ND Chapter of the American Academy of Pediatrics; ND Long-term Care Association; ND Public Health Association; ND Dental Association; ND Board of Nursing; ND Attorney General; Fetal Alcohol Syndrome Center at UND; Child Care Aware; childcare facilities; hospitals, and clinics.

A copy of the current cooperative agreement to assure care and improve health status is in place between DHS, DoH, the Primary Care Office, and the Primary Care Association can be found in Section IV. Medicaid IAA/MOU. Title V leadership acknowledges it needs to be updated.

Qualitative and Quantitative Information on Established Family/Consumer Partnerships:

Please refer to the "Process" and "MCH Population Needs" discussions in this section.

II.C. State Selected Priorities

No.	Priority Need
1	Reduce tobacco use in pregnant women.
2	Increase the rate of breastfeeding at 6 months.
3	Reduce disparities in infant mortality.
4	Reduce fatal motor vehicle crash deaths to adolescents.
5	Reduce overweight and obesity in children.
6	Increase the utilization of medical home.
7	Increase the number of children with special health care needs receiving transition support.
8	Increase preventive dental services to children.

The needs assessment was a comprehensive evaluation of both qualitative and quantitative data to identify and prioritize the needs of North Dakota's (ND) maternal and child health (MCH) population. Qualitative activities consisted of surveying stakeholders to gain their input into perceived needs of their MCH communities; a kick-off meeting of MCH program staff and stakeholders; and a post-prioritization survey of stakeholders and presentations to a variety of entities to gather input on whether the areas prioritized reflected the needs of the MCH population. Quantitatively, an epidemiological review of all available MCH indicators and outcomes data at the state and national levels and a criteria-based ranking and weighting prioritization tool were utilized to look at eighteen areas of need. A consensus based approach was used to streamline the identified priorities and to align them with the Maternal and Child Health Bureau's population groups and set of national priority areas.

As a result of the needs assessment process, ND selected ten state priorities. The MCH leadership team utilized their experience and expertise to determine which of the eight required national priority areas to develop five-year action plans around. Conclusively, following is the list of the eight selected priority needs, rationale for why they were selected and a discussion if the priorities were continued, replaced or added since the previous five-year reporting cycle.

- Reduce tobacco use in pregnant women (Women's/Maternal Health)
- Rationale: In ND, about 18 percent of women (1 in 5) reported smoking at any point during their pregnancy, compared to about 11 percent nationally (1 in 10). Smoking during pregnancy can cause a baby to be born too early, have low birth weight, and increases the risk of Sudden Infant Death Syndrome (SIDS). Smoking is also a risk factor for cardiovascular and respiratory diseases, cancer, and other illnesses. In addition, secondhand smoke causes numerous health problems in infants and children, including more frequent and severe asthma attacks, respiratory infections, and ear infections. Smoking is a modifiable risk factor that if reduced and/or eliminated would have numerous positive short-term and long-term health benefits.
- This is a new state priority; however, it is modified from previous federal performance measure #15, the percent of women who smoke in the last three months of pregnancy. ND has seen small, but steady declines in smoking rates during pregnancy over the past few years. There are strong partnerships and adequate funding for tobacco prevention efforts in the state; hence, the momentum for continued change exists.

- Increase the rate of breastfeeding at 6 months (Perinatal/Infant Health)
 - Rationale: In 2013, about 45 percent of ND women reported having breastfed their infants at 6 months, compared to about 50 percent nationally. Breastfeeding has benefits for both baby and mother. Research suggests that breastfed babies have lower risks of asthma, ear infections, childhood obesity and SIDS. For moms, breastfeeding leads to lower risks for breast and ovarian cancer and type 2 diabetes.
 - This is a new state priority; however, it is continued from previous federal performance measure #11, the percent of mothers who breastfeed their infants at 6 months of age. ND has seen some small improvements with breastfeeding initiation; however, there are a couple of areas that continue to present challenges, including the low numbers of American Indian mothers who choose breastfeeding and the low breastfeeding duration rates at six months for lower income women.

- Reduce disparities in infant mortality (Perinatal/Infant Health)
 - Rationale: In ND, the American Indian infant death rate is about 4 times greater than that of the White infant death rate. Infants born to American Indian mothers are at much higher risk for poor birth outcomes, including being born too early, being born at low birth weight, and to die in the first year of life. Update: the current American Indian death rate is about 3 times greater than that of the White infant death rate; this current data is reflected in other parts of the grant.
 - This is a new state priority; however, data gathered from previous state priority #1, Form and strengthen partnerships with families, American Indians and underrepresented populations – helped to determine this as a new priority. In addition, ND's involvement in the Infant Mortality Collaborative for Improvement and Innovation (ColIN) initiative has raised awareness for this important issue.

- Reduce overweight and obesity in children (Child Health)
 - Rationale: In ND, about 36 percent of children and teenagers between the ages of 10 through 17 are considered overweight to obese, compared to 31 percent nationally. There are many reasons for childhood obesity including poor food choices and reduced physical activity. Children that are overweight have an increased risk for heart disease, diabetes, asthma and low-self-esteem. If children can learn and adapt healthy eating and physical activity habits early in life, these tendencies may have long lasting effects during their life-course.
 - This is a continued priority from previous state priority #10, promote healthy eating and physical activity within the MCH population, although modified to focus on children. While there were many successful activities relating to this priority during the past years, data indicates that ND's childhood overweight and obesity rates are not improving; hence, there is still much more work to be done to address this critical issue.

- Reduce fatal motor vehicle crash deaths to adolescents (Adolescents)
 - Rationale: In ND in the past three years, unintentional injuries among youth ages 15 through 24 due to motor vehicle crashes ranged from about 19 to 27 per 100,000. Motor vehicle crashes are preventable and proven strategies can improve the safety of young drivers on the road.
 - This is a new state priority; however, it is modified from previous federal performance measure #10, the rate of deaths to children ages 14 years and younger caused by motor vehicle crashes per 100,000 children, and from previous state priority # 9, reduce the rate of deaths resulting from intentional and unintentional injuries among children and adolescents. Motor vehicle crashes are the number one killer of teenagers and young drivers are twice as likely as adult drivers to be in a fatal crash; hence, this new priority was modified to focus on

adolescents.

- Increase the utilization of medical home (Children with Special Health Care Needs)
- Rationale: In ND, approximately one in seven children (13.9%) has special health-care needs. In the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), it was reported that 47.8 percent of children, ages 0 to 18, received coordinated, ongoing and comprehensive care within a medical home. While ND is doing better than the nation (43%), this percentage represents a decrease from 2005/06 (55%).
- This is a continued priority from previous federal performance measure #3, the percent of children with special health care needs (CSHCN) age 0-18 who receive coordinated, ongoing, comprehensive care within a medical home; and state priority #3, support quality health care through medical homes. A medical home means a child has a personal doctor or nurse as a usual source of care, gets needed referrals, receives effective care coordination and assures families are actively involved in their child's care. Children with a medical home are more likely to receive preventive care, are less likely to be hospitalized, and are more likely to be diagnosed early for chronic or disabling conditions.

- Increase the number of children with special health care needs receiving transition support (Children with Special Health Care Needs)
- Rationale: Transition into adulthood is cited as a challenge by families in the National Survey for CSHCN, with only about 47 percent of families in 2009/10 reporting having adequate resources for successful transition, down from about 51 percent in 2005/06.
- This is a new state priority; however, it is continued from previous federal performance measure #6, the percent of youth with special health care needs who receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. Transition to adulthood is a critical developmental period. Children who do not receive transition services are more likely to have unmet health needs as adults. Transition includes discussions about adult doctors, changing health needs, health insurance, and appropriate self-care and management.

- Increase preventive dental services to children (Cross-cutting/Life Course)
- Rationale: The burden of oral disease is not uniformly distributed throughout ND. Access to oral health services is an ongoing concern and challenge. Vulnerable and underserved populations face a variety of barriers to oral health care including transportation issues; lack of insurance or ability to pay for care; inability to take time off work to go to the dentist or transport their children; limited availability of providers accepting Medicaid; and lack of understanding of the importance of good oral health and its impact on overall health. In ND, only about 42 percent of Early Periodic Screening Diagnostic and Treatment-eligible children ages 6 through 9 (less than half) reported having received any dental services.
- This is a new state priority; however, it is modified from previous federal performance measure #9, the percent of third-grade children who have received protective sealants on at least one permanent molar tooth. The case for good oral hygiene keeps getting stronger. Understanding the importance of oral health and its connection to overall health is a critical need.

Two other state priorities were selected and strongly considered to align with the required eight national priority areas:

- Decrease depressive symptoms in adolescents
- Increase adequate insurance coverage to the MCH population.

These two state priorities have been selected as State Performance Measures (SPM) and are discussed in Section II.E., Linkage of State Selected Priorities with State Performance and Outcome Measures.

As part of public input, a stakeholder survey was conducted – *Did we select the best MCH priorities for 2016-2020?* The purpose of this survey was to evaluate whether the state priorities and national priority areas selected represented the public perception of the needs in ND; and if not, what they felt should be included. Developmental screening was cited by 21 of the 222 respondents as a suggested state priority. As a result of this feedback, the MCH leadership team thoroughly re-evaluated this priority using the same criteria-based ranking and weighting prioritization tool as used for the other priorities, and also considered it under its relevant population domain. The final score put developmental screening below the other priority areas picked for this population domain; hence, developmental screening was not included as a state priority. The results of the survey and the final list of state priorities and national priority areas were shared with stakeholders via email. In this email, stakeholders were informed that additional data was analyzed relating to developmental screening and that the prioritization tool was once again utilized; however, after a thorough review and discussion of the data, it was determined not to include developmental screening. The email recognized the critical importance of developmental screening and assured continued partnerships on efforts to move this issue forward.

Additional areas of need that were examined, but ultimately not included as state priorities included home visiting programs, suicide, youth and adult smoking rates, incidence of sexuality transmitted infections, obesity in adulthood, racial disparities, and American Indian mortality ages 0-44.

There has been no change to ND's state selected priorities in this interim year.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 1 - Percent of women with a past year preventive medical visit
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 5 - Percent of infants placed to sleep on their backs
- NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
- NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
- NPM 11 - Percent of children with and without special health care needs having a medical home
- NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
- NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

The findings of the five-year needs assessment informed the state's selection of national performance and outcome measures for programmatic focus by North Dakota's (ND) Title V program. The Title V/MCH leadership team, partners and stakeholders identified the 10 highest priority needs for ND that aligned with national performance and outcome measures. These ten were then narrowed down to the eight priority areas that were selected to be addressed by the ND Title V program over the next five-year period. The rationale for each of the eight selected priorities and their linkage with national performance and outcome measures follows:

1. National Performance Measure (NPM): Well Women Care

State priority related to NPM: Reduce tobacco use in pregnant women

Approximately 18 percent of pregnant women in ND smoke at any point during their pregnancy, compared to about 11 percent nationally. Smoking during pregnancy is a modifiable risk factor that if reduced and/or eliminated would have positive short-term and long-term health benefits to women, mothers, and infants. By increasing the percent of women receiving an annual preventive visit to reduce the prevalence of smoking during pregnancy, impacts on National Outcome Measures (NOMs) are anticipated which include: reduction of maternal morbidity and mortality; reduction in the proportion of low birth weight and very low birth weight infants; reduction in the proportion of early preterm, late preterm, and early term births; and reduction in perinatal, neonatal, infant, preterm-related and post-neonatal mortality rates per live births.

2. NPM: Breastfeeding

State priority related to NPM: Increase the rate of breastfeeding at 6 months

As of 2013, about 45 percent of ND women report having breastfed their infants at 6 months, compared to about 50 percent nationally. Breastfeeding is associated with a reduced risk of SIDS and reduces a child's risk of becoming overweight as a teen or adult. It has also been linked to decreased risk of breast and ovarian cancer in women. Positive health outcomes can be achieved by increasing the proportion of infants ever breastfed and percentage of infants breastfed exclusively through six months. Linked NOMs include; decreased infant, post-neonatal and sleep-related Sudden Unexpected Infant Death (SUID) mortality rates per live births.

3. NPM: Safe Sleep

State priority related to NPM: Reduce disparities in infant mortality

In ND, the American Indian infant death rate is about 3 times greater than that of the white infant death rate. For

calendar year 2014, the three year average mortality rate of American Indian infants was 13 per 1,000, compared to white infants at 4.1 per 1,000. Significant disparities exist in infant deaths between races with infants born to American Indian mothers being at much higher risk for poor birth outcomes, including being born too early, being born at low birth weight and to die in the first year of life. By increasing the proportion of infants placed to sleep on their back, anticipated outcomes include: decreased infant, post-neonatal and sleep-related SUID mortality rates per live births, and a reduction in disparity between American Indian and White infant death rates.

4. NPM: Injury

State priority related to NPM: Reduce fatal motor vehicle crash deaths to adolescents

In ND, fatal unintentional injuries among youth ages 15 through 24 due to motor vehicle crashes ranged from about 19 to 27 per 100,000 between 2010 and 2013. Motor vehicle crashes are the number one killer of teenagers with young drivers being twice as likely as adult drivers to be in a fatal crash. These crashes are preventable and evidence-based strategies can improve the safety of young drivers on the road. By decreasing the rate of injury-related hospital admissions for the population aged 0 through 19 years, anticipated outcomes include: reduction in the child and adolescent death rates, a reduction in adolescent motor vehicle mortality rate and a reduction in the adolescent suicide rate.

5. NPM: Physical Activity

State priority related to NPM: Reduce overweight and obesity in children

Approximately 36 percent of children and teenagers between ages 10 through 17 in ND are considered overweight to obese, compared to 31 percent nationally. Children that are overweight have an increased risk for heart disease, diabetes, asthma, and low self-esteem over their lifetime. By increasing the proportion of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day, expected improvements in NOMs include: an increase in the percentage of children in excellent or very good health and a decrease in the percent of children and adolescents who are overweight or obese.

6. NPM: Medical Home

State priority related to NPM: Increase the utilization of medical home

Approximately 48 percent of ND families of children with special health care needs ages 0 to 18, report having received coordinated, ongoing, comprehensive care within a medical home. Children with a medical home are more likely to receive preventive care, are less likely to be hospitalized, and are more likely to be diagnosed early for chronic or disabling conditions. By increasing the percent of children with and without special health care needs having a medical home, impacts on NOM's are anticipated which include: an increased proportion of children and youth with special health care needs receiving care in a well-functioning system; an increased percent of children in excellent or very good health; an increased percent of children ages 19 through 35 months who have received the 4:3:1:3(4):3:1:4 combined series of routine vaccinations; an increased percent of children ages 6 through 17 years who are vaccinated annually against seasonal influenza; an increased percent of adolescents ages 13 through 17, who have received at least one dose of the HPV vaccine; an increased percent of adolescents 13 through 17 who have received at least one dose of the Tdap vaccine, and an increased percent of adolescents who have received at least one dose of the meningococcal conjugate vaccine.

7. NPM: Transition

State priority related to NPM: Increase the number of children with special health care needs receiving transition support

In ND, about 47 percent of parents of children with special healthcare needs (less than half) report having adequate resources for their child's transition into adulthood. Transition to adulthood is a critical developmental period. Children who do not receive transition services are more likely to have unmet health needs as adults. Transition includes discussions about adult doctors, changing health needs, health insurance, and appropriate self-care and management. Increasing the percent of children with and without special health care needs who receive services necessary to make transitions to adult healthcare is linked to the improvements in NOMs related to the following: an increased percent of children and youth with special health care needs receiving care in a well-functioning system and the percent of children in excellent or very good health.

8. NPM Oral Health

State priority related to NPM: Increase preventive dental services to children

Approximately 42 percent of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible children ages 6 through 9 in ND reported having received any dental services. Oral health is an important component of overall health throughout life and is a great unmet health need among certain population groups within the state. People with limited access to oral health care are at greater risk for chronic diseases. By increasing the proportion of infants and children ages 1 through 17 who had a preventive dental visit in the past year, improvements in linked NOMs include: the reduction of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months, as well as the percent of children and adolescents in very good health.

Evidence-based Strategy Measures (ESMs) have been developed for all of the selected national measures and are presented in the detail sheets on Form 10C of this application.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 1 - Decrease depressive symptoms in adolescents.
- SPM 2 - Increase adequate insurance coverage to the MCH population.
- SPM 3 - Implement North Dakota state mandates delegated to North Dakota Department of Health Title V / Maternal and Child Health Program.

Through the five-year needs assessment process, the Title V/Maternal and Child Health (MCH) leadership team, partners and stakeholders identified the 10 highest priority needs for North Dakota (ND) that aligned with national performance and outcome measures. Of the ten priority areas identified, eight priorities were selected to be addressed by the ND Title V/MCH Program over the next five-year period as National Performance Measures starting in 2016. The remaining two priority areas were selected as the state priorities starting in 2017, along with an additional measure on existing state mandates. Adolescent depressive symptoms and adequate health insurance were determined top priorities by both quantitative and qualitative need and through the perception of stakeholders. Consequently, the Title V/MCH leadership team agreed that these two priorities would be retained as State Performance Measures. A consensus based approach evaluated three other measures for consideration that included: developmental screening, social determinants of health in the MCH population, and the implementation of relevant state mandates for the MCH population. After assessing the Title V/MCH Program capacity and the resources available, the Title V/MCH leadership team agreed on the implementation of state mandates as the third priority and State Performance Measure.

Rationale for the selection of the three State Performance Measures is addressed below. Additionally, detail sheets associated with these measures are in Form 10B of this application.

Decrease depressive symptoms in adolescents (Adolescents)

- The 2015 ND Youth Behavior Risk Survey (YRBS) indicated that 19.6 percent of high school students grades 9 through 12 reported feeling so sad or hopeless that they stopped doing some usual activities during the 12 months before the survey. Mental/behavioral health conditions have been increasing among children. Bullying is a major public health problem that may contribute to depression, antisocial behavior, suicidal thoughts, poor school performance, etc. Adolescence is a unique developmental period that encompasses the biological changes of puberty, along with other psychological, cognitive, and behavioral changes. Adolescents require access not only to medical care for illness and injury but also to family planning services, substance abuse treatment, mental health services, anticipatory guidance, and various informational and educational activities oriented toward the development of positive health behaviors. Some of their health problems arise from risky health behaviors, which increase rates of sexually transmitted diseases, unintended pregnancy, substance abuse, injuries, and violence. Intervening during adolescence provides an opportunity to prevent the onset of health-damaging behavior as well as to introduce and establish healthy new behavior patterns that may span a lifetime.

Increase adequate insurance coverage to the MCH population (Cross-cutting/Life Course)

- Women and children are disproportionately represented among the uninsured and those with inadequate insurance. Expanding health insurance coverage to this group will increase access to necessary health services. In 2014, 9 percent of residents under age 65 in ND lacked health insurance coverage (91 percent had some form of health coverage). This rate is lower than the national average of 14 percent and has decreased since 2013. White residents under age 65 were the highest of the insured at 91.2 percent, while AI's reported the lowest rates of insurance at only 66.2 percent. Adults least likely to be covered tend to be in younger age groups. ND residents in the age range of 25 through 34 tended to have the lowest coverage at 87.3 percent. In 2014, an estimated 93 percent of children in the state had health insurance, very similar to the

national rates. ND children who are White have insurance at a rate higher than the state's average (94%), while AI children are insured at rates substantially lower than the state's average, at 86 percent – although this rate has increased from 80 percent in 2012. According to the 2011/2012 National Survey of Children's Health, about 23 percent of all ND children did not have adequate health insurance to meet their needs, compared to 28 percent of Children with Special Healthcare Needs (CSHCN). A benefit of health insurance is better access to care. However, individuals with continuous insurance coverage may still not be adequately insured. Inadequate insurance can lead to delayed or foregone care. Problems include cost-sharing requirements, benefit limitations, and inadequate coverage of needed services.

Implement North Dakota state mandates delegated to North Dakota Department of Health Title V/Maternal and Child Health Program (Cross-cutting/ Life Course)

- Priorities are often influenced by state mandates, which in turn, are generally reflective of expressed need within the state over time. Inclusion of these mandates epitomizes the successful federal/state partnership by honoring a state's unique priorities. ND has several mandates addressing the health of the MCH population that direct Title V work efforts and require use of significant resources for successful implementation. A list of these mandates can be found in Supporting Document #02, Title V-MCH State Mandates.

State Outcome Measure:

Decrease the disparity of mortality among American Indian infants

- In ND, the American Indian infant death rate is about 3 times greater than that of the White infant death rate. For calendar year 2014, the three year average mortality rate of American Indian infants was 13 per 1,000, compared to White infants at 4.1 per 1,000. Infants born to American Indian mothers are at much higher risk for poor birth outcomes, including being born too early, being born at low birth weight, and to die in the first year of life. Several risk factors have been identified which can increase the chances of infant mortality including birth defects, preterm births, low birth weight, maternal complications during pregnancy and injuries. Risk factors associated with poor birth outcomes include inadequate prenatal care, being a young mother, smoking, alcohol and drug use during pregnancy; and gestational diabetes. Health disparities are caused by an assortment of factors including individual behavior, but the social determinants of health framework recognize that social and physical environments also profoundly impact the ability to experience good health. The Healthy People 2020 initiative for improving population health examines social determinants of health in five key areas: economic stability, education, social and community context, health and health care and neighborhood and built environment. Traumatic events during infancy and childhood, termed adverse childhood experiences, also contribute to health problems as an adult. Additionally, inter-generational impacts of historical trauma and disruption of cultural practices significantly influence the health outcomes for American Indians. While disparities can occur at every stage of the life course, health disparities for many American Indians begin prenatally and among the vast majority of infants who live past their first year, can have long-lasting implications.

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

Women/Maternal Health

State Action Plan Table

State Action Plan Table - Women/Maternal Health - Entry 1

Priority Need

Reduce tobacco use in pregnant women.

NPM

Percent of women with a past year preventive medical visit

Objectives

1. Title V staff will strengthen existing partnerships and develop at least three new partnerships that can assist with the integration of tobacco cessation and prevention activities for pregnant women and women of reproductive age by September 30, 2020.

Strategies

1a. Promote tobacco prevention and cessation service integration before, during, and after pregnancy to improve birth outcomes. FY Activities 2017 (October 1, 2016 through September 30, 2017):

- Provide training to the Optimal Pregnancy Outcome Program (OPOP) staff regarding various aspects of tobacco cessation.
- Increase awareness of the benefits of tobacco cessation by promoting media campaigns and social media that specifically target pregnant women and women of reproductive age.
- Continue to promote the use of Text4baby and monitor the number of participants in the program.
- Promote the use of 5A's (Ask, Advise, Assess, Assist, and Arrange) in the Women, Infants and Children (WIC), OPOP, and family planning programs.
- Include tobacco cessation information in MCH publications.
- Include tobacco cessation education as a requirement in the "Promoting Safe Sleep Environments for Infants" mini-grants.

1b. Collaborate with the North Dakota (ND) Infant Mortality Collaborative for Improvement and Innovation Network (CollIN) initiative for a multi-system approach to ensure families engage in safe sleep practices by reducing commercial tobacco use, second hand smoke exposure, and increase rates of prenatal care, along with other risk-factor reducing efforts. FY Activities 2017 (October 1, 2016 through September 30, 2017):

- Title V will support a contract with American Indian Public Health Resource Center (AIPHRC) to continue to work with American Indian (AI) reservations on tobacco cessation and prevention activities.
- Title V staff will be engaged in the review and updates regarding strategies and activities outlined in the ND CollIN "Blueprint for Change."

ESMs

ESM 1.1 - Number of partnerships established to assist with the integration of tobacco cessation and prevention activities for pregnant women and women of reproductive age.

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Measures

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	65	67	68	70	72	74

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	65.7 %	2.3 %	84,849	129,167
2013	63.3 %	2.0 %	77,756	122,881
2012	61.9 %	2.3 %	73,568	118,853
2011	61.0 %	2.2 %	71,296	116,806
2010	67.4 %	2.4 %	75,079	111,459
2009	68.0 %	2.4 %	76,095	111,856

Legends:

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 1.1 - Number of partnerships established to assist with the integration of tobacco cessation and prevention activities for pregnant women and women of reproductive age.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	11.0	12.0	13.0	14.0

Women/Maternal Health - Plan for the Application Year

Reduce Tobacco Use in Pregnant Women

Nationally, more than half of all pregnancies are unintended, which causes a host of public health concerns. The 2010 unintended pregnancy rate in ND was 44 percent, slightly below the national average (Guttmacher Institute, 2016). The health of a baby is not only determined by a mother’s health and behaviors during the prenatal period; the preconceptional and perinatal periods also play a vital role in determining a baby’s health. People who smoke are at an increased risk for cancer, heart disease, and other major health problems. Women who smoke have a more difficult time conceiving a baby than those who do not. A woman who is pregnant and smokes is more likely than other women to have a miscarriage, preterm birth, and a baby to be born with low birth weight. Smoking during and after pregnancy also increases the risk of an infant to die of Sudden Infant Death Syndrome (SIDS). Babies born to women who smoke are also more likely to have certain birth defects.

Risk factors for smoking in pregnancy include women with a decreased level of education, those who are uninsured or underinsured, those who use government assistance programs (e.g. WIC, Medicaid), and women under 20 years of age. In 2007, nationally, 89.6 percent of women abstained from smoking cigarettes during pregnancy (National Vital Statistics System-Nativity (NVSS-N), CDC/NCHS, 2015). The goal of Healthy People 2020 is 98.6 percent of women who abstain from smoking while pregnant. In North Dakota (ND) in 2014, 89.3 percent of women abstained from smoking during pregnancy. This number has slowly, but steadily, been increasing since 2007 (85.2%).

ND's largest minority population is American Indians (AI), which account for 5.4 percent of the total population, approximately 64 percent of which live on reservations. There are five federally funded tribal nations and one Indian community in ND. The AI population has significantly higher risk factors that lead to poor birth outcomes. ND American Indians are 8.3 times more likely than Whites to have inadequate prenatal care, 2.7 times more likely to smoke during pregnancy, and AI babies are 7.6 times more likely to die from Sudden Infant Death Syndrome (SIDS).

Title V staff are collaborating with the American Indian Public Health Resource Center (AIPHRC), Master of Public Health Program, North Dakota State University, on the CollIN initiative to reduce infant mortality and improve health disparities in the AI population. The framework of this partnership focuses on tribal outreach, engagement, and interventions that can increase rates of prenatal care, reduce tobacco use in pregnant women, encourage safe sleep practices, and improve birth outcomes. Enhancing the relationship with tribal councils can help to build trust and target efforts to tobacco cessation within this high-risk population. Title V staff will be involved with activities in the CollIN project and will promote tobacco cessation and prevention efforts.

Preventive visits promote good health and can help with early detection and prevention of diseases. In 2014, 65.7 percent of ND women received a past year preventive medical visit. By placing efforts into prevention and providing resources to various entities in the state, we can positively influence individual behaviors, which can improve the overall health of women. Targeted for September 1, 2016, Title V will be awarding mini-grants to promote safe sleep environments for infants. As a requirement of the grant, applicants will be required to integrate other risk reduction education training including smoking cessation, second hand smoke exposure and breastfeeding. In addition, new culturally relevant education materials are being created for consistent messaging relating to safe sleep environments. These materials will contain content relating to the risks of smoking and second hand smoke exposure, including information on ND's tobacco cessation program NDQuits. These materials will be distributed statewide to health care systems, local public health, home visiting programs, child care facilities, WIC, OPOP, etc. Tobacco cessation information is also included in other MCH publications such as Parenting the First Year Magazine and the Information About Pregnancy and Abortion_booklet. New this year in these publications is information on electronic cigarettes.

Title V staff will also work to enhance existing relationships and develop new partnerships with various programs dedicated to promote tobacco prevention and cessation efforts specific to women before, during, and after pregnancy on a statewide and national level. These partnerships are vital to help to achieve the Healthy People 2020 goal of 98.6 percent of women who abstain from smoking while pregnant. Collaborative efforts will help to reach the high-risk population of women who smoke by promoting social media in communities through television and radio advertisements, Facebook, Twitter, as well as the integration of additional outreach educational materials that may already exist. ND has a strong partnership with March of Dimes ND Chapter, and as a result, has cobranded Text4baby materials that provide expectant mothers with weekly text messages that promote healthy behaviors and includes a variety of health-related topics throughout their pregnancy; post-partum and infant health through age one.

Existing and potential stakeholders include:

- North Dakota Department of Health Tobacco Prevention and Control Program
- Tobacco Free North Dakota (TFND)
- North Dakota Center for Tobacco Prevention and Control Policy (Breathe ND)
- March of Dimes, ND Chapter
- North Dakota Medicaid
- Women, Infants, and Children (WIC)
- Optimal Pregnancy Outcome Program (OPOP)
- North Dakota Infant Mortality Collaborative for Improvement and Innovation Network (CollIN)
- American Indian Public Health Resource Center (AIPHRC), Master of Public Health Program, North Dakota State University
- American Lung Association
- Home Visiting Programs/Coalition

- Tribal Health Clinics
- North Dakota Department of Public Instruction (DPI)
- Cribs for Kids Programs

Women/Maternal Health - Annual Report

NPM 15 *Percentage of women who smoke in the last three months of pregnancy.*

Smoking during pregnancy can lead to health problems for the mother and her baby. Pregnant women who smoke have poorer birth outcomes, which lead to a higher rate of miscarriage, low birth weight, premature birth, increased risk of certain birth defects, and an increased risk of Sudden Infant Death Syndrome (SIDS). Smoking while pregnant is associated with maternal, fetal, and infant morbidity and mortality, yet it is the most modifiable cause of such outcomes. In North Dakota (ND) in calendar year 2014, 10.7 percent of women smoked during the last three months of pregnancy. Since 2007 (14.8 %), this percentage has continued to decline annually for an overall decrease of 4.1 percent.

Educational efforts to reach women of reproductive age, especially pregnant women, continue to be a priority in ND. To help coordinate these efforts, the Partnership for Tobacco Prevention and Cessation for Women of Reproductive Age workgroup met on a quarterly basis to collaborate on opportunities to discuss tobacco cessation and prevention. The workgroup includes staff from the ND Tobacco Prevention and Control Program, Women, Infants and Children (WIC), Infant and Child Death Services Program (ICDS), Cribs for Kids, Family Planning, Children's Special Health Services, and March of Dimes. An important goal of this workgroup is to relay valuable information to partners at the local level, where they can then educate patients on the importance of tobacco cessation and prevention.

The WIC Nutritionist is the liaison to the local WIC staff who communicates periodic updates from the ND Tobacco Prevention and Control Program. The local WIC staff continued to promote the NDQuits Pregnancy Program; a phone and web-based program that includes nine coaching calls (four prenatal and five postpartum) that provide tobacco cessation education and offer incentives to women who complete their coaching calls. The program began in July 2013 and had enrolled 89 pregnant women as of September 30, 2015.

Also in collaboration with the ND Tobacco Prevention and Control Program, the local WIC staff used *Keep Your Baby Safe From Tobacco, Drugs and Alcohol* and *Secondhand Smoke Hurts Kids* nutrition education cards to counsel families. The State WIC staff posted the Centers for Disease Control and Prevention (CDC) Prenatal Nutrition Surveillance System information containing the smoking behaviors of women, before, during and after pregnancy, on the state WIC website pages. This data was used by local public health units and tobacco coalitions to develop strategic planning to increase tobacco cessation.

The BABY & ME - Tobacco Free™ (BMTF) program, administered through the ND Tobacco Prevention and Control Program provides tobacco cessation counseling services to pregnant women who use tobacco. This program assists pregnant women to quit smoking and stay tobacco free by providing a voucher for diapers every month the mother remains tobacco free after the baby is born (for up to one year). Eight BMTF sites enrolled 175 women for the period of July 2014 to June 2015. Many of the 17 Cribs for Kids partner sites also provided education on NDQuits and BMTF to their clients on the correlation of smoke exposure being a risk factor for SIDS. Information regarding NDQuits and the harmful effects of tobacco usage and second hand smoke were included in the *Information About Pregnancy and Abortion* booklet and *Parenting the First Year* Magazine that were published in 2013. Both of these publications will be updated in 2016 and will include information on the risk of electronic cigarettes.

These publications can be viewed at: http://www.ndhealth.gov/familyhealth/Preg_Abortion_booklet_final.pdf
http://www.ndhealth.gov/familyhealth/publications/parentingnewsletter/Parenting_Birthto12Months.pdf

NPM 18 *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Early and adequate prenatal care helps to promote a healthy pregnancy for the mom and her developing fetus. Prenatal care can improve birth outcomes by promoting healthy behaviors and identifying important risk factors that may have a negative impact on woman's pregnancy. Because the fetus is continually growing and developing, the health of the mother is extremely important during this critical period.

According to data from the North Dakota Department of Health (NDDoH), Division of Vital Records, the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester has remained fairly consistent between 2002 (85.5%) and 2014 (81.8%). The highest percent since 2002 was recorded in 2003 (86.5%) and the lowest was in calendar year 2014 (81.8%).

The Optimal Pregnancy Outcome Program (OPOP) is a primary prevention program that was established in 1982 to increase the availability and access to comprehensive prenatal and postpartum services to pregnant women in ND. OPOP provides patients with a multidisciplinary approach by offering nursing, social work, and nutritional services in addition to prenatal care received by a health care provider. Title V funding supported five OPOP sites in ND during this reporting period and served 196 unduplicated patients. One OPOP site discontinued services in 2015 due to limited client participation. OPOP's Client Visit Record (CVR) database was updated during this reporting period to align patient outcomes to the objectives listed in Maternal, Infant, and Child Health, in Healthy People 2020. Information regarding OPOP was provided on the ND Department of Health website.

Parenting the First Year magazine was developed by the North Dakota Department of Health (NDDoH), in collaboration with the North Dakota Department of Human Services (DHS), to provide parents education and resources on babies' age birth to 12 months. This magazine is available electronically on the NDDoH's website, is available to healthcare providers who provide prenatal services, and is distributed to birthing hospitals throughout the state. This publication will be updated in 2016 with an expanded distribution list (e.g., thrift stores, child care, home visiting programs).

The Birth Review Program, which is collaboratively administered by staff from the NDDoH and DHS, helps to identify, inform, and refer families with at-risk newborns to designated services within the State of ND. The program promotes general child health and well-being and healthy pregnancies with optimal birth outcomes by helping parents identify whether possible risk factors are present that could affect their child's development or healthy outcomes in future pregnancies. About one-third of new birth families participated in the program during the reporting period.

Title V staff collaborated with March of Dimes on the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN). Through this partnership, hospitals in ND were invited to sign a pledge to reduce early elective deliveries; all ND hospitals signed the pledge in November 2015. Title V staff also continued to collaborate with March of Dimes by serving on the Program Services Committee. This committee works with other agencies throughout the state to discuss opportunities that can enhance prenatal care for pregnant women, decrease the incidence of early preterm deliveries and improve the relationship with the American Indian population in ND.

Additional CoIIN activities were addressed through the State Systems Development Initiative (SSDI). Efforts focused on development of CoIIN measures, determining a process to obtain quarterly Vital Records data for entry into the

COLIN Collaboratory, and leadership of the Social Determinants of Health Workgroup.

Local Women, Infants and Children (WIC) Program staff provided intake assessments to pregnant women at their first WIC appointment. If the patient had not yet sought prenatal care, she was then referred to a local health care provider. Over the course of the pregnancy, local WIC staff discussed healthy practices that promote positive birth outcomes by emphasizing the importance of prenatal care through individualized counseling.

SPM 10 *The percent of healthy weight among adults age 18-44.*

The North Dakota Behavioral Risk Factor Surveillance System (BRFSS) data shows that in 2014, only 35.4 percent of adults ages 18 through 44 reported a healthy Body Mass Index (BMI), a slight decrease from the previous year of 36.6 percent. In addition, North Dakota (ND) has fallen short of the Healthy People 2020 objective of 40.7 percent of the population reporting a healthy weight. Public health professionals are concerned with the apparent decline over the past five years, with 2011 reporting the highest percentage of healthy Body Mass Index at 42.3 percent.

A balanced diet and regular physical activity benefit the health of children and adults. Poor diet quality and physical inactivity contribute to many serious and costly health conditions including obesity, heart disease, diabetes, some types of cancer, high cholesterol, and high blood pressure. Given the consequences, it is imperative that Title V utilizes a number of partners and methods to help address this important concern.

On an on-going basis, Title V staff continued to collaborate with and provide technical assistance to communities and organizations that support healthy eating and physical activity policies and initiative. Staff also promoted healthy eating and physical activity by using consistent messaging disseminated through program educational materials including the use of social media (e.g., breastfeeding, etc.). Staff also analyzed and distributed the results of the Youth Risk Behavior Survey (YRBS) and the BRFSS related to healthy eating and physical activity.

Additional program accomplishments included:

- The State Maternal and Child Health (MCH) Nutritionist attended the Association of State and Territorial Public Health Nutritionists (ASPHN) annual meeting and participated in MCH Nutrition Council meetings. These meetings built capacity to connect MCH nutrition programs and chronic disease programs specific to nutrition and physical activity.
- Title V staff participated in, and provided input quarterly, to the statewide Nutrition and Physical Activity in Early Childhood Committee.
- Title V staff coordinated the annual meeting of public health nutritionists, allowing local and state staff to share progress and challenges over the past year.
- Title V staff coordinated a sustainability training that 12 local Healthy Communities Coalitions participated in, to help move their efforts forward on a continual basis with health policies.

The Women, Infants and Children (WIC) Program is an important partner in addressing healthy weight among the Title V population. Local WIC staff continued to conduct nutrition risk assessments (including collecting body mass index information), provided tailored food packages, personalized nutrition education and made referrals as needed.

Participant education is a vital benefit of WIC. Staff continued to provide informative segments on nutrition and physical activity topic areas in the monthly ND WIC participant newsletter, offering fun ideas on ways to increase activity. WIC staff continued to provide nutrition education materials for staff to use when discussing physical activity with participants including physical activity tips for toddlers and preschoolers, indoor activity ideas, and weight loss tips for breastfeeding/delivered women. Staff also continued to educate and encourage WIC families to make low-fat milk choices, consume whole grain foods and drink appropriate amounts of fruit and vegetable juices. The past two

years, state and local WIC staff focused the year's nutrition education efforts around MyPlate and its nutrition education concepts (which were reflected in many of the local agencies nutrition education plans). *Your Child's Weight* and *Sensible Weight Loss* (for women) are nutrition education cards that ND WIC continued to have available for staff to use when discussing weight issues with their participants. WIC state staff were able to observe and assess the quality and content of the personalized nutrition education and counseling provided by local WIC staff when completing the onsite monitoring visits to all 23 local agencies. This past year, the WIC final food rule was implemented that required only low-fat milks be provided for all women participants and children over two years of age.

Perinatal/Infant Health

State Action Plan Table

State Action Plan Table - Perinatal/Infant Health - Entry 1

Priority Need

Increase the rate of breastfeeding at 6 months.

NPM

A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Objectives

1a. Increase by 6 the number of hospitals that are designated North Dakota (ND) Breastfeeding-Friendly by September 30, 2020.

1b. Increase by 40 the number of ND businesses designated Infant-Friendly by September 30, 2020.

1c. Two reservations will be trained with Breastfeeding-Friendly Skills Training by September 30, 2020.

1d. Fund three MCH grantees to implement evidence-based, evidence-informed and/or promising practices efforts to increase breastfeeding rates at six months through September 30, 2020.

Strategies

1a. Train hospital staff and implement policies on evidence based practices for supporting breastfeeding mother-baby dyads. FY Activities 2017 (October 1, 2016 through September 30, 2017):

- Identify influential stakeholders in birthing facilities who can assist in implementing the five-step breastfeeding-friendly designation.
- Assess needs from hospitals.
- Provide handouts, presentations and print-ready materials to use to educate stakeholders at birthing facilities about evidence-based maternity care practices.
- Maintain and promote a one-hour webinar for each of the five steps that can be accessed through the breastfeeding website at any time.
- Promote breastfeeding at birthing facilities through established professional association channels via conferences, newsletters, list- serves and websites.

1b. Provide technical assistance to businesses in developing policies to support breastfeeding mothers at the workplace. FY Activities 2017 (October 1, 2016 through September 30, 2017):

- Provide policy templates for development of worksite breastfeeding policies.
- Promote the designation program at various conferences, association meetings and worksite wellness trainings across the state.
- Provide resources such as privacy door hangers, bookmarks, brochures, posters and window clings to businesses that are designated “Infant-Friendly.”
- Recognize businesses that have implemented policies through a statewide press release, recognition on ND breastfeeding website, and at breastfeeding displays.
- Apply for grant opportunities, as appropriate to enhance work efforts.

1c. Provide a Breastfeeding-Skills Training to professionals who work in reservations with mother and infants in the prenatal, perinatal and post-natal periods. FY Activities 2017 (October 1, 2016 through September 30, 2017):

- Provide a culturally-sensitive breastfeeding-skills training on the importance of skin-to-skin, latch and positioning, hand expression, supplementation for breastfed infants, breastfeeding pumps, and positive messaging.

1d. Fund evidence-based, evidence-informed and/or promising practices intervention strategies through MCH contracts. FY Activities 2017 (October 1, 2016 through September 30, 2017):

- Monitor, oversee and provide technical assistance to the three MCH grantees to assure contract activities and requirements are being met.
- Include breastfeeding education/support as a requirement in the “Promoting Safe Sleep Environments for Infants” mini-grants
- Establish a structure that will facilitate communication with MCH grantees.

ESMs

ESM 4.1 - Number of North Dakota hospitals that are designated as North Dakota Breastfeeding-Friendly.

NOMs

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table - Perinatal/Infant Health - Entry 2

Priority Need

Reduce disparities in infant mortality.

NPM

Percent of infants placed to sleep on their backs

Objectives

1a. Increase by four the number of programs that utilize safe sleep approaches and messaging by September 30, 2020.

1b. All birthing hospitals will have implemented safe sleep policies by September 30, 2020.

1c. Two reservations will have implemented community informed media campaigns/interventions as a result of community assessments by September 30, 2020.

Strategies

1a. Align work of all areas and programs within the North Dakota Department of Health (NDDoH) and among other partners (e.g., WIC, immunization, tobacco, home visiting) to ensure consistent approaches and messaging regarding safe sleep. FY Activities 2017 (October 1, 2016 through September 30, 2017): • Continue to provide safe sleep educational materials to local Women, Infants and Children (WIC) sites and home visiting programs for distribution to clients. • Continue to implement the Cribs for Kids Program in Home Visiting Programs. • Explore expansion of the Cribs for Kids Program to additional WIC sites. • Provide “Promoting Safe Sleep Environments for Infants” mini-grant opportunities for promotion of safe infant sleep activities including messaging and education on breastfeeding and tobacco cessation-related to safe sleep.

1b. Use policy as a lever to promote safe infant sleep practices within all North Dakota (ND) birthing hospitals and to consumers. FY Activities 2017 (October 1, 2016 through September 30, 2017): • Work with Sanford Medical Center Bismarck to implement a pilot crib sheet messaging project and to develop a policy on safe infant sleep. • Distribute sample safe infant sleep hospital policy to all birthing hospitals in ND.

1c. Ensure safe sleep messaging is culturally-sensitive and tailored to reach and resonate with the most vulnerable populations. FY Activities 2017 (October 1, 2016 through September 30, 2017): • Develop culturally-appropriate messaging for distribution to American Indian populations. • Title V will support a contract with American Indian Public Health Resource Center (AIPHRC) to continue to work with American Indian (AI) reservations to reduce infant mortality and improve health disparities in the AI population. • Continue to implement the ND Infant Mortality Collaborative for Improvement and Innovation Network (CoIIN) “Blueprint for Change” strategy priorities.

ESMs

ESM 5.1 - Number of hospitals that have implemented safe infant sleep policies.

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Measures

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	84.0	85.0	86.0	87.0	88.0	90.0

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	79.4 %	2.9 %	8,196	10,329
2011	82.4 %	2.7 %		
2010	85.9 %	2.6 %		
2009	75.7 %	3.4 %		
2008	72.5 %	2.8 %		
2007	75.2 %	2.8 %		

Legends:

-  Indicator has an unweighted denominator <50 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	23.0	24.0	25.0	26.0	27.0	28.0

Data Source: National Immunization Survey (NIS)

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2012	21.0 %	2.9 %	2,090	9,977	
2011	22.5 %	2.9 %			
2010	15.6 %	2.7 %			
2009	15.6 %	2.7 %			
2008	19.2 %	2.2 %			
2007	15.3 %	2.3 %			

Legends:

- 🚫 Indicator has an unweighted denominator <50 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 4.1 - Number of North Dakota hospitals that are designated as North Dakota Breastfeeding-Friendly.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	6.0	8.0	10.0	12.0

NPM 5 - Percent of infants placed to sleep on their backs

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	70.5	72	73.5	75	76.5	77

FAD not available for this measure.

ESM 5.1 - Number of hospitals that have implemented safe infant sleep polices.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	4.0	6.0	8.0	12.0

Perinatal/Infant Health - Plan for the Application Year

Increase Breastfeeding Rates at Six Months

The advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk support optimal growth and development by providing all required nutrients during that time. Research demonstrates that breastfed children are less likely to die of sudden infant death syndrome (SIDS); may be less likely to develop juvenile diabetes, may have a lower risk of developing childhood obesity and asthma and tend to have fewer dental cavities throughout life. Breastfeeding also has many positive effects for the mother as well, such as a lowered risk for breast and ovarian cancers, Type 2 diabetes and postpartum depression. Emotionally, mothers benefit from breastfeeding by forming a stronger bond with their baby.

According to the National Immunization Survey, 20.95 percent of North Dakota (ND) mothers exclusively breastfed their infants at six months of age in 2012. The Healthy People (HP) 2020 goal for exclusively breastfed infants at 6 months is 25.5 percent. Over the past 10 years, the percentage of mothers initiating breastfeeding in the total population has slowly increased and is now nearly 83 percent; meeting the HP 2020 goal of 82 percent. More than 75 percent of women working in ND are mothers of young children. The fastest growing segment of the workforce is women with children younger than three. In ND, going back to work and school are the most commonly reported reasons for moms who stop breastfeeding.

There are two statewide breastfeeding designations that currently support, and will continue to support, breastfeeding mothers and infants; the Infant-Friendly business designation and the ND Breastfeeding-Friendly hospital designation. Currently, there are 71 businesses designated "Infant-Friendly." Four out of the twelve birthing hospitals have initiated the process of becoming "Breastfeeding-Friendly", with one of these hospitals becoming designated in August of 2015.

The Infant-Friendly business designation was developed to support businesses in ND to become breastfeeding-friendly for their employees. Per ND law, an employer may use the designation "infant-friendly" on its promotional materials if the employer adopts an approved workplace breastfeeding policy that includes the following:

- Flexible work scheduling, including scheduling breaks and permitting work patterns that provide time for expression of breast milk.
- A convenient, sanitary, safe and private location, other than a restroom, allowing privacy for breastfeeding or expressing breastmilk.
- A convenient, clean and safe water source with facilities for washing hands and rinsing breast-pumping equipment located near the private location.
- A convenient place for temporarily storing breast milk, such as a refrigerator or cooler.

Local maternal and child health (MCH) nutritionists are working with businesses to assist them in qualifying for the designation. Once a business has applied for designation, the state MCH nutritionist reviews their policy and designates the business infant-friendly by sending a congratulatory letter, certificate and breastfeeding in the workplace materials. Other partners in the program include the ND Breastfeeding Coalition (NDBC) and Healthy North Dakota Worksite Wellness Program. Promotion is done through worksite wellness trainings and displays across the state. The MCH State Nutritionist is currently applying for a mini-grant (\$15,000) to promote the Infant-Friendly business initiative. If awarded, the grant funds would start August 15, 2016 and go through February 15, 2017. Funds will be used to pay a small portion of the MCH Nutritionist's salary to provide technical assistance to businesses, update the breastfeeding website, and update and print promotional materials.

The ND Breastfeeding-Friendly hospital designation was developed and initiated in 2014 to support hospitals in implementing policies that support the breastfeeding mother-baby dyad. The program focuses on five of the ten Baby-Friendly Hospital steps. These steps are evidence-based practices that are well received in hospitals across the nation and world. The five steps that were chosen by the hospitals were done collaboratively in an initial breastfeeding survey. The five steps include:

1. Train all health care staff in skills necessary to implement a breastfeeding policy.
2. Inform all pregnant women about the benefits and management of breastfeeding.

3. Help mothers initiate breastfeeding within one hour of birth.
4. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infant.
5. Give infants no food or drink other than breast milk, unless medically indicated.

From this designation came many opportunities to educate staff on breastfeeding. One educational opportunity developed is a three-hour intensive breastfeeding skills training. This particular training covers skin-to-skin, latch and positioning, supplementation for breastfed infants, breastfeeding pumps and positive messaging. Professionals working with mothers and babies in the prenatal, perinatal and post-natal periods are encouraged to attend this training.

To ensure sustainability and versatility of this training, collaboration has occurred with the NDBC and local breastfeeding coalitions to provide trainers and space for the training. Through potential collaboration with the American Indian Public Health Resource Center (AIPHRC), Masters of Public Health Program at the University of North Dakota and United Tribes Technical College, an intensive breastfeeding skills training will be provided for at least two reservations in order to better reach disparate populations.

As a result of MCH Transformation 3.0 and the new needs assessment findings, the state Title V Director revised the mechanism for allocating local MCH funds. In the past, MCH funds were allocated to all local public health units on a funding formula. A new, competitive grant application targeting ND MCH priorities was sent out in September 2015 with applications due January 15, 2016. A committee reviewed and scored applications in January 2016 with grant funds being awarded April 1, 2016. Three local public health units were awarded funds to increase the rate of breastfeeding at 6 months. These grantees will be funded through September 30, 2021.

Targeted for September 1, 2016, Title V will be awarding mini-grants to promote safe sleep environments for infants. As a requirement of the grant, applicants will be required to integrate other risk reduction education training including breastfeeding, smoking cessation, and second hand smoke exposure. In addition, new culturally relevant education materials are being created for consistent messaging relating to safe sleep environments. These materials will contain content relating to the benefits of breastfeeding. These materials will be distributed statewide to health care systems, local public health, home visiting programs, child care facilities, WIC, OPOP, etc. Breastfeeding information is also included in other MCH publications (e.g., *Parenting the First Year Magazine*).

Additional critical partnerships/initiatives include:

- Maternal, Infant and Early Childhood Home Visiting (MIECHV) – dissemination of breastfeeding information through home visiting programs as well as breastfeeding education being provided to home visitors.
- Infant Mortality CollIN – increasing breastfeeding is included as a strategy in ND's CollIN "Blueprint for Change."

Reduce Disparities in Infant Mortality

According to 2011 National Vital Statistics System (NVSS) data, infant mortality is more likely to occur in homes where the mother is less than 20 years of age, has less than a high school education or is of American Indian/Alaska Native heritage. When comparing overall infant mortality data to the Sudden Unexpected Infant Death (SUID) NVSS data, it is found that these deaths are also more likely to occur to those mothers with a less than high school education or are of American Indian/Alaska Native heritage. In addition, mothers who have lower income and are on North Dakota (ND) Medicaid or participate in WIC are also more at risk to have a child die unexpectedly. According to the ND Department of Health's (NDDoH) Division of Vital Records, the overall infant mortality rate per 1,000 live births has decreased from 6.4 in Calendar Year (CY) 2009 to 5.0 in CY 2014. While encouraging, these numbers need to be looked with caution due to the overall low numbers of infant deaths.

Currently, ND is involved in the national Infant Mortality Collaborative for Improvement and Innovation Network (CollIN). This national collaborative is set up to assist states in reducing infant mortality and to move the needle in a short period of time. By using ND infant mortality data, specific action steps can be taken to target the areas where infant

mortality is most likely to occur.

One of the first steps to decrease infant mortality is to align efforts throughout the state to ensure consistent messaging on safe sleep practices since many SUID deaths are attributed to unsafe sleep environments. Through the CoIIN project, a team has been established to review potential strategies and implement projects. Educational materials on safe sleep were provided to WIC directors to distribute to clients. Through the CoIIN initiative, a project has been developed to pilot safe sleep messaging on crib sheets in the hospital setting. This will be piloted within the Sanford Medical Center Bismarck to determine effectiveness on educating families and staff about safe sleep practices. A new safe sleep ND logo and messaging has been developed for this project.

Targeted for September 1, 2016, Title V will be awarding mini-grants to promote safe sleep environments for infants. As a requirement of the grant, applicants will be required to integrate other risk reduction education training including breastfeeding, smoking cessation, and second hand smoke exposure. In addition, new culturally relevant education materials are being created for consistent messaging relating to safe sleep environments. The design selected for the crib sheet messaging project will be incorporated to assure consistent messaging and branding. These materials will be distributed statewide to health care systems, local public health, home visiting programs, child care facilities, WIC, OPOP, etc.

Another step to decrease infant mortality is to assist hospitals in developing safe sleep policies. Currently, 2 of the 12 birthing hospitals have specific safe sleep policies in place. A model policy will be developed, with the assistance of CoIIN team members, to distribute to facilities to assist them in creating their own policies. Policies will help to ensure that staff are modeling safe sleep practices and educating families about safe sleep.

Cribs for Kids is a program that provides a safe sleep environment to families who are not able to afford one. This program has been in place in ND since 2010 and there are currently 19 partner sites statewide. A Cribs for Kids site has been piloted in one of the WIC sites located at the Spirit Lake Reservation. This has been a success and expansion to other WIC sites throughout the state will be explored. Prevent Child Abuse ND (PCAND) has also implemented Cribs for Kids within their home visiting program through the Maternal, Infant and Early Childhood Home Visiting (MIECHV) grant.

Collaboration is continuing with the American Indian Public Health Resource Center (AIPHRC), Masters of Public Health Program at the University of North Dakota. In 2016-17, efforts will focus on tribal outreach and engagement; development of tribal resolutions/memorandums of understanding and data sharing agreements to conduct community needs assessments; coordination, analysis and dissemination of community needs assessments; and creation of a statewide or tribal specific coalition of key stakeholders to share strategies for addressing infant mortality in ND tribal communities. The AIPHRC has reported that one major area of concern being voiced through their community needs assessments is substance exposed newborns; this has also been identified as a major area of concern statewide. In response to this challenge, the Task Force on Substance Exposed Newborns was created in 2015 by Senate Bill 2367. The purpose of the task force is to research the impact of substance abuse and neonatal withdrawal syndrome, evaluate effective strategies for treatment and prevention, and provide policy recommendations. While not a member of the task force, the State Title V Director stays informed of task force activities and recommendations.

ND recently received the Pregnancy Risk Assessment Monitoring System (PRAMS) Grant. A contract has also been established with the AIPHRC to assist in developing relationships with the American Indian population to assure successful oversampling. The AIPHRC will also develop and disseminate culturally-competent, custom-fit PRAMS educational materials designed to educate American Indian women about the survey. They will also assist with obtaining data sharing agreements and Internal Review Board approvals from the five reservations. The first data points from this survey will be available in 2018 and will greatly benefit maternal and child health programs, including the CoIIN initiative.

Additional critical partnerships/initiatives include:

- Healthy Start – collaboration with this program will help encourage collaboration with many of the tribal entities throughout ND.
- Family to Family – family engagement will be important in determining the best way to get information to

families in a form that will encourage best safe sleep practices.

- State Systems Development Initiative (SSDI) – this will support data needs regarding this performance and outcome measures annually to support the state action plan.
- Local Public Health – information dissemination will be important to educate clients on safe sleep.

Perinatal/Infant Health - Annual Report

NPM 1 *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

The North Dakota (ND) Newborn Screening (NBS) Program successfully identified infants at risk who were in need of definitive diagnostic testing and treatment. ND screens for 49 conditions. In calendar year (CY) 2014, there were sixteen confirmed positive cases. All sixteen, or 100 percent, received timely follow-up to definitive diagnosis and clinical management. This excellent result is a consistent finding over the last decade.

In addition, 23 individuals were served through the Metabolic Food Program and 11 children received services through the Metabolic Disorders Clinic during the federal fiscal year 2015 reporting period.

ND has several state mandates for the state's NBS Program:

- North Dakota Century Code Chapter 23-01-03.1 Newborn Metabolic and Genetic Disease Screening Tests
- North Dakota Century Code Chapter 25-17 Testing and Treatment of Newborns
- Administrative Code Chapter 33-06-16 Newborn Screening Program

The ND NBS Program works with the State Hygienic Laboratory at the University of Iowa to process NBS specimens. ND's NBS staff collaborates with University of Iowa follow-up staff and ND health care providers regarding short-term follow up on newborn screening cases. Newborns with definitive diagnosis and need for clinical management were seen by a primary care provider and/or a medical consultant of choice within five to seven days of birth for long-term planning and treatment management.

Additional long-term follow-up activities were conducted by Children's Special Health Services (CSHS), which included the following:

- Follow-up for families with screen positive newborns to link them to services and coordinate care.
- Provision of medical food and low-protein modified food products to individuals with phenylketonuria (PKU) and maple syrup urine disease (MSUD).
- Funding of metabolic disorders clinics to coordinate management of various metabolic disorders.
- Provision of diagnostic and treatment services for children birth to age 21 who meet medical and financial eligibility criteria.

Staff continues to work in partnership both within and outside the ND Department of Health (NDDoH). Internally, staff from the Divisions of Family Health and CSHS met throughout the year to share information and address programmatic issues. Periodic conference calls were also held to coordinate with Iowa follow-up staff. The short-term follow-up nurse from the University of Iowa who provides care coordination for infants born in ND, traveled to the state in March 2015, met with the ND NBS team, and provided an overview of some of the disorders. ND newborn screening staff also traveled to Iowa for a comprehensive visit of short term follow-up and the laboratory in June 2015. Both of these site visits greatly increased the knowledge and further strengthened the working relationship for ND and Iowa staff. ND's NBS staff continues to provide regional coordination for ND, South Dakota, and Iowa focusing on quality assurance and education.

The Heartland Regional Collaborative was an important external partner. The ND NBS Program has plans to participate in a Collaborative Partners Project through the regional collaborative to investigate specimen rejections at one facility in ND. The project results will be presented to the collaborative at the national newborn screening symposium in March 2016. The ND NBS Program Advisory Committee, a group that provided consultation on a variety of screening-related issues, was another significant partner during the year.

In addition to ongoing screening, follow-up, direct service, and educational activities, the following accomplishments occurred during this reporting period:

- The contract for the ND NBS Program Medical Director was renewed in July 2015.
- A contract was established in July 2015 with Sanford Health for medical consultation services for abnormal newborn screenings.
- Resources, including additional staff time, were devoted to the implementation of Severe Combined Immunodeficiency (SCID), a potential area of NBS expansion.
- Educational resources were provided to the 12 birthing facilities and site visits to each facility was completed in fall 2015.
- ND's Century Code and Administrative Code relating to the NBS Program were updated to reflect current and best practices. These updates were presented in SB 2334 during the 2015 Legislative Session. The bill passed both the House and Senate and was put into effect following the Session's conclusion. The Administrative Rules were drafted and presented to the State Health Council in November 2015 for adoption.
- Children's Special Health Services (CSHS) provided a significant amount of program data to legislators when it was requested during the 2015 Legislative Session. Legislation was monitored and tracked by staff to plan for possible programmatic changes in the upcoming biennium.

Although Title V devotes significant effort in this area, challenges remain. Emerging issues include screening and care coordination issues for border babies, adequate provider coverage, limitations in the metabolic food program, and limited staff time with competing workload demands.

NPM 11 *The percent of mothers who breastfeed their infants at 6 months of age.*

According to the Centers for Disease Control and Prevention (CDC) Breastfeeding Report Card, which uses the CDC National Immunization Survey data collected annually, 48.1 percent of North Dakota (ND) mothers continued to breastfeed their infants at six months of age in 2014, which represents a decrease from 2013 (55%). Although ND still falls short of the Healthy People 2020 goal of 60.6 percent, ND has seen some small improvements with breastfeeding initiation which is reflected in five year trend of steady increases. There are areas that continue to present challenges, including the low numbers of American Indian mothers who choose breastfeeding and the low breastfeeding duration rates at six months for lower income women.

A strong collaboration between Title V and the Preventive Health and Health Services (PHHS) Block Grant has resulted in some significant accomplishments. Utilizing PHHS funding, the contract to maintain "Breastfeeding-Friendly" training and designation for birthing facilities, using five of the ten steps from the national baby-friendly hospital initiative, was continued and expanded upon. The training was provided to staff at one birthing facility, Sanford Medical Center Bismarck, on evidence-based practices to support breastfeeding. After the training, Sanford Medical Center Bismarck submitted paper work and was designated as the second ND Breastfeeding-Friendly hospital. Two other birthing facilities have submitted paper work to move towards the ND designation as well. To support the initiative, a ND Breastfeeding Skills Training was developed for professionals working with mothers and infants in the prenatal, perinatal and post-natal stages. This hands-on training provided three hours of continuing education for nurses, dietitians and certified lactation counselors. While PHHS and the Association of

State and Territorial Health Officials (ASTHO) funds were used to support the contract for the training, the overall initiative was directed by the Maternal and Child Health (MCH) Nutritionist who is supported by Title V funding.

State and local Women, Infants and Children (WIC) programs and the Optimal Pregnancy Outcome Program (OPOP) encouraged breastfeeding to prenatal clients as the optimal method of feeding healthy infants and provided breastfeeding support through the following activities:

- The ND infant-friendly workplace designation was promoted across the state and seven new businesses developed breastfeeding-friendly worksite policies to be designated as Infant-Friendly Workplaces.
- The ND Breastfeeding Coalition shared ideas to help promote and support breastfeeding, as well as ways to improve maternity care practices in ND hospitals. The majority of the committee's work this reporting period focused on coalition sustainability and developing bylaws.
- The state MCH Nutritionist and WIC Nutritionist supported and provided technical assistance to nine existing coalitions. The coalition members shared information, organized breastfeeding activities in their communities, identified and promoted community breastfeeding experts, and offered expertise to support the community and breastfeeding mothers.
- State Title V and WIC staff maintained current breastfeeding data (breastfeeding initiation rates by county and by birthing hospital), disseminated information through email lists and posted the data on the state breastfeeding website: <http://www.ndhealth.gov/breastfeeding>.
- The state MCH Nutritionist participated in subcommittees (continuity of care to community and increasing breastfeeding rates and duration) relating to the National Collaborative for Advancing the Ten Steps to Successful Breastfeeding (NCATS).
- Title V staff assisted in developing a breastfeeding skills training to increase competencies of professionals working with mother-baby dyads in the prenatal, perinatal and post-natal stages.

WIC is a significant partner with breastfeeding promotion and support. The state WIC Program continued to purchase hospital-grade breast pumps for local agencies (six new and two replacements and two reconditioned Symphony) and provided a number of participant nutrition education cards including breastfeeding tips, formula versus breast milk, and breastfeeding websites. Addition collaborative activities with WIC included:

- State WIC staff supported the 12th biennial breastfeeding conference in October 2014 by providing technical assistance to the planning committee and sharing the conference save-the-date information with local agency WIC staff as well as state WIC staff in South Dakota, Minnesota, and the ND Tribal WIC programs.
- The WIC Breastfeeding Committee, comprised of state and local WIC staff, promoted activities for World Breastfeeding Week, (including reprinting a Loving Support® poster on encouragement), reviewed and purchased breastfeeding materials for participants (including a new booklet and brochure on breastfeeding and working), developed a handout on infant stomach size, compiled a list of breastfeeding participant and staff resources, and revised the breastfeeding tips for newborns nutrition education card. In addition, state WIC staff revised a WIC breastfeeding promotion and support training module to use when training new staff and piloted a breastfeeding bag project at a local agency with a high American Indian population.
- WIC state staff provided training and technical support to the three peer counseling sites through quarterly calls, review of quarterly reports, etc. A participant survey of the breastfeeding peer counseling program was completed at each agency.
- Two more local WIC staff were supported in their efforts to become an International Board Certified Lactation Consultant (IBCLC) this past year. There are currently five IBCLCs statewide. WIC also supported WIC staff to attend advanced breastfeeding training to become certified lactation consultants (CLC).
- State WIC offered a one-day baby behavior training for local agency staff with trainers from the University of California Davis Human Lactation Center and distributed the California WIC Program's baby behavior materials (print materials and DVDs) for use in local WIC sites. Participant and staff materials were adapted

for use from the California and Colorado WIC Programs. Materials adapted included: *Getting to Know Your Baby* magazine and DVD, baby behavior poster, appointment guide, baby behavior class clips DVD, and infant states reference. Staff that were not able to attend the training were encouraged to view the new WIC Works Learning online training, *WIC Baby Behavior Basics*.

- The State WIC director participated in the State Breastfeeding Coalition and provided updates, as appropriate, on the coalition's activities to the local agency staff. She also supported local agency staff in participating with coalition activities including conference calls, an annual meeting and various trainings.

As a result of MCH Transformation 3.0 and the new needs assessment findings, the state Title V Director revised the mechanism for allocating local MCH funds. In the past, MCH funds were allocated to all local public health units on a funding formula. A new, competitive grant application targeting four ND MCH priorities, including increasing the rate of breastfeeding at 6 months, was sent out in September 2015 with applications due January 15, 2016. A committee reviewed and scored applications in January 2016 with grant funds being awarded April 1, 2016. Successful grantees will be funded through September 30, 2021.

Grant applications were accepted in order to provide up to \$80,000 in federal funds. A variety of entities were allowed to apply for funding including advocacy groups/agencies, child care facilities, colleges/universities, faith-based organizations, healthcare providers/institutions, local public health units, private or public non-profit entities, regional education associations, regional public health networks, schools, state agencies, and tribal governments/affiliates. A link to the new, competitive grant application package can be viewed at: <http://www.ndhealth.gov/FamilyHealth/MCH-Grant-Application.htm>.

NPM 12 *Percentage of newborns that have been screened for hearing before hospital discharge.*

North Dakota (ND) is unique in the administration of its Early Hearing Detection and Intervention (EHDI) Program. The North Dakota Center for Persons with Disabilities (NDCPD) at Minot State University has been designated as the lead agency and the bona fide agent, acting on behalf of the North Dakota Department of Health (NDDoH). In turn, a staff member from the Division of Children's Special Health Services (CSHS) serves as state implementation coordinator on the grants management team responsible for the ND EHDI program.

NDCPD received a federal Maternal and Child Health Bureau EHDI grant for the period of April 1, 2014 through March 31, 2017. NDCPD also received a Centers for Disease Control and Prevention Early Hearing Detection and Intervention Information System (EHDI-IS) Surveillance Program grant for the period July 1, 2011 through June 30, 2016. The grants are intended to reduce loss to follow-up and enhance electronic system capacity to collect data; ensure children receive recommended screening and follow-up services; and, exchange data accurately, effectively, securely, and consistently between the EHDI-IS and electronic health record systems. Specific goals of the grants are on reducing the duplicate data entry burden and providing a reduction in loss to recommended follow-up services (screening, diagnosis and intervention).

According to data obtained from the NDDoH, Division of Vital Statistics, and the OZ| eSP system via the ND EHDI Program, screening rates for calendar years 2014 and 2015 remained high at 98.5 and 98.1 percent respectively. Despite the success regarding the number of initial birth screens, ND has continued to struggle with loss to follow-up. ND EHDI follow-up coordinators have worked diligently to mitigate these issues. They have sent letters to parents whose infants have missed or referred on their birth hearing screen, emphasizing the need for follow-up. Referrals have continued to be made to Right Track providers who are able to make home visits, complete otoacoustic emissions (OAE) screens and report results back to the ND EHDI follow-up coordinators. Program staff has also continued working closely with birthing hospital staff, audiologists, Tribal Tracking, the Parent Infant Program, and

Infant Development (Early Intervention) staff to have results entered into the EHDI tracking system. The state EHDI coordinator also maintains a working relationship with bordering states, to ensure that babies crossing the border after birth are followed accordingly.

In addition to these helpful partnerships, ND EHDI staff have endeavored to find ways to run the program more effectively. Several members of the ND EHDI team have attended national EHDI conferences the past few years. Educational sessions at this conference have helped foster program enhancements, including the restructuring of a state EHDI Advisory Committee and new ideas for quality improvement projects. A successful quality improvement project undertaken during the reporting period increased use and functionality of the Oz eSP system to improve efficiency with family follow-up reminder letters, which decreased duplication and workload burden of EHDI staff.

Family support has remained a need for families of children with hearing loss. In recognition of this, CSHS funded two major family support organizations, one of which was specifically geared for children who were deaf or hard of hearing.

The following information was provided to families through various outreach strategies:

- EHDI program information including the 1-3-6 initiative (screen for hearing loss by one month of age, diagnose hearing loss before three months of age, and enroll in early intervention before six months of age)
- Family support options
- State and local services
- Care coordination efforts through the state office and various partners

NPM 17 *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

The number of very low birth weight infants delivered at facilities for high-risk deliveries and neonates has been increasing since calendar year 2008. According to data from the North Dakota Department of Health (NDDoH), Division of Vital Records, the number of very low birth weight infants delivered at facilities for high-risk deliveries and neonates for calendar year 2014 was 62.4 percent. This is a decrease from 74.6 percent in 2013. There are currently five birthing hospitals in the state that self-report as a level 3 facility. These hospitals are located in the state's larger cities of Fargo, Bismarck and Grand Forks.

Title V staff worked with the March of Dimes North Dakota Chapter through a Program Services Committee to develop goals to reduce pre-term deliveries, increase early prenatal care and to enhance relationships with the American Indian population. Title V staff also participated in the national Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) project. Through this project, Title V staff worked with the March of Dimes North Dakota Chapter and the South Dakota CoIIN team on an initiative to reduce non-medically indicated early-term deliveries in both states. In March of 2015, letters were sent to all ND birthing facilities inviting them to sign a pledge to reduce non-medically indicated early-term deliveries. The letters were sent and signed by the First Lady of the state of ND and the State Health Officer. All ND hospitals signed the pledge by November 2015. An in-person ND CoIIN team meeting occurred in November 15, 2015 that included a press conference recognizing all birthing hospitals. ND and South Dakota continue to update each other on their state's progress. Additional CoIIN activities were addressed through the State Systems Development Initiative (SSDI). Efforts focused on development of CoIIN measures, determining a process to obtain quarterly Vital Record data for entry into the CoIIN Collaboratory, and leadership of the Social Determinants of Health Workgroup.

Title V staff continue to participate in the Birth Review Program serving as the point of contact for families with at-risk newborns. Staff answers questions related to the information that is provided to families upon their request. The Birth

Review Program collaborates with other NDDoH staff and programs, along with North Dakota Department of Human Services. The Birth Review Committee has reviewed all materials provided to families that are flagged for the Birth Review Program. This review included updating information so that families received the most up-to-date resource information. This will continue to be addressed in future Birth Review meetings.

A collaborative resource directory entitled *A Connection for Families and Agencies: Resources for North Dakota Families with Young Children Ages Birth ~ 8* has been developed as a resource for families and includes hospitals in North Dakota, as well as various neonatal intensive care unit levels. The directory was revised in October 2013 and is reviewed biannually. This directory is currently published in English and is available as a digital document, searchable on the web: <http://www.ndhealth.gov/familyhealth/publications/ConnectionDirectory.pdf>.

SPM 5 Priority Need Statement: *Increase access to available, appropriate and quality health care for the MCH population.*

Performance Measure: *Increase the number of children ages 0 to 2 served by an evidenced-based home visiting program.*

The degree of services offered by home visiting programs varies by agency/program in North Dakota (ND). For example, many local public health units provide one to three newborn home visits to new mothers and their infants; while one local public unit utilizes the evidenced-based Nurse Family Partnership model to support first time mothers prenatally and up to the child's second birthday. Additional home visiting services/programs in ND include Early Head Start, Early Intervention, Healthy Families America, Parent as Teachers, and Right Track.

The number of children ages 0-2 served by an evidence-based home visiting program (Healthy Families America, Nurse Family Partnership, Parents as Teachers) increased from a rate of 15.8 in 2013 to 16.7 in 2014; however, this still does represent a decrease from the rate of 18.1 in 2012. Prevent Child Abuse North Dakota (PCAND) is the state's Maternal, Infant and Early Childhood Home Visiting (MIECHV) grantee. During the last two reporting periods, challenges occurred in the targeted reservations of Turtle Mountain and Spirit Lake that resulted in transitioning from Healthy Families America to Parents as Teachers. This transition may account for the decline in the rate of children served from 2012 to 2013 by an evidence-based home visiting program. However, the increase from 2013 to 2014 hopefully indicates that the transition to the Parents as Teachers model has been successful.

The state Title V Director serves on PCAND's MIECHV Advisory Committee. Through this role, the Title V Director has been able to facilitate increased collaboration between Title V programs and home visiting programs. One example includes PCAND becoming a partner site with Cribs for Kids to provide safe cribs to families served within the home visiting programs. In addition, PCAND's executive director and MIECHV grant manager are active members of ND's Infant Mortality Collaborative for Improvement and Innovation Network (CoIIN) team.

To further support home visiting in ND, PCAND developed a state level directory of early childhood services and developed a children's services coalition to better coordinate services in a tribal area. The directory can be viewed at: http://www.ndkids.org/images/Home_Visitation_Directory.pdf. PCAND also helped to develop and support ND's Home Visiting Coalition, which meets on a quarterly basis. The state Title V Director attends meetings as her schedule allows.

To further increase access to available, appropriate and quality health care for the maternal and child health populations beyond home visiting programs, several programs provide direct services including family planning, oral health, children with special health care needs (CSHCN) and Women, Infants and Child (WIC). Title V either takes the lead (e.g., CSHCN) or works collaboratively with these programs to support and enhance access to care.

Child Health

State Action Plan Table

State Action Plan Table - Child Health - Entry 1

Priority Need

Reduce overweight and obesity in children.

NPM

Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Objectives

1a. Fund three maternal and child health (MCH) grantees to implement evidence-based, evidence-informed and/or promising practices efforts to reduce overweight and obesity in North Dakota (ND) children through September 30, 2020.

Strategies

1a. Promote healthy nutrition and physical activity among the maternal and child health (MCH) population throughout the lifespan by exploring opportunities to improve nutrition and physical activity efforts in the community (e.g., schools, child care centers, businesses). FY Activities 2017 (October 1, 2016 through September 30, 2017):

- Support MCH staff time to work with the Diabetes, Heart Disease, Obesity and School Health (DHDOSH-1305) Grant in their efforts to institute model policies for physical activity in all ND schools, including recess components.
- Monitor, oversee, and provide technical assistance to the three MCH grantees to assure contract activities and requirements are being met.
- Establish a structure that will facilitate communication with and among MCH grantees.
- Share and promote resources with state and local programs/staff (e.g., WIC, school nursing), local coalitions/foundations, etc.

ESMs

ESM 8.1 - Numbers of schools maternal and child health (MCH) grantees are working in to reduce overweight and obesity in North Dakota children.

NOMs

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Measures

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Annual Objectives

	2016	2017	2018	2019	2020	2021
Annual Objective	40	41	42	43	44	45

Data Source: National Survey of Children's Health (NSCH) - CHILD

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	38.9 %	3.0 %	19,367	49,796
2007	35.7 %	2.6 %	15,248	42,662
2003	32.6 %	2.3 %	16,044	49,253

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 8.1 - Numbers of schools maternal and child health (MCH) grantees are working in to reduce overweight and obesity in North Dakota children.

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	21.0	32.0	43.0	54.0	65.0

Child Health - Plan for the Application Year

Reduce Overweight and Obesity in North Dakota Children

A balanced diet and regular physical activity benefit the health of children and adults. Poor diet and physical inactivity contribute to many serious and costly health conditions including obesity, heart disease, diabetes, some types of cancer, unhealthy cholesterol and high blood pressure. Title V recognizes that a multi-pronged approach is needed in order to make a meaningful change.

According to the National Survey of Children's Health, 38.9 percent of ND children ages 6-11 were physically active at least 60 minutes per day, showing a steady increase from 2003 (32.6%). According to the 2015 Youth Risk Behavior Survey (YRBS), 28.7 percent of North Dakota (ND) students in grades 9 through 12 had a body mass index (BMI) of 85 percent or greater (overweight and obese). This number has increased over time from 23.4 percent in 2007, to 24.4 percent in 2009, and 25.5 percent in 2011; however, was relatively unchanged from 2013 (28.6). The YRBS also indicated in 2015 that only 25.4 percent of ND students in grades 9 through 12 were physically active for a total of at least 60 minutes per day of the past seven days. Although low, this does represent a slight increase from the 2007 level of 21.8 percent. This number does increase when looking at the number of students in grades 9 through 12 that were physically active for at least 60 minutes per day for 5 or more days to 51.3 percent. The amount of time students are required to spend in a physical education (PE) course varies. In ND, elementary grades 1 through 6 must offer a minimum of 90 minutes of PE each week. Students in grades 9 through 12 must have at least one credit of PE, of which half can be health education. By working with the child population, it is anticipated that the establishment of healthy behaviors will be incorporated throughout the lifespan.

In addition to physical activity, the YRBS also monitors dietary intake. Over half (58.5%) of students in grades 9 through 12 ate vegetables one or more times per day during the seven days before the survey. However, this number drops by about half (24.3%) for those students that ate vegetables two or more times per day during the seven days before the survey.

As a result of MCH Transformation 3.0 and the new needs assessment findings, the State Title V Director revised the mechanism for allocating local MCH funds. In the past, MCH funds were allocated to all local public health units on a funding formula. A new, competitive grant application targeting four ND MCH priorities, including reducing overweight and obesity in children, was sent out in September 2015 with applications due January 15, 2016. Three grantees including a Regional Educational Association, a local public health unit, and a university were awarded funding (April 1, 2016 through September 30, 2021) to implement evidence-based strategies to reduce overweight and obesity in children by working within schools, child care facilities and communities. The Title V Director, State Maternal and Child Health (MCH) Nutritionist, and the Chronic Disease School Health Specialist will play a large role in providing oversight and technical assistance to these grantees, in addition to assuring consistent communication and sharing among grantees and other partners.

The MCH Nutritionist also works with partners on the State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity, and Associated Risk Factors and Promote School Health (DHDOSH-1305) Grant. This grant uses a coordinated approach to promote health and prevent chronic diseases and their associated risk factors through the collaboration between the state's chronic disease prevention programs (e.g., diabetes, tobacco, heart disease, stroke, cancer). Title V and chronic disease programs have very similar priorities, objectives, strategies and activities; hence, working together increases effectiveness and creates efficiencies. The DHDOSH-1305 staff has outlined a number of action steps to work with schools to implement recess and physical activity policies. The DHDOSH-1305 School Health Specialist is actually under the direct supervision of the Title V Director, thereby showing how collaborative in nature Title V and chronic disease programs work together.

The MCH Nutritionist is also leading an effort on a Pediatric Obesity Collaborative Improvement and Innovation Network (CoIIN) mini grant to enhance efforts related to nutrition and physical activity in children ages 2-5 through May of 2017. Through collaboration with Child Care Aware of ND, the ND Department of Public Instruction, and the ND Department of Human Services, work is being done to develop companion guides to the Early Learning Guidelines (ELG) specific to nutrition and physical activity. ELG are research-based, measurable descriptions of the

things young children are expected to know and be able to do at each age and stage of development. These guidelines provide parents, teachers, caregivers and policy makers with common language and expectations that they can use to plan, execute, and evaluate early childhood environments and services. The goal of this CollIN initiative is to reach as many providers and parents working with children to help lay the groundwork for healthy eating and physical activity behaviors at a young age.

When it comes to obesity prevention, breastfeeding has been proven to help reduce obesity. Breastfeeding promotion and support is also an integral component to work of the MCH Nutritionist. Information regarding breastfeeding strategies and activities are discussed in the Perinatal/Infant Health domain, breastfeeding priority.

Title V staff partner with the Women, Infants and Children (WIC) Program and their work to reduce obesity and increase physical activity. WIC is an important partner in addressing healthy weight among the MCH population. Local WIC staff conduct nutrition risk assessments (including collecting BMI information), provide tailored food packages, personalized nutrition education and make referrals as needed. High BMI levels in ND WIC children mirror what is happening nationally. While the trend is a concern for all ND WIC children, it is of particular concern for American Indian children who are more likely to be overweight and at risk of overweight than the state average.

While many different entities are dedicating resources to reduce childhood overweight and obesity, there has never been statewide effort focused on turning back childhood obesity. In addition, dedicated funding to address this critical issue is also lacking. Recognizing this need, the North Dakota Department of Health's, Division of Nutrition and Physical Activity, continue to identify potential new funding opportunities, such as CollIN. Staff also follow and support a number of promising initiatives going on within local communities that impact childhood obesity such as CassClayalive! and Go!Bismarck-Mandan. While these are not statewide initiatives, it is hoped that these models can be replicated in other communities/counties. One of the new MCH grantees, Fargo Cass Public Health, is working collaboratively with CassClayalive! on their grant strategies and activities. These models can be viewed at: <http://www.dakmed.org/cass-clay-alive/> and <http://gobismarckmandan.org/>.

Child Health - Annual Report

NPM 7 *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilis Influenza, and Hepatitis B.*

Immunizations are not only important for the individual, they are also important for the community and those who cannot be immunized. The spread of disease can be prevented by receiving immunizations according to the recommendations and guidelines set forth by the Centers for Disease Control and Prevention (CDC). Immunizations are cost effective and have saved millions of lives throughout the years.

As with many programs, collaboration between partners is essential to achieve common goals. Title V and the Immunization Program have a Memorandum of Agreement (MOA) that was established in July 2003 to define the responsibilities of the each party. As a result of this collaboration, staff work together to educate partners who provide direct services to children to increase immunization rates. The State School Nurse Consultant maintains a school nurse listserv, which allows for the distribution of educational materials and opportunities on various topics, including immunizations. School nurses review student immunization records and provide recommendations to the staff regarding immunization schedules. The Department of Public Instruction (DPI) maintains a listserv for the school administrators, which functions in the same manner as the school nurse listserv. DPI also receives school immunization data for children entering kindergarten and middle school. This information is also available on the internet.

According to the 2014 CDC National Immunization Survey (NIS) and the U.S. Census Bureau, the immunization rate for children ages 19 to 35 months in North Dakota (ND) was 73.0 percent. Trend data for this national performance

measure is difficult to analyze due to vaccine shortages and changes to the immunization requirements. The Immunization Program assessed school immunization rates for kindergarten and middle school students in ND. For the 2014 to 2015 school year, the kindergarten immunization percentage rates were as follows: Polio – 90.95; DTaP – 89.59; MMR – 89.78; HepB – 92.82; Varicella (includes immunity from vaccine or disease) – 89.50. The survey also showed a kindergarten exemption rate of 3.01 for no immunization record; 0.28 for medical exemption; 0.53 for religious exemption and 1.87 for philosophical exemption. The middle school immunization percentage rates were as follows: Polio – 94.96; DTaP – 94.08; MMR – 93.40; HepB – 94.18; Varicella (includes immunity from vaccine or disease) – 93.75; Tdap – 86.37; MCV – 84.71. The exemption rate for middle school students was 1.24 for no immunization record; 0.43 for medical exemption; 0.39 for religious exemption and 1.81 for philosophical exemption.

Title V staff work closely with local public health and Women, Infants and Children (WIC) to verify immunization status and document the findings in the WIC computer system during certification visits. Follow up referrals are made on an as needed basis. Updates on immunizations were provided by the Immunization Program to health-care partners such as school nurses, childcare health consultants, Head Start, WIC and local public health. Title V funding provided assistance to nineteen local public health units to administer immunizations.

Information regarding immunizations is distributed by Title V staff in a variety of ways including *Parenting the First Year* magazine, newsletters, information packets, websites and listservs.

NPM 9 *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

The 2014-2015 Oral Health Basis Screening Survey (BSS) for third grade children indicated that 53 percent of third grade children in North Dakota (ND) received protective sealants on at least one permanent molar; this represents a decrease from 2009-2010 BSS (60.4%). Factors contributing to this decline may include a decrease in funding for program implementation in 2011 and the rapid increase of student population related to out-of-state families moving into the state for energy-related jobs.

In 2009, a law was passed authorizing general supervision of licensed dental hygienists for procedures authorized in advance by a dentist. As a result of this legislation, the Oral Health Program implemented a school-based fluoride varnish and sealant program (Seal! North Dakota). In the fall of 2011, four public health hygienists employed by the Department of Health and supported through a Health Resources and Services Administration (HRSA) Workforce grant, began applying fluoride varnish and dental sealants to children pre-kindergarten through sixth grade in approximately 50 schools throughout the state. In some schools, small numbers of students in grades 7 through 12 were served as well. From 2009 through 2012, approximately 1,700 students per school year had received services through this program. Between the 2013 and 2014 school year, there was a lapse in funding to the program decreasing the number of schools served from 50 to two. In July 2014, funding to the program was reinstated allowing for the Oral Health Program to continue collaboration with the Department of Public Instruction to identify high risk schools for participation based on free and reduced lunch rates. This increased the number of schools served from two to 18. During the 2014-2015 school year (September 2014 through May 2015), public health hygienists placed sealants on 896 children within the 18 participating schools. A cost-benefit analysis of the program is in process.

The Oral Health Coalition, safety net clinics and the Ronald McDonald Care Mobile continued to be instrumental in supporting the sealant and fluoride varnish programs. The Oral Health Coalition had determined funding the school-based dental sealant and fluoride varnish program to be a priority for the 2015 Legislative Session. A bill was introduced to provide general funds to support the program; however, it did not pass.

Children's Special Health Services continued to cover preventive dental care (oral exams, teeth cleaning, sealants, fluoride treatments and x-rays) as well as restorative, surgical and emergency care for children with eligible dental conditions.

NPM 10 *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Since 2012, there has been a trend of declining death rates (last three years) to children 14 years and younger due to motor vehicle crashes in North Dakota (ND). From 2012, the rates began to drop from 2.4 to 1.3 in 2013, and to .7 in 2014. Although the Child Passenger Safety (CPS) Program has access to mortality data through the North Dakota Department of Health (NDDoH) and the crash report data from the North Dakota Department of Transportation (DOT), the program lacks access to hospital discharge data that would give the program more details about the injuries and deaths from motor vehicle crashes.

The Injury Prevention and Control Program provided continuing collaboration and support with DOT efforts such as having representation on the Strategic Highway Safety Plan (SHSP) Steering Committee, SHSP Executive and the SHSP Young Driver Committee. The above meetings are as scheduled as determined by the DOT Safety Division and by the chair of the Young Drivers subcommittee.

The CPS Program continued a contractual relationship with the DOT for funds to administer the state's program. Funding is directed towards programs focusing on caregivers with children ages birth to 13 years of age. The goal of the program is to reduce injury and death due to motor vehicle crash events.

The program offered several trainings throughout this reporting period. One of the trainings included the August 2015 CPS Conference, which was well attended by 85 CPS certified technicians. The conference offered technical CPS information to technicians to improve their knowledge and bring them up-to-date with the latest CPS technologies. Technicians received continuing education units to maintain their two-year certification. Other successful trainings for this reporting period included:

- Four National CPS Certification Trainings throughout ND, which created 59 more certified technicians statewide.
- Seven CPS trainings to law enforcement training centers with 153 law enforcement personnel in attendance.

The CPS Program partners annually with many agencies to disseminate CPS best practices information including public health agencies, Women, Infants and Children (WIC) clinics, Indian Health Services, law enforcement, Safe Kids Coalitions, private clinics, hospitals, schools, Head Start/Early Head Start, and other agencies who work with caregivers that have contact with children.

Eighty local agencies statewide participated in CPS month activities in February 2015. New CPS classroom presentation guides and activity booklets were created for children K-6 grades and were distributed to agencies participating in the campaign. Approximately 18,219 children received the buckle up in the back seat safety messages through 479 classroom presentations and/or via educational materials.

DOT funds were used to purchase 528 car seats for the 32 car seat distribution programs throughout the state. Car seat distribution was reduced to distributing exclusively to low-income families during this program year.

The CPS Program coordinated car seat checkups throughout the state by either providing a certified instructor

or CPS technician proxy on-site or by providing supplies and technical assistance to certified technicians who served as lead instructors. The program assisted with 69 car seat checks, inspecting 838 seats. During the car seat checkups, program staff worked with approximately 230 certified child passenger safety technicians, assisting them with their recertification.

To evaluate the program, CPS observation surveys were conducted in the 10 largest cities in ND in the spring of 2015. The survey is a point in time survey that gives the program a picture of how caregivers are transporting their children. Statewide results are as follows:

- 100 percent of infants were riding in a car seats (compared to 99% in 2012)
- 92 percent of toddlers ages 1-5 were riding in a car seat or seat belt (no change since 2012)
- 81 percent of children ages 6-10 were in a seat belt or booster seat (a decrease compared to 88% in 2012)
- 87 percent of the children younger than 11 years were restrained with either a car seat, booster seat or seat belt (compared to 91% in 2012)
- 15 percent of the children younger than 11 years were restrained in the front seat (compared to 12% in 2012)

The CPS Program continued to work with a statewide CPS Advisory Committee, which met four times in 2015. Currently, there are 22 members, which include professionals and the public such as a child care provider, a physician, advocates, emergency medical services, law enforcement, nurses and government agencies. In May 2015 an Occupant Protection Assessment was completed with the ND DOT and its stakeholders. The advisory committee worked together to create plans to address the occupant protection for children recommendations that came from this assessment.

NPM 13 *Percent of children without health insurance.*

Children without health insurance have limited access to health care (whether preventive or ongoing) which can lead to a greater risk of illness and hospitalization. In addition, a lack of health insurance can have a negative influence on school attendance and participation in extracurricular activities, and increased financial and emotional stress among parents.

The percent of children in North Dakota (ND) without health insurance varies slightly depending on the data source, but generally has a range of 7 to 10 percent. The 2014 American Community Survey reported 7 percent of ND children were uninsured which is approximately 11,797 children. Small sample sizes can cause state estimates to fluctuate widely year-to-year, so an annual reliable estimate was used from the American Community Survey. For 2014, ND Kids Count reported 7 percent of children under the age of 18 as uninsured using an annual estimate. Nationally, 6 percent of children were without health insurance coverage. Among the 50 states, ND ranks 37 for uninsured children.

The 2011/2012 National Survey of Children's Health reported 93.5 percent of ND children were insured at the time of the survey (6.5% uninsured) compared to the national average of 94.5 percent (5.5% uninsured). The 2009/2010 National Survey of Children with Special Healthcare Needs reported 7.3 percent of ND children with special healthcare needs were without insurance at some point during the past year, compared to 9.3 percent in the nation. The next survey data from the NSCH will not be available until 2017. Starting in 2016, the NSCH and the National Survey of Children with Special Health Care Needs will be combined and completed annually.

Children's Special Health Services (CSHS) monitored whether children served had a source of health care coverage. In Federal Fiscal Year (FFY) 2015, 92 percent of ND children with special health care needs served by CSHS had a source of health care coverage; 71.8 percent of these children were covered by private insurance; 27.6

percent were covered by ND Medicaid, and 0.65 percent was covered by the Children's Health Insurance Program (CHIP). 1.6 percent of children served by CSHS during FFY 2015 had no source of coverage and insurance status was unknown for 6.2 percent of children.

Healthy Steps and ND Medicaid have been effective public programs in reducing the number of uninsured, low income children in the state. Healthy Steps provides premium-free, comprehensive health, dental and vision coverage to uninsured children up to 19 years old who do not qualify for ND Medicaid. The income eligibility limit is at 175 percent of the federal poverty level (FPL). Modest co-payments apply for certain services, which are waived for American Indian children. ND Medicaid is available to children ages 0 to 6 (thru the month they attain age 6) at 152 percent of the FPL (147% plus the 5% disregard) and children ages 6 to 18 (thru the month they attain age 18) are covered at 138 percent of the FPL (133% plus the 5% disregard). ND Medicaid has some limitations or restrictions for some covered services.

For State Fiscal Year (SFY) 2015, there were a total of 116,366 ND Medicaid recipients compared to 105,539 in SFY 2014. Of that group of recipients, 30.38 percent were White, 21.3 percent were American Indian, 2.7 percent were Black, 0.7 percent were Asian/Pacific Islander and 0.1 percent were Other. Of the 116,366 total recipients, 57,157 or approximately 49.1 percent were birth through 20 years of age. Of the 57,157 birth through 20 years of age, 40.2 percent were ND Medicaid recipients 0 through 5 years of age, 54.1 percent were 6 through 18 years of age and 5.7 percent were 19 through 20 years of age.

While outside of this reporting period, numbers during the open enrollment period for Medicaid or CHIP from November 1, 2015 through February 1, 2016 are noteworthy of mentioning, as 21,604 people in ND enrolled through HealthCare.gov. However, people can enroll directly through ND Medicaid as well, and enrollment in Medicaid and CHIP continue year-round as there is no limited enrollment window. Among those that enrolled, 35 percent were new consumers and 65 percent were reenrollees. In addition, 23 percent were less than 18 years old and 40 percent were 0 through 44. Females accounted for 55 percent of those enrolled, compared to males at 45 percent. Among female and male enrollees, 22 and 24 percent were less than 18 years old respectively. Of all those enrolled, 86 percent were white, 6 percent American Indian, 3 percent Latino, 2 percent African American, and 2 percent Asian. Individuals from rural areas accounted for 61 percent of the enrollees, while 39 percent were from urban areas.

1-877-KIDS-NOW is a toll-free resource line that helps uninsured families learn about low-cost and free health coverage programs in ND. A seamless eligibility process for health coverage programs has helped to assure coverage for ND's children. In March 2016, the monthly child enrollment in Medicaid and CHIP in ND was 46 percent compared to 51 percent in the U.S. The total monthly Medicaid and CHIP enrollment in ND was 21 percent compared to 27 percent in the US during the same period.

Title V programs continued to link clients and families to adequate insurance resources to reduce out-of-pocket costs. Title V staff also accessed information, attended trainings, and participated in meetings on the Health Insurance Marketplace. *Parenting the First Year* magazine was developed by the North Dakota Department of Health, in collaboration with the North Dakota Department of Human Services (DHS), to provide parents education and resources on babies ages birth to 12 months. Health insurance and coverage options are provided in this magazine, which is disseminated statewide.

Women, Infants and Children (WIC) is an important partner when it comes to supporting and informing lower income families on health insurance. This past year, State WIC staff shared a number of resources (webinars and flyers) on the Affordable Care Act (ACA) with local WIC agency staff.

CSHS continued to widely disseminate the Health Care Coverage Options brochure:

<http://www.ndhealth.gov/cshs/docs/Health%20Care%20Coverage%20Options.pdf>.

Financial Help and Health Care Coverage packets were provided to all families that requested additional information.

NPM 14 *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Since Women, Infants and Children (WIC) is the leading public health nutrition program that reaches so many low-income and culturally diverse infants and children, it has an important role to play in reducing childhood obesity and overweight in North Dakota (ND). In 2015, ND WIC served 21,690 women, infants and children who were nutritionally or medically at risk. Of those served, 6,451 were children (ages 2-5 years of age) and 6,764 were infants (about 60 percent of the infants born in the state). WIC staff (primarily public health nutritionists located in local public health programs, hospitals and tribal agencies) provided services in 80 communities across the state.

The data shows that ND WIC's Body Mass Index (BMI) percentages are over double the expected rate in a normal distribution. In 2015, as in past years, ND's overweight and obese percentage of 34 percent is comparable to national data. There appears to be a leveling off and even a slight decline when compared to the past 5 years, which is encouraging. (CDC categorizes 85th -<95th percentile as children "overweight" and those at the 95th percentile and above as "obese").

Local WIC staff provided participant-centered services through nutrition assessments, including BMI, nutritious food packages, nutrition education and counseling, and referrals. As part of the nutrition assessment, local WIC staff collected BMI information on participants and provide education and/or counseling. Every participant received a food package tailored to his or her needs. The recent changes to the WIC food package contributed to a healthier diet by providing fresh fruits and vegetables and whole grain products. This year, the final food rule of requiring only providing low fat milks to all women participants and children over two years of age was implemented.

Education is offered to all WIC participants addressing good nutrition and physical activity; this year's nutrition education efforts centered on MyPlate and its nutrition education concepts. To complement the initiative, WIC staff utilized *Your Child's Weight* and *Sensible Weight Loss* nutrition education cards when discussing weight issues with participants.

During this reporting period, State WIC staff continued to provide informative segments on nutrition and physical activity topic areas in the monthly ND WIC participant newsletter titled *Pick-WIC Paper*: <http://www.ndhealth.gov/WIC/Publications.asp?ProgramID=93>. Each month, the "Turn Off the TV" section continued to offer fun ideas to families on how to get children active. Educational materials were provided to local WIC nutritionists to use when discussing physical activity including specific indoor and outdoor activity ideas for toddlers and preschoolers, and weight loss tips for breastfeeding and delivered women.

Local WIC staff promoted breastfeeding as the normal way to feed infants and young children because it reduces the likelihood of childhood obesity. Breastfeeding classes, support groups, peer counselors and breast pump supplies were provided to WIC moms to support them in their decision to breastfeed. This past year, all WIC staff were trained on the Secrets of Baby Behavior by the University of California Davis Human Lactation Center. This training provided staff the tools to teach WIC participants how to identify their infants' behavior, which helps parents meet their infants' needs, breastfeed longer, and prevent overfeeding.

Partners are important for outreach, for offering other services, and to promote consistent nutrition and physical

activity messages using community-based approaches. This year, State WIC staff worked closely with the ND Chronic Disease Healthy Communities Coordinator and met frequently to get updated on activities. State WIC staff helped in the preparation and evaluation of the Title V annual plan and in particular, those objectives related to breastfeeding, nutrition and physical activity.

The State Maternal and Child Health (MCH) and Healthy Communities Nutritionists partnered with WIC staff on initiatives that impact their common populations. The MCH Nutritionist coordinated an annual meeting for the ND public health nutritionists in which State WIC staff provided an update of WIC activities. The MCH Nutritionist continued to manage the North Dakota Department of Health's (NDDoH) infant friendly initiatives including the department's policy for "baby at work."

Also during this reporting period, the State MCH Nutritionist supported efforts to increase nutrition and physical activity in the child care setting by serving as the facilitator on the Nutrition and Physical Activity in Early Child Care (NPAEC) Committee. The committee continued to promote the use of the previously developed Best Practices for Physical Activity in a Child Care Setting document and developed a Best Practices for Nutrition in a Child Care Setting documents.

As a result of MCH Transformation 3.0 and the new needs assessment findings, the state Title V Director revised the mechanism for allocating local MCH funds. In the past, MCH funds were allocated to all local public health units on a funding formula. A new, competitive grant application targeting four ND MCH priorities, including decreasing overweight and obesity in children, was sent out in September 2015 with applications due January 15, 2016. A committee reviewed and scored applications in January 2016 with grant funds being awarded April 1, 2016. Successful grantees will be funded through September 30, 2021.

Grant applications were accepted in order to provide up to \$80,000 in federal funds. A variety of entities will be allowed to apply for funding including advocacy groups/agencies, child care facilities, colleges/universities, faith-based organizations, healthcare providers/institutions, local public health units, private or public non-profit entities, regional education associations, regional public health networks, schools, state agencies, and tribal governments/affiliates.

SPM 2

Priority Need Statement: *Form and strengthen a comprehensive system of age-appropriate screening, assessment and treatment for the MCH population.*

Performance Measure: *The percent of Medicaid enrollees receiving Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening services.*

According to the North Dakota Department of Human Services (DHS), Medical Services Division Health Tracks Program, 57.7 percent of North Dakota (ND) Medicaid enrollees received Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening services in 2014. This percentage remained relatively unchanged from 2013 (58%).

Staff within the Division of Children's Special Health Services (CSHS) have continued to participate on various committees and work projects with State Medicaid staff in an effort to work more cohesively. However, the ND Health Enterprise Medicaid Management Information System (MMIS), a project that began in approximately 2004 and went live in October 2015, has continued to take priority for Medicaid staff and has made it a challenge to meet regarding issues outside of the project due to competing workload demands.

Updated informational materials have been gathered to enhance the Information and Resource Center housed within CSHS, which is utilized to provide outreach materials to families regarding screening, basic health information, and available resources. These outreach mailings included Bright Futures Health Supervision Guidelines, which are best practice standards endorsed by the American Academy of Pediatrics (AAP). Title V also promoted screenings through various methods including education of providers regarding condition specific screening (e.g., autism, Critical Congenital Heart Disease pulse oximetry screening, etc.), multidisciplinary clinic outreach, cardiac follow-up information, Supplemental Security Income (SSI) letters, and numerous special request mailings.

Although these work efforts have been effective, North Dakota (ND) has continued to lack an all-encompassing screening system. With that in mind, relationships have continued with ND's Early Childhood Comprehensive System (ECCS) Program that is aimed to expand developmental screening throughout the state with a focus on mental health and special emphasis on social-emotional development. ND's ECCS grantee is Prevent Child Abuse North Dakota (PCAND). The Title V Director and a representative from CSHS has been participants on their restructured committee and have continued in assisting with revision of the project's work plan and goals. It is hoped that this will contribute to a more cohesive approach regarding state-wide screening.

Depression is one of the most prevalent and treatable mental health disorders. Screening tools are effective ways of identifying potential physical and mental health conditions. The Suicide Prevention Program Director provided reimbursement of funding to support mental health screenings in the MCH population by using the Patient Health Questionnaire (PHQ) for patients in the Family Planning Program and the Optimal Pregnancy Outcome Program (OPOP). Staff were required to assess the mental health of all patients by using the PHQ-2. If the PHQ-2 was positive, the patient received further evaluation by completing the PHQ-9. If the patient score warranted treatment for a depressive disorder, the appropriate referrals were made. Data from the Family Planning Program for Calendar Year (CY) 2015 indicated that 10,780 PHQ-2 screenings had been completed. Of those screened, 213 received a positive screen and a PHQ-9 was completed. Referrals were completed for these clients to a variety of support services/programs including private counselors and physicians, local hospitals, the National Suicide Prevention Lifeline Call Back Program, and the DHS.

SPM 3

Priority Need Statement: *Support quality health care through medical homes.*

Performance Measure: *The percent of children age 0 through 17 receiving health care that meets the American Academy of Pediatrics (AAP) definition of medical home.*

A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. In a family-centered medical home, a pediatric care team works in partnership with a child and a child's family to assure that all of the medical, non-medical and dental needs of the patient are met. Through this partnership, the pediatric care team can help the family/patient access, coordinate, and understand specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the child and family.

A dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referrals to dental specialists when appropriate.

According to the 2011/2012 National Survey of Children's Health (NSCH), 61.9 percent of North Dakota (ND) children age 0 through 17 receive health care that meets the American Academy of Pediatrics (AAP) definition of medical home. This is slight decrease from the 2007 NSCH (64%). The next survey data from the NSCH will not be available until 2017. Starting in 2016, the NSCH and the National Survey of Children with Special Health Care Needs will be combined and completed annually.

Support of quality health care through medical and dental homes has been promoted for the MCH population through the following activities:

- Funding the ND Chapter of the AAP for medical home infrastructure through a liaison position as well as reimbursement for care coordination services in two medical home practices.
- Funding Minot State University, North Dakota Center for Persons with Disabilities, for a Medical Home Education in ND project which provides an on-line course that addresses the fundamentals of medical home for children with special health care needs (CSHCN).
- Promotion of medical home for the CSHCN population through information dissemination (e.g., Children's Special Health Services library and website links; topical calls; other health information center activities; etc.).
- Oral Health Program partnership with the North Dakota Dental Association and others to increase the number of children that have a dental home.

Please refer to National Performance Measure #3 for a more in-depth description of medical home activities for children with special health care needs.

SPM 4

Priority Need Statement: Increase participation in and utilization of family support services and parent education programs.

Performance Measure: The percent of parents who reported that they usually or always got the specific information they needed from their child's doctor and other health care providers during the past 12 months.

The positive effects of education and counseling of persons with chronic and acute conditions are well documented, and health-care providers generally are considered credible sources for patient and family education and information. Education and family support services promote self-management and encourage family empowerment that leads to improved health and well-being. According to the 2011/2012 National Survey of Children's Health (NSCH), 88.3 percent of North Dakota's (ND) children had parents who usually or always received the specific information they needed from their child's health-care provider, compared to 86.3 percent in the 2007 NSCH. The national average for 2011/2012 was 85.2 percent. The next survey data from the NSCH will not be available until 2017. Starting in 2016, the NSCH and the National Survey of Children with Special Health Care Needs will be combined and completed annually.

In an effort to distribute accurate educational materials for the MCH population and ensure consistency in messaging, Title V staff partnered with various programs and agencies to develop combined newsletters, mailings, etc. *A Connection Directory for Families and Agencies* has been posted on the ND Department of Health's website, and provides a list of agencies, telephone, fax, toll-free numbers and websites for services offered to children, women and families.

Parents have also indicated a need for education and support to help them improve their child's growth and development. Parent education programs and family support services have been shown to strengthen families by

increasing parent involvement, confidence and skills. There are a variety of community resources and partners that parents look to for parent support and education. These include family lead support agencies, state government agencies, county social services, Head Start, schools, Parent Information Resource Centers, mental health professionals and nonprofit organizations. The Division of Children's Special Health Services (CSHS) has been providing funding to two family-led organizations, Family Voices of North Dakota and North Dakota Hands and Voices to provide information, training and support services for children with special health care needs and their families.

To achieve more successful outreach during an era where technology has become more prevalent, Title V programs developed and monitored Facebook pages to provide public health education and build relationships with individuals and organizations that may not respond to traditional media. These pages have been accessed by families, partners and Title V staff. Local and national training events and information sharing on these pages have increased accessibility for educational opportunities that may have not been accessible otherwise.

These successes have not come without challenges. In a time where federal funding uncertainty has become more common, ND's population has experienced tremendous growth. Because of this substantial growth, family support agencies and other organizations that provide care coordination to families have needed to provide more services, despite a decrease in resources.

SPM 7

Priority Need Statement: *Increase the number of child care health consultants and school nurses who provide nursing health services to licensed child-care providers and schools.*

Performance Measure: *The ratio of students per school nursing FTE.*

Health and academics are closely linked. Children need to be healthy to learn and must learn to be healthy. In both early childhood and school-age populations, nursing services support the continuum of the educational process by contributing positively to the health, health attitudes and behavior of today's child and consequently tomorrow's adult.

School nursing services are preventative in nature and include education to encourage lifelong healthy behaviors, first aid, screening, medication administration, injury prevention, nutrition education, physical activity promotion, emergency care, referrals and appropriate management of acute and chronic health conditions of students and staff. The majority of school nurses in North Dakota (ND) work part time and the predominant model of school nursing delivery is through local public health units.

The ND School Nursing Services Survey is conducted every other year; participation in the survey is voluntary. The State School Nurse Consultant collaborated with multiple partners to disseminate and review the survey. The partners included the North Dakota School Nurse Organization (NDSNO), North Dakota Department of Public Instruction (NDDPI), North Dakota School Board Association (NDSBA), North Dakota Education Association (NDEA), and North Dakota Board of Nursing (NDBON). In spring 2014, the survey indicated there was approximately one nurse for every 1,478 students and about 42.2 full time equivalents (FTEs), in comparison to previous data from 2012, which reflected one nurse to every 2,057 students and 28.4 FTEs. A consideration for a variance in the results is that the ratio is only reflective of the schools who participated in the survey. The collection of this data continues to be a challenge, as schools lack access to a statewide data system with a health services component. The data was distributed to a variety of partners. Plans are currently underway for another school nursing survey to be completed in 2016.

Title V staff collaborated with multiple partners to develop educational materials that support healthy behaviors which

were tailored to school and child-care settings. Consultation services were provided on an as-needed basis to schools, child care centers, and the general public.

In 2013, legislation was passed that mandated schools to have staff trained to administer medications during the school day. Although the legislation mandated training, the bill lacked the specific details of how schools should implement this change. The State School Nurse Consultant continues to provide guidance and act as the liaison between the NDSNO, NDDPI, NDSBA, NDEA and NDBON. To provide further guidance for school nurses and personnel within the schools, the collaboration amongst partners resulted in the creation of a medication administration in schools PowerPoint training tool, which is posted on the ND Department of Health's (NDDoH) website.

The State School Nurse Consultant also participated in the Johnson and Johnson School Health Leadership Program (JSHLP). This team from ND worked on developing an enduring change plan, to be piloted in the Mid Dakota Education Cooperative (MDEC), which is located in Minot and surrounding communities. The enduring change plan included focus areas of training school staff and nurses on medication administration, developing a standardized health history form, and developing a virtual school nurse model.

In September 2015, the JSHLP team received a \$5,000 grant from Power of the Purse (a local Minot grant). The majority of this funding was used to conduct a Training of the Trainer (ToT) education module for medication administration in schools. Plans are being made to conduct a ToT class in Minot for two Registered Nurses, who in turn will train approximately 20-25 Minot Public School staff on medication administration. With this funding, medication administration kits were purchased for the return demonstration portion of the class. Another mini-grant from Johnson and Johnson for \$1,200 was submitted in October 2015 to assist with these efforts. Plans to standardize a health history form will be worked on in 2016.

Child Care Health Consultants (CCHC) work through Child Care Aware® of North Dakota to provide information and training on a variety of topics to help child care providers create and maintain a healthy environment for the children in their care. During the 2015 Legislative Session, House Bill 1247 was passed requiring the ND Department of Human Services to adopt rules to require an early childhood service provider and the provider's staff members who are responsible for the care or teaching of children under the age of one to annually complete a department approved sudden infant death syndrome prevention training course. The CCHCs and the NDDoH's Infant and Child Death Services Program Director have been contacted to assist with the development of the training course.

Adolescent Health

State Action Plan Table

State Action Plan Table - Adolescent Health - Entry 1

Priority Need

Reduce fatal motor vehicle crash deaths to adolescents.

NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives

- 1a. Utilize Child Passenger Safety (CPS) Observation Survey infographics to support CPS best practice education and outreach in ND through September 30, 2020.
- 1b. Increase the number of child passenger safety technician proxies within the state by September 30, 2020.
- 1c. The Injury Prevention Program Director will maintain and/or increase the number of partnerships to support activities outlined in the ND Injury Prevention Plan by September 30, 2020.
- 1d. Implement the Impact Teen Drivers Program in twenty (20) schools by September 30, 2020.

Strategies

1a. Utilize Child Passenger Safety Observation Survey data to support the implementation of best practice recommendations within communities. FY Activities 2017 (October 1, 2016 through September 30, 2017): • Distribute the ND CPS observation survey infographics statewide to help communities assess what they need to do to target CPS prevention activities.

1b. Enhance community child passenger safety outreach. FY Activities 2017 (October 1, 2016 through September 30, 2017): • Recruit qualified certified child passenger safety technicians who are willing to become proxies and conduct child passenger safety community outreach. • Train the CPS technician(s) to become a proxy and on how to conduct community outreach activities.

1c. Utilize partnerships to implement effective strategies to reduce fatal motor vehicle crashes in adolescents. FY Activities 2017 (October 1, 2016 through September 30, 2017): • Participate in the Young Drivers Committee facilitated by the ND Department of Transportation (NDDOT). • Work with the ND Injury Prevention Coalition and other stakeholders to implement the state plan to reflect current data and best practice recommendations. • Distribute the updated ND Injury Prevention Plan to various organizations, stakeholders, partners, etc.

1d. Engage communities to implement the Impact Teen Drivers Program. FY Activities 2017 (October 1, 2016 through September 30, 2017): • Facilitate three (3) train-the-trainer Impact Teen Drivers Program workshops in selected communities. • Determine a contracted entity to coordinate program activities. • Monitor and oversee contract activities and requirements including performing site reviews in schools implementing the program.

ESMs

ESM 7.1 - Number of certified child passenger safety technician proxies in North Dakota.

NOMs

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

State Action Plan Table - Adolescent Health - Entry 2

SPM

Decrease depressive symptoms in adolescents.

Objectives

1. Title V staff will partner with the North Dakota Department of the Health's (NDDoH) Suicide Prevention Program, the ND Department of Public Instruction (DPI), and the ND Department of Human Services (DHS) on efforts to reduce bullying through September 30, 2020.

Strategies

1a. Monitor ND data related to adolescent behavioral health and intergrade and coordinate activities across various entities. FY Activities 2017 (October 1, 2016 through September 30, 2017): • Title V staff will participate on the School Health Interagency Workgroup (SHIW) to assist with Youth Risk Behavior Survey (YRBS) question section and data dissemination. • Title V staff will monitor other data resources related to adolescent behavioral health (e.g., National Survey of Children's Health, Kids Count) • Title V staff will collaborate with the NDDoH's Suicide Prevention Program and participate on the ND Suicide Prevention Coalition. • The State Systems Development Initiative (SSDI) Coordinator will participate on ND's State Epidemiological Outcomes Workgroup (SEOW).

Measures

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Adolescent Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	294	288	282	276	270	264

Data Source: State Inpatient Databases (SID) - ADOLESCENT

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	319.6	18.9 %	286	89,495
2012	350.2	19.1 %	335	95,649
2011	401.8	20.9 %	370	92,080

Legends:
 Indicator has a numerator ≤10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

ESM 7.1 - Number of certified child passenger safety technician proxies in North Dakota.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	12.0	14.0	16.0	20.0

Adolescent Health - Plan for the Application Year

Reduce Fatal Motor Vehicle Crash Deaths to Adolescents

Childhood injuries continue to be a leading cause of death to children in North Dakota (ND). In 2013, non-fatal injury hospitalization rates for children ages one through nine start at a high rate of 149.12 per 100,000 and increases as children get older and enter adolescence (ages 10-19) to 319.57 per 100,000. Motor vehicle crashes are the number one killer of teenagers; young drivers are twice as likely as adult drivers to be in a fatal crash. Motor vehicle crashes are preventable and proven strategies can improve the safety of young drivers on the road.

The ND Injury Prevention State Plan will be updated this year with a focus on decreasing motor vehicle crashes (MVC). The ND Department of Health’s (NDDoH), Division of Injury Prevention and Control, will work with the ND Injury Prevention Coalition to update the plan. Numerous partners are actively engaged in this coalition including health-care organizations, law enforcement, highway patrol, local public health, Emergency Medical Services, Safe Kids Coalitions, *American Automobile Association*, ND Parks and Recreation Association, ND Safety Council, Indian Health Services, and state agencies such as the ND Departments of Public Instruction, Human Services, Game and Fish, Transportation and Office of the ND Attorney General-Fire Marshal Division. The coalition will continue to support public information/awareness and education efforts to decrease motor vehicle fatality rates in high-risk populations, including young drivers.

The ND Department of Transportation (DOT) is developing a new Strategic Highway Safety Plan (SHSP) with emphasis on young drivers. As a result, a Young Driver’s Committee comprised of a variety of stakeholders has been formed to create a united effort to increase education to this high-risk population. The NDDoH’s Injury Prevention Program Director will begin participating in this committee in the upcoming year. Additional collaborative activities will include supporting efforts to strengthen the restricted driver’s license law into a best practice graduated driver’s license law in ND, and to promote young driver programs such as Dare to Prepare. Dare to Prepare is an educational resource for parents and teens aimed at teen driver safety.

To help reduce injuries and deaths to children due to motor vehicle crashes, the NDDoH's, Child Passenger Safety (CPS) Program, promotes communities to offer car seat checkups/fitting stations to assist caregivers with their child passenger safety needs. To maintain qualified certified child passenger safety technicians, the CPS Program offers the National Highway Traffic Safety Administration (NHTSA) Child Passenger Safety Certification Trainings to professionals throughout the state every year. Currently, ND has approximately 231 nationally certified child passenger safety technicians throughout the state; the certification is valid for two years. In order to maintain the certification, child passenger safety technicians need to be observed by a qualified child passenger safety instructor or a proxy (a proxy can recertify technicians but they do not teach the certification curriculum). Currently, ND only has nine instructors and eight proxies. Access to these 17 professionals isn't always feasible; hence, the CPS Program plans to increase the number of cps proxy's throughout the state in an effort to maintain the child passenger safety technician population and increase child passenger safety outreach. The outreach will include offering car seat checkups and other child passenger safety promotions within their communities. Other activities will include offering local child passenger safety best practice presentations to professionals and caregivers, attending local health fairs and making efforts to ensure to reach all populations within the community.

In 2016, new infographic fact sheets designed and developed from the 2015 ND CPS Observation Survey data were shared statewide with stakeholders including public health, law enforcement, hospitals, clinics, etc. The CPS Program will continue to share the results of the surveys statewide to increase awareness and promote best practice recommendations. Using seatbelts correctly save lives. By focusing efforts on effective restraint and seatbelt use in childhood, it is more likely that these behaviors will continue into adolescence and adulthood. The infographic factsheets can be viewed at: <http://www.ndhealth.gov/injuryprevention/childpassenger/ObservationSurveys.htm>.

Another strategy to reduce fatal motor vehicle crash deaths to adolescents includes engaging communities to implement the Impact Teen Drivers Program: <http://impactteendrivers.org/>. This program is an evidence-based program that uses engaging awareness and educational materials for teens, parents, teachers and health professionals. This curriculum facilitates engaging classroom discussion focused on reckless and distracted driving and the importance of making good decisions behind the wheel. Discussions are currently underway with Kelly Browning, PhD, Executive Director of Impact Teen Drivers, to develop a plan for implementation of Train-the-Trainers sessions in ND. Quality education and communication is essential in addressing the problem of reckless and distracted driving. Impact Teen Drivers strives to expand the pool of proficient facilitators through Train the Trainers—a workshop that empowers first responders, educators, health professionals, and community members to successfully carry out the Impact Teen Drivers program in their communities to help stop the number one killer of young people in America.

The Division of Injury Prevention and Control participated in a State Technical Assessment Team (STAT) visit on June 20-23, 2016. The purpose of the site visit was to assess the current injury programs, provide feedback, guidance and present staff with resources and tools to help reduce injuries in ND. Moving forward, this guidance will provide the Division of Injury Prevention and Control the ability to more fully implement the above stated strategies and activities and to plan for future needs.

Decrease Depressive Symptoms in Adolescents

Mental/behavioral health conditions have been increasing among children. The North Dakota (ND) 2015 Youth Behavior Risk Survey (YRBS) indicated that 19.6 percent of high school students grades 9 through 12 reported feeling so sad or hopeless that they stopped doing some usual activities during the 12 months before the survey; representing a hopeful decrease from the 2013 YRBS which showed 25.4 percent of students grades 9 to 12 reporting the same symptoms. For ND students in grades seven and eight in 2015, 47.7 percent had ever been bullied on school property according to the YRBS, down slightly from 2013 (52%). The percent who had ever been electronically bullied was 27.8 percent, which was virtually unchanged from 2013 (28%).

Bullying is a major public health problem that may contribute to depression, antisocial behavior, suicidal thoughts, poor school performance, etc. Adolescence is a unique developmental period that encompasses the biological changes of puberty, along with other psychological, cognitive, and behavioral changes. Adolescents require access not only to medical care for illness and injury but also to family planning services, substance abuse treatment, mental health services, anticipatory guidance, and various informational and educational activities oriented toward the

development of positive health behaviors. Some of their health problems arise from risky health behaviors, which increase rates of sexually transmitted diseases, unintended pregnancy, substance abuse, injuries, and violence. Intervening during adolescence provides an opportunity to prevent the onset of health-damaging behavior as well as to introduce and establish healthy new behavior patterns that may span a lifetime.

Bullying is repeated exposure over time to deliberate, negative actions on the part of one person or more than one person that is unprovoked, resulting in a physical and/or psychological power imbalance. One-time incidents have been deemed bullying by the Office for Civil Rights (OCR) as well. In school, bullying generally occurs in 'hot spots' where adult supervision is commonly minimal – playground, bathrooms, hallways, bus and locker rooms. Bullying also occurs via electronic means – Facebook, Twitter, websites, cell phone/texting; this is known as 'cyber-bullying' and can be difficult to control as this form of bullying is most often done away from school. Although the consequences of this type of bullying are often played out at school, the victim impact is difficult to control as schools have limited disciplinary authority to respond due to First Amendment protections. There is no typical stereotype for the bully, but generally a student who is small, weak, different or academically challenged becomes the victim of bullying. Bullies bully in the following ways: physical, emotional, sexual, verbal, cyber-bullying and even by way of exclusion. The role of the bystander is critical; the bystander actually has more power than the bully and can impede or hinder bully behavior with even subtle unsupportive actions.

As a result of HB 1465, introduced and passed during the 2011 North Dakota legislative session, every school district must develop and implement a bullying policy. In an effort to curb bullying behavior which has far-reaching personal and social consequences, the legislation is designed to allow districts the flexibility to create a policy and select a program or curriculum that best meets their school and community culture, climate and values.

The issue of bullying and reducing depressive symptoms in adolescents are problems that require a multi-pronged and integrated approach. Title V staff participate on the School Health Interagency Work Group, which is facilitated by the ND Department of Public Instruction. This work group is made up of members from a variety of state agencies and other organizations (e.g., NDDoH, NDDHS, ND Department of Transportation, ND Center for Tobacco Prevention and Control Policy) and is responsible for YRBS question selection and assists with YRBS publications and dissemination.

Title V staff also collaborate with the ND Department of Health's Suicide Prevention Program (SPP) and participate on the ND Suicide Prevention Coalition. Recently, the SPP contracted with an advertising firm to launch a media campaign to promote mental health by reducing stigma and supporting help-seeking amongst youth and families. The SSP is gathering broad-based support across sectors and communities as a largely preventable public health problem. The SPP and Title V staff partnered with the ND Department of Human Services Behavioral Health Prevention's Parents Lead Program to promote wellness in families and mental health by empowering parents and guardians. Grassroots prevention programming can be found in each corner of the state and the SPP is working to coordinate effective efforts through the ND Suicide Prevention Coalition.

The State Systems Development Initiative (SSDI) Coordinator participates on ND's State Epidemiological Outcomes Workgroup (SEOW). The SEOW was initiated in 2006 by the North Dakota Department of Human Services, Division of Mental Health and Substance Abuse Services. The mission of the North Dakota SEOW is to identify, analyze, and communicate key substance abuse and related behavioral health data to guide programs, policies, and practices. The SEOW relies on a systematic and unbiased approach to data collection, analysis, and interpretation. The goals of the SEOW is to use data to inform and enhance state and community decisions regarding behavioral health programs, practices, and policies, as well as promote positive behavioral and mental health over the lifespan. The SSDI Coordinator provides updates on the work of the SEOW at the bi-monthly Title V meetings.

Adolescent Health - Annual Report

NPM 8 *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

In 2014, the three-year birth rate for teenagers aged 15 through 17 years was 10.19 per 1,000 births. This was a decrease from the three-year rate of 10.65 per 1,000 births for this age group in 2013. Three-year birth rates are

reported due to fluctuations in annual births to teens. American Indian teens have higher rates of birth than Whites. For all races in this group, the annual birth rate in 2014 was 9.01 per 1,000 as compared to 36.38 per 1,000 for the American Indian population.

The Family Planning Program (FPP) provides reproductive health-care services to men and women giving preference to low-income, adolescent and women-in-need populations. Services include Pap smears, breast exams, testicular exams, level-one infertility services, pregnancy planning, a broad range of birth control methods including abstinence, confidential medical counseling, as well as Sexually Transmitted Infection (STI) and Human Immuno-deficiency Virus (HIV) testing and counseling. Services are currently provided by nine sub-recipients composed of one university, two non-profit agencies, and six local public health units. These sub-recipients also provide services in nine satellite clinics, resulting in 18 family planning clinic locations statewide. In 2015, 540 female clients ages 15 through 17 years received services.

The FPP provides educational resources for parents on how to talk to their adolescents about sexuality, encourages parental involvement in the services received, and provides counseling and education to the adolescents themselves on the importance of family involvement in reproductive health decisions. The adolescent's choice to involve family or not, does not have any impact on their ability to receive services from the family planning site.

The FPP continues to have strong relationships within the ND communities including other state programs, social service agencies, schools, hospitals, private providers and other community-based agencies. Educational programs related to reproductive health are provided by family planning clinicians in their respective communities upon request. All sub-recipients perform outreach and education in their communities, targeting specifically schools, churches, health fairs, and other community services. Each site is responsible for tracking their community involvement and outreach.

Collaboration among state program partners allows the use of available resources to focus on decreasing the negative outcomes often associated with teen pregnancy (i.e., low birth weight infants, complications related to untreated STI's, depression). The FPP received funding through the STI Program to cover medication treatment costs; unfortunately, these funds will no longer be available to the FPP in 2016. The Suicide Prevention Program provides additional funding to the sub-recipients to support ongoing depression screenings. A partnership with the Tobacco Prevention and Cessation for Women of Reproductive Age Workgroup allows for participation in the Baby and Me Tobacco Free Program with the sub-recipients, as well as clinics and hospitals within the community. The FPP is continuously looking at ways to strengthen health and education partnerships within state agencies and communities.

The FPP clinics continue to offer a broad range of acceptable and effective family planning methods and services, either on-site or by referral. Counseling and education about all methods of contraception, reproductive health and spacing of children are offered directly onsite by clinic personnel. Clinicians work with clients to ensure their ability to reach an informed decision regarding their reproductive health and their continued use of family planning services.

Although pregnancy rates for teenagers ages 15 through 17 in ND continue to slowly move downward, preventing pregnancy in this population remains a challenge. While family planning clinics are located statewide, not every teen has close access or the transportation needed to get to a clinic. Many of the FPP clinics, especially those located in rural parts of the state have limited clinic hours due to clinician availability which also limits access to care.

NPM 16 *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

From October 1, 2014 to September 30, 2015; 9 North Dakota (ND) residents ages 15 to 19 died by suicide. Of

these lives lost, eight were listed as White. Due to confidentiality, the racial identity of the remaining death data cannot be disclosed.

The goal of the North Dakota Department of Health's Suicide Prevention Program (SPP) is to reduce injury and death across all ages and races caused by suicide and suicide attempts. The ND Suicide Prevention Program employs the following objectives to decrease attempted and completed suicides.

- Promote education and socially responsible messaging for suicide prevention.
- Promote best practices and evidence-based strategies.
- Gather and distribute existing data while working to expand data collection to include attempted suicides.
- Coordinate existing statewide resources by collaborating with multisector partners and the ND Suicide Prevention Coalition to advance best practice programming across the state.
- Provide grants for effective suicide prevention programs and activities.

In this reporting period, the SPP implemented several goals from the National Strategy for Suicide Prevention Goals and Objectives for Action. Focused efforts included implementing and promoting primary care screening and referral sites. The SPP objectives and grant awards are determined by the Suicide Prevention Advisory Committee which includes representation from the Indian Affairs Commission and multiple governmental departments. Epidemiologists and multisector subject matter experts are consulted throughout grant review and program planning processes.

During this period, the SPP funded eight regional Public Health Family planning sites across ND to perform Patient Health Questionnaire-2 (PHQ-2), a depression and suicide risk screening for each patient visit. Patients found at risk with use of this screening are assessed with use of the Patient Health Questionnaire-9 (PHQ-9). Patients found at risk through the PHQ-9 will be asked directly about suicide and referred to the most appropriate resources given patient risk level.

While referral and treatment resources vary based on community size, the SPP promotes a variety of evidence-based programs to help meet the needs of those in crisis. The SPP partnered with FirstLink, the statewide 24/7 crisis call center to provide on-call crisis service to ND citizens calling the National Suicide Lifeline, as well as providing follow-up "callback" services to patients and community members that are referred through the Family Planning Screening project. FirstLink also acts as the statewide communications and referral center for those at risk due to homelessness, regularly updating their comprehensive list of community resources.

The SPP worked with ND Cares Coalition in "Strengthening an accessible, seamless network of support for Service Members, Veterans, Families and Survivors" (SMVFS). Through the SPP's SMVFS focused initiatives, SPP funded Counseling on Access to Lethal Means (CALM) for first responders' "train the trainer" program. This program targeted ND law enforcement, military and those who have served. The statewide evidence-based project attracted U.S. Airforce and National Guardsmen, veterans, Highway Patrol as well as local police. This initiative has resulted in trainings being held in clinical and instructional settings across disciplines.

The SPP has funded three Regional Education Cooperatives in oil-impacted regions to provide gatekeeper trainings to all of their constituency school staff. The projects include the best practice models of QPR, SafeTALK and ASIST suicide prevention gatekeeper trainings. Each project can be found in detail on the SAMHSA Suicide Prevention Best Practice registry on the Suicide Prevention Resource Center (SPRC) found at <http://www.sprc.org/>.

Sources of Strength, another best practice program found within the National SPRC best practice registry has flourished in ND schools with the support of the SPP. Turtle Mountain Indian Reservation and Bismarck School District have implemented suicide prevention programming in the majority of their high schools. Turtle Mountain Reservation combines this upstream strengths-based model with the evidence-based cognitive behavioral skill curriculum, American Indian Life Skills, for a comprehensive and culturally relevant school program.

The SPP continued to provide training and outreach resources in collaboration with the North Dakota Chapter of the American Foundation for Suicide Prevention, the ND Suicide Prevention Coalition and many partners across the state and in tribal lands. Collaborative efforts include a state registry of certified best practice trainers and a statewide awareness calendar. These activities, training resources and the current ND Suicide Prevention Plan can be found at <http://www.ndhealth.gov/suicideprevention/>.

SPM 6

Priority Need Statement: *Promote optimal mental health and social-emotional development of the MCH population.*

Performance Measure: *Decrease the percent of students who reported feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.*

The North Dakota (ND) 2015 Youth Behavior Risk Survey (YRBS) indicated that 19.6 percent of high school students grades 9 through 12 reported feeling so sad or hopeless that they stopped doing some usual activities during the 12 months before the survey; representing a hopeful decrease from the 2013 YRBS which showed 25.4 percent of students grades 9 to 12 reporting the same symptoms.

The North Dakota Department of Health's Suicide Prevention Program (SPP) collaborates with Title V staff to promote optimal mental health and social-emotional development. During this reporting period, the SPP contracted with Odney Advertising to launch a media campaign to promote mental health by reducing stigma and supporting help-seeking amongst youth and families. The SSP is gathering broad-based support across sectors and communities as a largely preventable public health problem.

The SPP and Title V staff partnered with the ND Department of Human Services Behavioral Health Prevention's Parents Lead Program to promote wellness in families and mental health by empowering parents and guardians. Grassroots prevention programming can be found in each corner of the state and the SPP is working to coordinate effective efforts through the North Dakota Suicide Prevention Coalition.

See the narrative for National Performance Measure 16 for additional activities related to this measure.

SPM 8

Priority Need Statement: *Reduce violent behavior committed by or against children, youth and women.*

Performance Measure: *Reduce the number of students who were bullied on school property during the past 12 months.*

The North Dakota (ND) 2015 Youth Risk Behavior Survey (YRBS) reported that 24 percent of students in grades 9

through 12 reported they had ever been bullied on school property during the past 12 months. More females (29.3%) reported having ever been bullied on school property than males (19%). In grades seven and eight, 47.7 percent had ever been bullied on school property, a decrease from 52.2 percent in 2013. For students in grades 9 through 12, 15.9 percent of students reported they had ever been electronically bullied during the past 12 months. In grades seven and eight, 27.8 percent reported to had ever been electronically bullied, with a significant difference between females (38.1%) and males (17.8%).

The Centers for Disease Control and Prevention awarded funding to the North Dakota Department of Health (NDDoH) to manage the Rape Prevention and Education (RPE) Cooperative Agreement. The NDDoH funded two local Domestic Violence/Rape Crisis agencies in ND to conduct activities related to primary prevention of sexual violence. Both agencies have population based strategies that involve presentations, *Friendships that Work* and *Teen Talk*, to classrooms on healthy relationships. The RPE funds were also used to create the NDDoH Sexual Violence & Intimate Partner Violence Prevention Toolkit, an online toolkit with primary prevention resources: http://www.ndhealth.gov/injury/nd_Prevention_Tool_Kit/default.html. The toolkit was finalized in the summer of 2015 and three webinars have been hosted by the NDDoH to provide an introduction to primary prevention and showcase the toolkits resources. Attendance included domestic violence/rape crisis agencies, local public health, universities, law enforcement, and youth organizations. The toolkit also serves as a launching point for a new group that will begin meeting in 2016. This group, tentatively named Primary Prevention Partners, will seek to unite those conducting sexual violence and intimate partner violence primary prevention activities to share resources and discuss collaboration opportunities.

The State Domestic Violence/Rape Crisis Program awarded state and federal funds to 18 local domestic violence/rape crisis agencies for domestic and sexual violence prevention and intervention services. Several agencies use portions of these funds to present in schools on teen dating violence, bullying and healthy relationships.

The State Domestic Violence/Rape Crisis Program Coordinator shared resources with the Department of Public Instruction (DPI), Safe and Healthy Schools Unit, during Sexual Assault Awareness Month and Teen Dating Violence Awareness Month. This information was distributed to principals, physical education teachers, and regional education unit directors.

Conducting activities related to bullying prevention continues to be a challenge due to limited funding and a lack of staff to coordinate. A small amount of Title V funding is used for bullying prevention activities in local public health units. Local domestic violence/rape crisis agencies primarily use funding for intervention services and the small amount of funding used for prevention is focused on domestic and sexual violence prevention activities. While domestic and sexual violence have similar risk factors, the education is not usually targeted specifically toward reducing bullying, but rather toward promoting healthy relationships. The NDDoH met with the DPI about the bullying legislation passed in 2011. The DPI reported they collect the policies and provide training as requested, but have not reviewed the policies or provided recommendations. The DPI has created a fact sheet regarding bullying and the related legislation, which can be viewed at: <https://www.nd.gov/dpi/uploads/31/Bullying.pdf>.

The NDDoH's Division of Injury Prevention and Control is planning their biennial ND Conference on Injury Prevention and Control Injury for August 2016 and several breakouts and one keynote speaker will present on bullying prevention. The Maternal and Child Health/State School Nurse Consultant serves on the planning committee and will assist with marketing to school staff and local public health. Conference information can be found at: http://www.ndhealth.gov/injury/Trainings/2016_Injury_Conference/Save_the_Date_Postcard.pdf.

SPM 9

Priority Need Statement: *Reduce the rate of deaths resulting from intentional and unintentional injuries among children and adolescents.*

Performance Measure: *The rate of deaths to individuals ages 1 through 24 caused by intentional and unintentional injuries per 100,000 individuals.*

Between 2011 and 2014, there was a 17 percent decrease in the rate of deaths per 1,000 individuals for individuals ages one through 24 caused by intentional and unintentional injuries. Obtaining hospital discharge data to monitor and access intentional and unintentional injury rates continues to be a challenge.

The 2014 ND Conference on Injury Prevention and Control “Sharing Risk and Protective Factors: Bringing the Pieces Together” was held with 125 participants from across the state attending. Keynote speakers presented on long-term risks associated with childhood maltreatment, concussions and human trafficking in North Dakota (ND).

The overall goal of the Injury Prevention Program (IPP) is to reduce injuries to North Dakotans, with a special emphasis on caregivers and children. The program uses a variety of best practice strategies including primary prevention theories; data collection and analysis; intervention design and development; training and technical assistance; policy and education; and evaluation.

The ND Injury Prevention Coalition, which meets quarterly, is a multi-disciplinary partnership with a mission to reduce unintentional and intentional injuries and deaths. The ND Injury Prevention Plan is currently under revision. The plan emphasizes prevention strategies which are implemented through partnerships with various local statewide agencies and organizations. Critical partners include the ND Department of Transportation, ND Department of Public Instruction, and Safe Kids Coalitions in Grand Forks and Fargo-Moorhead.

Program strategies in place to maintain and/or enhance this performance measure are varied and diversified. They include poison prevention that involves distribution of educational materials, Poison Helpline magnets and phone stickers, prevention brochures, and a Poison Look Alike Kit available to communities for health fairs, school events or public health displays.

Bike safety educational materials are available on the injury prevention website for children from kindergarten through grade six. The “Home Safety Checklist: Are Children Safe in Your Home?” was updated March 2015 and is a popular publication used by multiple partners. News releases are issued throughout the year that includes prevention messages about bike safety, unintentional poisoning, playground, falls, and traffic safety. The IPP works with the Consumer Product Safety Commission to do a specific number of product safety recall effectiveness checks throughout the state. An Injury Prevention and Control Facebook page is currently used to help distribute program best practices and educational messaging: <https://www.facebook.com/NDInjuryPreventionAndControl>.

Additional IPP strategies to reduce the rate of deaths resulting from intentional and unintentional injuries among children and adolescents are included in National Performance Measures 10 and 16, and State Performance Measures 6 and 8.

Children with Special Health Care Needs

State Action Plan Table

State Action Plan Table - Children with Special Health Care Needs - Entry 1

Priority Need

Increase the utilization of medical home.

NPM

Percent of children with and without special health care needs having a medical home

Objectives

1a. Title V staff will sustain existing relationships and develop at least two new partnerships to advance medical home within the state by September 30, 2020.

1b. By September 30, 2020, increase the number of partners educated and trained to provide care coordination for CSHCN.

1c. Fund at least one grantee to implement evidence-based, evidence-informed and/or promising practices to advance medical home in ND through September 30, 2020.

Strategies

1a. Identify, recruit, and collaborate with stakeholders who have interest or are currently engaged in medical home initiatives (e.g., payers, providers, associations, health system representatives, care coordinators, universities, family organizations, etc.). FY Activities 2017 (October 1, 2016 through September 30, 2017):

- Seek technical assistance to plan successfully for medical home coalition development, sustainability, and spread.
- Inform partners about results from the National Survey for Children's Health to identify components of medical home that have the most opportunity for improvement to target strategies.
- Initiate a meeting with ND Medicaid to determine interest in joint work efforts that support development of "health homes" for Medicaid beneficiaries.

1b. Collaborate with partners who have direct access to families of CSHCN (e.g., family support organizations, county social service staff, medical home practices, etc.) to promote care coordination best practices. FY Activities 2017 (October 1, 2016 through September 30, 2017):

- Identify and disseminate best practice care coordination resources, (e.g., toolkits, training curriculums, strategies, etc.) to share with partners.
- Collaborate with Family Voices of ND in providing joint care coordination training opportunities that support families of CSHCN.

1c. Provide funding for medical home demonstration or quality improvement projects. FY Activities 2017 (October 1, 2016 through September 30, 2017):

- Create a new request for proposal that that will be used to fund future CSHCN system development demonstration projects.
- Monitor, oversee, and provide technical assistance to grantees who are awarded to assure contract activities and requirements are being met.

ESMs

ESM 11.1 - Number of individuals who have received education and training on care coordination for CSHCN.

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

State Action Plan Table - Children with Special Health Care Needs - Entry 2

Priority Need

Increase the number of children with special health care needs receiving transition support.

NPM

Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Objectives

1a. Title V staff will sustain existing relationships and develop at least two new partnerships to advance health care transition within the state by September 30, 2020.

1b. Provide education and training on health care transition for health professionals, youth/young adults, and families by September 30, 2020.

1c. Fund at least one grantee to implement evidence-based, evidence-informed and/or promising practices to advance health care transition in ND through September 30, 2020.

Strategies

1a. Identify, recruit, and collaborate with stakeholders who have interest or are currently engaged in transition-related initiatives (e.g., ND Department of Public Instruction, NDDoH Community Health Section, pediatric and adult providers, associations, care coordinators, universities, family organizations, etc.). FY Activities 2017 (October 1, 2016 through September 30, 2017): • Inform partners about results from the National Survey for Children's Health to identify components of transition that have the most opportunity for improvement to target strategies. • Work with family support organizations to recruit youth or young adults as potential participants on committees, workgroups, or projects.

1b. Collaborate with partners to promote health care transition best practices. FY Activities 2017 (October 1, 2016 through September 30, 2017): • Disseminate information on health care transition including best practice resources. • Implement specific training on youth transition for local county social service staff. • Survey pediatric and adult providers on current transition activities using the Six Core Elements of Health Care Transition and disseminate survey results.

1c. Provide funding for health care transition demonstration or quality improvement projects. • Create a new request for proposal that that will be used to fund future CSHCN system development demonstration projects. • Monitor, oversee, and provide technical assistance to grantees who are awarded to assure contract activities and requirements are being met.

ESMs

ESM 12.1 - Number of individuals who have received education and training on healthcare transition.

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

Measures

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	50	52	54	56	58	60

Data Source: National Survey of Children's Health (NSCH) - CSHCN

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	48.6 %	4.1 %	13,294	27,361
2007	58.4 %	3.3 %	14,912	25,546

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	64.9 %	1.9 %	78,482	120,928
2007	65.2 %	1.5 %	73,190	112,208

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 11.1 - Number of individuals who have received education and training on care coordination for CSHCN.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	30.0	35.0	40.0	45.0	50.0

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	47	48	49	50	51	52

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	46.5 %	3.5 %	4,021	8,641
2005_2006	51.2 %	3.0 %	3,651	7,125

Legends:

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 12.1 - Number of individuals who have received education and training on healthcare transition.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	30.0	35.0	40.0	45.0	50.0

Children with Special Health Care Needs - Plan for the Application Year

Increase the Utilization of Medical Home

According to the 2011/2012 National Survey of Children’s Health (NSCH), children with special health care needs (CSHCN) have less access to a medical home (48.6 %) compared to children without special health care needs (64.9%). Broken down even further, younger CSHCN who are 0-5 years old are less likely (32.5 %) than school-aged children, ages 6-11 (55.9%) to have access to a medical home. Care coordination is a vital component in medical home. Nearly three in four CSHCN (74%) in ND needed one or more aspects of care coordination. Of that group, nearly six in 10 (59.5%) who did need help received all needed care coordination. Effective medical homes utilize families as partners in decision making. In the 2009/2010 National Survey for Children with Special Health Care Needs, more than 14,000 CSHCN (75%) in North Dakota (ND) met the criteria in which families are partners in shared decision-making for their child’s optimal health.

The first step to advance medical home within the state is to build infrastructure. Efforts will address three focus areas. The first area is building partnerships with the goal of advancing medical home policies and practices in ND. Stakeholders who have interest or are currently engaged in medical home initiatives (e.g., payers, providers, associations, health system representatives, care coordinators, universities, family organizations, etc.) will be identified and recruited. A crucial step toward that will help assure success is obtaining technical assistance to help staff with medical home development, sustainability, and spread. The second area of infrastructure development will be engaging with ND Medicaid in efforts to promote “health homes”, an approach used successfully by many other states to further medical home. Lastly, data to inform partners about components of medical home that need improvement is essential in targeting strategies and resources. Through these various efforts, utilization of medical home will improve.

The second objective is increasing the number of partners educated and trained to provide care coordination for CSHCN. Collaboration with those who have direct access to families is key. Those targeted for education and training activities include family support organizations such as Family Voices of ND, county social service staff that help administer CSHS programs at the local level, and staff in medical home practices or integrated networks.

Primary activities focus on identification and dissemination of best practice care coordination resources such as toolkits and training curriculums, and provision of collaborative care coordination training opportunities that support families of CSHCN.

The third objective is to provide funding to one or more grantees to implement evidence-based, evidence-informed, and/or promising practices to advance medical home in ND. The intent is to provide funding for small demonstration or quality improvement projects. Activities include development of a new request for proposal process that will be used to fund a CSHCN system development project. Projects once funded will require monitoring, oversight, and technical assistance to assure contract activities and requirements are being met.

Family or patient-centered medical homes are important for providing a framework for organizing systems of quality, cost-efficient and effective care at both the practice and community level. To assure success, families will need to play a key role in all of the above strategies and activities.

Additional critical partnerships/initiatives include:

- Maternal, Infant and Early Childhood Home Visiting (MIECHV) – explore dissemination of medical home educational materials and need for care coordination training by home visitors in reservation communities.
- Early Childhood Comprehensive Systems (ECCS) Workgroup – this workgroup’s mission is to advocate for age-appropriate statewide developmental screening. Partnerships on this group will continue, as these efforts can be endorsed more successfully through a medical home.
- Early Periodic Screening, Diagnosis and Treatment (EPSDT) and Healthy Steps (Children’s Health Insurance Program (CHIP) – partnerships with ND Medicaid will be further enhanced in an effort to improve medical home infrastructure.
- Family organizations – family engagement is a priority in the medical home model. Information and educational opportunities on medical home and care coordination will be disseminated and/or provided through family support organizations.
- State Systems Development Initiative (SSDI) – SSDI will support analytical and data needs (e.g., performance measure data and analysis of national survey data, etc.).
- Bright Futures – Bright Futures materials such as the “Recommendations for Preventive Pediatric Health Care” will be disseminated to partners and families. These guidelines emphasize the great importance of continuity of care in comprehensive health supervision.
- Medical home partners – Examples include payers, providers, associations such as the ND Chapter of the American Academy of Pediatrics, health system representatives, care coordinators such as local county social service staff, universities, and family organizations such as Family Voices.

Increase the Number of CSHCN Receiving Transition Support

The transition to adulthood is a critical developmental period during which youth undergo extra stress and are particularly vulnerable, especially those with special health care needs. According to the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), 46.5 percent of North Dakota (ND) children received the necessary services needed to successfully transition to adult care compared to the national average of 40 percent. Children with significantly complex health needs experienced less success transitioning to adult health care. In the NS-CSHCN, 64.0 percent of children within a medical home received the necessary services needed to successfully transition to adult health care compared to those without a medical home (30.2%).

The Six Core Elements of Health Care Transition are intended for use by pediatric, family medicine, and internal medicine practices to assist youth and young adults as they transition to adult-centered care. They are aligned with the American Academy of Pediatrics/American Academy of Family Physicians/American College of Physicians Clinical Report on Transition. The six core elements are:

- Transition Policy
- Transition Tracking and Monitoring
- Transition Readiness
- Transition Planning
- Transfer of Care

- Transfer Completion

The first step to advance health care transition within the state is to build infrastructure. Building partnerships with the goal of advancing health care transition policies and practices is an important work effort. Stakeholders who have interest or are currently engaged in transition initiatives (e.g., ND Department of Public Instruction, ND Department of Health (NDDoH) Community Health Section, pediatric and adult providers, associations, care coordinators, universities, family organizations, etc.) will be identified and recruited. During the year, staff will work with family support organizations to recruit youth or young adults as potential participants on committees, workgroups or projects. Adolescents need the opportunity to take an active role in the transition process, and need ongoing encouragement. By identifying opportunities for youth involvement in various programs and committees, youth and young adults can offer valuable feedback to achieve youth-centered health transitions. Staff will also provide data from the National Survey of Children's Health to inform partners about components of health care transition that need improvement to better target strategies and resources.

The second objective is increasing the number of individuals educated and trained on health care transition for CSHCN. The Division of Children's Special Health Services (CSHS), currently operates an Information Resource Center and disseminates transition materials to individuals age 14 to 21 that are utilizing services. These efforts will be enhanced in the next year. Those targeted for education and training activities include health professionals, youth/young adults, and families. Primary activities will focus on dissemination of best practice health care transition resources, implementing a specific training on youth transition for local county social service staff, and conducting a survey of pediatric and adult providers on current transition activities using the Six Core Elements of Health Care Transition and then disseminating the survey results. Evaluation of current transition processes by pediatric providers is needed to gain understanding of what is currently occurring with health care transition and the type of education needed by the medical community.

The third objective is to provide funding to one or more grantees to implement evidence-based, evidence-informed, and/or promising practices to advance health care transition in ND. The intent is to provide funding for small demonstration or quality improvement projects. Activities include development of a new request for proposal process that will be used to fund a CSHCN system development project. Projects once funded will require monitoring, oversight, and technical assistance to assure contract activities and requirements are being met.

Title V will align work efforts with family support organizations, established committees, and other partners to provide family-centered information and training regarding youth transition.

Additional critical partnerships/initiatives include:

- Minot State University, ND Center for Persons with Disabilities – the “Teens Entering Adult Medicine” (TEAM) project will help serve as a means to get youth more involved while collaborating with a pilot group of primary care physicians.
- ND Transition Community of Practice – this committee provides opportunities for collaboration with school personnel, vocational rehabilitation, developmental disabilities program managers, and many others who are working with transition-aged youth.
- Transition to Independence Program (TIP) – this program is designed to assist young people who struggle along the pathway into adulthood who otherwise do not qualify for transition assistance. TIP provides case management, coordination, referral, and resources that can help to achieve successful transition. Many of the young people served would be homeless without the program and its services.
- Family Organizations – family engagement is a priority in implementing successful health transitions. Information and educational opportunities on transition will be disseminated and/or provided through family support organizations.
- ND Medicaid – explore opportunities to educate youth receiving Medicaid about the transition to adult health care.
- State Systems Development Initiative (SSDI) – SSDI will support analytical and data needs (e.g., performance measure data)

Children with Special Health Care Needs - Annual Report

NPM 2 The percent of Children with Special Health Care Needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive.

According to the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), the percent of families that had CSHCN age 0 to 18 years in North Dakota (ND) whose families were partners in shared decision-making for their child's optimal health was 75.0 percent (three in four CSHCN in ND successfully met this outcome). This was higher than the national percentage, which was 70.3 percent. Disparities in achievement of this outcome were noted in various subgroups in ND (e.g., white vs. other race/ethnicity categories, insured vs. uninsured, high vs. low income status, etc.). The next survey data from the NSCH will not be available until 2017. Starting in 2016, the NSCH and the National Survey of Children with Special Health Care Needs will be combined and completed annually.

Ongoing Title V activities have focused on promoting family/professional collaboration, maintaining a Children's Special Health Services (CSHS) Family Advisory Council, funding family-led support organizations in the state and monitoring family satisfaction.

Program accomplishments within the 2015 federal fiscal year included the following:

- CSHS staff assured that effective family partnerships were a priority within the division. Staff encouraged active family engagement in CSHCN related meetings, committees, training opportunities, presentations, Title V Needs Assessment and MCH Block Grant activities, and work projects throughout the year. Representatives from Family Voices of ND, in particular, participated in many meetings led by CSHS staff, CSHS staff presented at family-led events such as the Pathfinder Parent Involvement Conference and the Family Voices Leadership Institute.
- CSHS continued to support a ten-member Family Advisory Council. During this reporting period, three meetings were conducted. CSHS reimbursed Family Advisory Council members for mileage, meals and lodging and provided a \$75/day consultant's fee for meetings that were attended. One new Family Advisory Council member was recruited to join the committee and others have expressed interest. Family Advisory Council members shared the value of CSHS through family stories and experiences. One such story has since been included on the CSHS website, disseminated at clinics, and in gift boxes for new families that have a baby born with a cleft lip/palate. The story can be viewed at: <http://www.ndhealth.gov/cshs/Stella.htm>.
- CSHS sustained support services for children and youth with special health care needs and their families. Funding was provided to Family Voices of ND and ND Hands and Voices, two family-led organizations that provide information/education, training, parent-to-parent programs, etc. for CSHCN and their families. Family Voices of ND is the state's family-to-family health information and education center and also houses a parent-to-parent program. ND Hands and Voices is dedicated to supporting families with children who are deaf or hard of hearing. CSHS promotes many other family support organizations in various outreach activities and through social media such as Facebook.
- As part of the five-year needs assessment process, a survey was disseminated electronically to stakeholders, including families, to evaluate accuracy of chosen priority areas derived from the MCH Title V Needs Assessment. Other family assessments are ongoing activities within the CSHS Division. Satisfaction with health information provided to families was assessed through a health information satisfaction survey, which evaluated family satisfaction, effectiveness of information, and referral efforts conducted or supported by CSHS. This survey was also available on the CSHS website homepage. Satisfaction was also reported by local grantees who received funds from CSHS as part of their annual quality assurance reports.
- Employment and effective utilization of experienced families was encouraged and supported through many other committees and work groups (e.g., State Developmental Disabilities Council, Interagency Coordinating Council, Autism Spectrum Disorder Expert Panel, etc.). Staff members from various family organizations were

meaningfully involved with the development of new Autism Spectrum Disorder Database brochures and the state autism report form.

- CSHS monitored 2015 legislation that could have a potential impact on services for children and families in ND (e.g., family support, autism, behavioral health, newborn screening, etc.).

Even though 75 percent of CSHCN meet this core outcome, disparities exist. More work is needed, not only to sustain, but to meaningfully enhance this measure. Competing workload demands and limited financial resources have the potential to affect capacity and sustainability for not only Title V, but also the family organizations that have partnered so long and well in these efforts.

NPM 3 The percent of Children with Special Health Care Needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

North Dakota (ND) recognizes the importance of the medical home for all children including those children with special health care needs. In the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) it was reported that 47.8 percent of children, ages 0 to 18, received coordinated, ongoing and comprehensive care within a medical home. Nationally, states range between 34.2 to 50.7 percent. The next survey data from the NSCH will not be available until 2017. Starting in 2016, the NSCH and the National Survey of Children with Special Health Care Needs will be combined and completed annually.

Children with more complicated needs benefit the most from receiving care in a medical home. Among the components of medical home, care coordination has continued to be a challenge. A data brief is available that highlights challenges families have experienced with care coordination in ND. The data brief can be viewed at: http://www.ndhealth.gov/cshs/docs/Outcome_2_ND_DOC.pdf.

Despite challenges with medical home infrastructure development, there have been noteworthy program accomplishments. Medical home status of children receiving services through CSHS was monitored. The local county social service offices throughout the state are mandated partners that provide care coordination for CSHCN served through the CSHS Treatment Program. County staff completed annual care coordination plans, which contain information on current providers, including children's medical and dental homes. Local staff also provided quarterly contacts to assess for other needs or issues. State staff provided oversight of the care coordination plans, training, technical assistance and advice to ensure that children were being referred for appropriate services within their community to best manage their health care needs. This has been challenging due to high staff turnover at the county level. To address this issue, CSHS staff offered both in-person and video conference training opportunities.

Through the CSHS Information Resource Center, staff disseminated information on medical homes and linked families to available providers. Dental homes were also promoted through various CSHS programs. Title V staff promoted dental homes when direct prevention services were provided to children while in school. All families received written information regarding the importance of utilizing a dental home, as well as educational information on continued oral care.

Although medical home was identified as a priority area for CSHCN based upon the Title V MCH Needs Assessment, collaborations and active engagement with health system partners has been somewhat limited. Meetings have recently taken place with one major health system that is moving medical home forward within its clinics and hospital.

No new sources of funding to support medical home implementation were found. However, funding was provided to Minot State University ND Center for Persons with Disabilities (NDCPD) for continuation of a medical home online

course. This curriculum addressed fundamentals of medical home for children and youth special health care needs and targeted service providers and families of CSHCN. The training was offered four times during the funding period. Although there were only thirteen participants during the year, overall satisfaction with the course was high.

Funding through CSHS was granted to the ND Chapter of the American Academy of Pediatrics (AAP) for a Medical Home Project. This funding was provided to promote the medical home model for CSHCN, to support care coordination services for two medical home providers in the state, and to develop care coordination learning calls. The two medical home providers practicing this model of care within ND are located at Sanford Health in Fargo and Trinity Health in Minot. These medical home providers served approximately 132 children. Participants on the care coordination learning call included medical providers, families, nursing care coordinators, and state program administrators. This year's care coordination learning call conducted in June 2015 included a case presentation to allow for feedback and information sharing for appropriate referrals for services and medical follow-up.

Although not associated with a medical home practice, other care coordination activities were supported. Funding was provided to Grand Forks Public Health Department to support care coordination services by a public health nurse in Grand Forks county. This care coordination program utilized a comprehensive approach, as the public health nurse attended appointments, school meetings, home visits, etc. and provided close monitoring and follow-up. The program was discontinued on September 30, 2015 due to limitations in CSHS resources.

In addition to local staff, state staff provided care coordination support to families. Support included information, referral, direct linkage to services, and health benefits counseling. CSHS staff have also provided state level care coordination for children with phenylketonuria (PKU) and maple syrup urine disease (MSUD) and assisted with providing no cost medical food and low-protein modified food products as described in ND Century Code 25-27-03. Care coordination was also provided to participants of CSHS multi-disciplinary clinics, to assist with accessing services and coordinating necessary medical follow-up.

Challenges include limited providers and lack of a statewide coalition to move the medical home concept forward in either the private or public sectors. Grant-funded activities have had limited participation and growth (e.g., NDCPD online course, AAP Project, etc.). Competing workload demands have the potential to affect capacity and sustainability not only for Title V, but for the entire state. Limitations in financial resources have not allowed for utilization of the medical home portal.

NPM 4 The percent of Children with Special Health Care Needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.

Access to quality health care is essential to increase the likelihood of a healthy life for the Maternal and Child Health (MCH) population. In addition to influencing overall physical, dental, mental and social health status, access to quality health care impacts prevention, detection and treatment of health conditions.

In the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), 60.1 percent of North Dakota (ND) families of children with special health care needs age 0 to 18 had adequate private and/or public insurance to pay for the services they needed compared to the national average of 60.6 percent. The NS-CSHCN assessed adequacy of insurance using three questions: whether or not health insurance benefits met the child's needs, whether non-covered services were reasonable, and whether the plan allowed the child to see providers he or she needed. The Division of Children's Special Health Services (CSHS) has developed a [data brief](#) highlighting this measure. The next survey data from the NSCH will not be available until 2017. Starting in 2016, the NSCH and the National Survey of Children with Special Health Care Needs will be combined and completed annually.

Major efforts to improve this performance measure have focused on monitoring coverage for CSHCN, providing gap-filling coverage for underinsured CSHCN and care coordination services to link families to health care coverage programs, health advocacy, coordination, and collaboration, and completing preparatory work needed to effectively utilize the new ND Health Enterprise Medicaid Management Information System (MMIS).

Staff continues to monitor the status of health care coverage for children directly served by CSHS. In federal fiscal year (FFY) 2015, 92% of children served had a source of coverage. Nearly three-fourths were covered by private insurance and over one-fourth by ND Medicaid.

CSHS helps families pay for care by providing gap-filling coverage for the underinsured. CSHS staff determined medical and financial eligibility, processed medical claim payments, and provided care coordination services to families in partnership with staff from local county social service offices. In FFY 2015, 65 children were eligible for diagnostic services and 139 children were eligible for treatment services.

CSHS has policies in place regarding coordination of payment between all available sources of health care coverage. Families applying for treatment services through CSHS were required to verify Medicaid and Healthy Steps (ND's Children's Health Insurance Program) eligibility as part of the application process. If ineligible, families were linked to other available resources. Information regarding Medicaid eligibility or support options such as the Children with Disabilities "Medicaid Buy-In" Program and various waivers were also disseminated.

Legislation was monitored and tracked for changes with other potential sources of coverage such as ND Medicaid and Healthy Steps.

CSHS partnered with many other entities to enhance the state's capacity to provide health benefits counseling and health systems advocacy through training and collaboration, including but not limited to:

- Participation on the ND Medicaid Pediatric Task Force when meetings were scheduled
- Participation on a DHS workgroup focused on increasing services for medically fragile children
- Provision of technical assistance for county social service staff
- Coordination with state Medicaid staff on covered services
- Participation on DHS conference calls and various training opportunities required for the anticipated rollout of the ND Health Enterprise MMIS

One of CSHS's major challenges was the new ND Health Enterprise MMIS. This system has been in development since 2004 and was implemented in October 2015. Since its inception, CSHS has devoted resources, both staff time and money, to this project. The new system will be used for eligibility, claims payment, and provider verification. During the year, CSHS staff actively participated in testing and training sessions to prepare for the system launch. Ongoing efforts will continue to be needed once the system goes live to assure it is able to meet CSHS functionality requirements. Although, the ND Health Enterprise MMIS project has enabled development of new relationships and coordination with DHS regarding claims payment, other areas of collaboration have been more challenging due to competing workload demands within DHS.

Changes with the Affordable Care Act (ACA) increased the need for a well-equipped information resource center. CSHCN who have health needs that are more complex or require a range of services are more likely to require adequate insurance to meet their needs. Through CSHS outreach strategies, families have had increased access to available sources of health care coverage and other assistance programs (e.g., patient

navigators).

NPM 5 The percent of Children with Special Health Care Needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily.

The percent of North Dakota (ND) Children with Special Health Care Needs (CSHCN) age 0 to 18 whose families report the community-based service systems are organized so they can use them easily was 67.9 percent, according to the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN). This is slightly better than the national average of 65.1 percent. The Division of Children's Special Health Services (CSHS) has developed a [data brief](#) to highlight this measure. The next survey data from the NSCH will not be available until 2017. Starting in 2016, the NSCH and the National Survey of Children with Special Health Care Needs will be combined and completed annually.

Title V staff promoted easy access to community-based systems through various work activities. CSHS utilizes county social service offices as its local partner rather than public health departments. A survey was administered in May 2015 to evaluate the credentials and experience level of county social service staff assigned to CSHS in an effort to better understand local staff capacity. Pertinent findings follow:

- Retention: Since January 2014, turnover of county staff assigned to CSHS was 38 percent. Since November 2011, it was 60 percent.
- Education: 79 percent of county social service staff working with CSHS were licensed social workers. Twenty-one percent (approximately one out of five) were not licensed social workers and had other job titles (e.g., eligibility worker).
- Length of time designated as CSHS worker: 64 percent of local staff have worked with CSHS less than five years (approximately two-thirds). 36 percent have worked with CSHS five or more years.
- Conclusion: Local staff turnover is significant. Although the majority of local staff have the educational preparation as social workers needed to fulfill eligibility determination and care coordination roles as defined by CSHS, a significant proportion of them do not stay in their position long enough to gain expertise through on-the-job experience that is likely needed to best serve CSHCN and their families.

Site visits, training activities, and technical assistance to county social service staff were offered to enhance workforce capacity. High staff turnover at the local level and competing workload demands have remained challenging, as has consistent community-level collaboration on behalf of CSHCN.

Efforts were also made to ensure that care was coordinated and accessible. This was accomplished by:

- Supporting ten types of multidisciplinary clinics, two of which were managed by state CSHS staff and eight that were funded through service contracts. These types of services were not easily available in the state. Over 500 children were helped through CSHS contracted services and over 1,200 children received services through clinics that were directly managed by CSHS staff.
- Disseminating a 2015 Multidisciplinary Clinic Directory that included a list of available ND pediatric specialists to approximately 2,650 community agencies and providers to link families to needed clinic services and specialty providers. This resource was also made available on the CSHS website.
- Enrolling and maintaining a list of CSHS qualified providers that required monitoring of licensure and board certification status to assure CSHCN and their families received high quality care.
- Providing educational opportunities and technical assistance to multidisciplinary clinic staff through an annual clinic coordinator call, site visits, social media, and outreach mailings.

Care coordination continued to be the pivotal strategy to ensure that the system is organized and easily accessible for children and families. This was achieved by:

- Providing support to link families to specialty health services in and outside the state. Staff also provided

information related to the child's special health care need and various health care coverage programs. Some families required extensive support to coordinate care provided by multiple providers and payers. ND's rural setting has often made travel and access to specialty care difficult.

- Partnering with others to assist and support families of CSHCN in accessing information and locating services (e.g., distributed program information in the Healthcare Coverage Options brochure).
- Providing funding to two family support agencies to assist families in accessing resources. Links to family support organizations and other important partners were provided through the division's website and distributed through direct mailings and display opportunities.
- Providing information and referral services to families and collaborating with other stakeholders involved with children's Supplemental Security Income (SSI). CSHS provided outreach to 301 families receiving SSI in FFY 2015.
- Monitoring and tracking 2015 legislation that supported enhanced community-based service delivery (e.g., autism, behavioral health, local social service funding, newborn screening, etc.)

In addition to local staff turnover, other challenges included provider shortages and travel required to access care. Efforts to improve services and systems for CSHCN were conducted through CSHS participation in 25-30 interagency workgroups and committees, which provided excellent opportunities for collaboration and advocacy on behalf of CSHCN.

NPM 6 The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.

NPM 6 Annual Report Narrative (must be written in paragraph format):

In the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), North Dakota (ND) families reported that 46.5 percent of children with special health care needs received transition services. ND ranked higher than the national average of 40 percent. Other states in the nation ranged between 31.7 to 52.7 percent. The Division of Children's Special Health Services (CSHS) has developed a [data brief](#) that discusses this measure. The next survey data from the NSCH will not be available until 2017. Starting in 2016, the NSCH and the National Survey of Children with Special Health Care Needs will be combined and completed annually.

According to the ND Department of Public Instruction's (DPI) Post-school Outcomes Survey evaluating the 2014-2015 school year, 79.0 percent of exiting students receiving special education services had health insurance. This was an increase from 76.0 percent in the previous school year. One year after exiting from school, 70.0 percent of those students continued to live with their parent or a relative, which indicated that many families are still involved with the youth as they continue the transition process.

ND has been working to improve the outcome of transition planning and assistance for CSHCN. CSHS continued to build partnerships and collaborate with other state agencies, family organizations and local providers to encourage emphasis on health transition issues such as continuous health care coverage and health advocacy for CSHCN.

Examples of such collaboration included:

- Participation on the state's Transition Community of Practice lead by DPI. This included participation on the Healthy Transitions Subcommittee that printed and distributed a "Health Snapshot Pocket Guide" at statewide conferences and transition fairs. The guide was developed for youth to assist them with organizing their medical information and to help them be better prepared with questions and concerns as they transition into independently managing their health needs.
- Representation on the Transition to Independence Program Advisory Council.
- Participation on the School Health Interagency Workgroup for meetings that focused on Youth Risk Behavior

Survey reporting.

- Exploring opportunities for transition-aged youth through activities supported by the State Council on Developmental Disabilities.

CSHS promoted the Teens Entering Adult Medicine program for youth with special health care needs and their families available through the ND Center for Persons with Disabilities.

CSHS staff reviewed and provided feedback regarding transition activities for youth ages 14 to 21 that were addressed in CSHS care coordination plans. The care coordination plans utilized by CSHS county social service staff addressed transition assessment and plan interventions. Local staff were able to assess for transition needs, and have resource information readily available to share with the youth or their family member.

CSHS staff sent individual transition packets to all transition aged youth, ages 14-21 years that received care coordination through CSHS or attended CSHS managed clinics. The packets were developed to meet the unique needs of youth during the course of their transition stages. CSHS continued to provide information at transition fairs, conferences, and through the NDDoH website at: <http://www.ndhealth.gov/cshs/TransitionToAdulthood.htm>.

Accomplishing a successful medical transition is complicated by the complexity of the medical care needed, as well as the availability of adult specialty providers within the state. Growth in ND's population has had an impact on the demand for services as have the medical provider shortage areas, which are especially evident in rural areas. Although some transition activities within the medical home have been initiated, challenges in recruiting key partners such as youth, providers, and families have impacted participation. ND will continue work to ensure that youth within ND receive adequate information as they transition to adult healthcare, work, and independence. Transition was identified as a priority area for the Children with Special Healthcare Needs population based upon the 2015-2020 Title V MCH Needs Assessment.

Cross-Cutting/Life Course

State Action Plan Table

State Action Plan Table - Cross-Cutting/Life Course - Entry 1

Priority Need

Increase preventive dental services to children.

NPM

A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Objectives

1a. Increase by 10 percent the number of third grade children with dental sealants on permanent teeth by September 30, 2020.

1b. Increase by 10 percent the number of ND Medicaid reimbursed fluoride varnish applications by September 30, 2020.

1c. Implement at least two strategies to increase medical/dental collaboration by September 30, 2020.

1d. Maintain the current percentage rate (97%) of the population served by community water systems who receive optimally fluoridated water by September 30, 2020.

Strategies

1a. Leverage resources to expand the school-based sealant and fluoride varnish program. FY 2017 Activities (October 1, 2016 through September 30, 2017): • Contact partners to determine their level of interest to participate in the school-based dental sealant and fluoride program, such as safety net dental clinics, private practice dentists, and Federally Qualified Health Centers (FQHC). • Focus program efforts on high-risk populations such as American Indians and low income. • Complete an assessment of the previous year's program efforts to assist with continuous quality improvement. • Complete the Head Start Oral Health Basic Screening Survey (BSS) to obtain base-line data for this population group.

1b. Engage appropriate entities in fluoride varnish application to children. FY 2017 Activities (October 1, 2016 through September 30, 2017): • Contact clinics, local public health and Head Start to determine their level of interest to apply fluoride varnish and schedule trainings and/or re-trainings as appropriate.

1c. Integrate oral health care into overall health care. FY 2017 Activities (October 1, 2016 through September 30, 2017): • Build connections and strengthen opportunities for medical/dental collaborations to occur. • Promote Smiles for Life curriculum in medical schools and in physician assistant, nurse practitioner and nursing programs. • Promote the "It's All Connected" campaign. • Re-design the Oral Health Program's website to include medical/dental collaboration as a topic area. • Explore efforts to increase oral health literacy.

1d. Support local community water fluoridation systems. FY Activities 2017 (October 1, 2016 through September 30, 2017): • Continue monthly community water fluoridation monitoring utilizing the Water Fluoridation Reporting System (WFRS). • Encourage local water operator's participation in water fluoridation training. • Assess water systems to determine if replacement equipment is necessary.

ESMs

ESM 13.1 - Number of children that receive dental sealants per school year.

NOMs

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table - Cross-Cutting/Life Course - Entry 2

SPM

Increase adequate insurance coverage to the MCH population.

Objectives

1a. By 2020, increase the percentage of the maternal and child health (MCH) population who are adequately insured.

1b. By 2020, enhance linkages to available sources of health care coverage and other financing or service options available for the MCH population.

Strategies

1a. Monitor the insurance coverage status of the MCH population and collaborate with partners to enhance adequacy of coverage. FY Activities 2017 (October 1, 2016 through September 30, 2017): • Collect data on the insurance status of the MCH population using various data sources (e.g., National Survey of Children's Health, Title V and ND Medicaid program data, HealthCare.gov, etc.). • Continue health systems advocacy by strengthening partnerships between Title V and other departments or organizations involved in insurance, financing, and navigation support (e.g., ND Department of Human Services Medicaid and CHIP programs, ND Insurance Department, health system navigators, etc.). • Track new legislation and monitor policies that impact adequacy of health care coverage for the MCH population.

1a. Provide gap-filling coverage for the MCH population. FY Activities 2017 (October 1, 2016 through September 30, 2017): • Provide diagnostic and treatment services for children with special health care needs. • Provide Family Planning services.

1b. Provide information, referral, benefits counseling, and care coordination services that support access to health care coverage sources and other financing or service options for the MCH population. FY Activities 2017 (October 1, 2016 through September 30, 2017): • Disseminate information on insurance, other coverage options, and safety net programs. • Provide referral training or education opportunities for families, local staff, and partners. • Provide care coordination services for children with special health care needs.

State Action Plan Table - Cross-Cutting/Life Course - Entry 3

SPM

Implement North Dakota state mandates delegated to North Dakota Department of Health Title V / Maternal and Child Health Program.

Objectives

1. Implement North Dakota (ND) state mandates delegated to North Dakota Department of Health (NDDoH) Title V/Maternal and Child Health (MCH) Programs through September 30, 2020.

Strategies

1a. Implement ND state mandates as cited in North Dakota Century Code (N.D.C.C.). FY Activities 2017 (October 1, 2016 through September 30, 2017):

- The Title V and Children with Special Health Care Needs directors will assure compliance for state mandates and oversee staff assigned to carry out roles and responsibilities related to the mandates.
- Maintain a list of ND state mandates delegated to the NDDoH MCH Programs.
- Updates on program implementation will be shared at bi-monthly Title V meetings.

Measures

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

FAD not available for this measure.

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	76.5	78.5	80.5	82.5	84.5	86.5

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	74.6 %	1.6 %	103,221	138,391
2007	77.2 %	1.2 %	102,309	132,482

Legends:

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 13.1 - Number of children that receive dental sealants per school year.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1,595.0	1,695.0	1,795.0	1,895.0	1,995.0

Cross-Cutting/Life Course - Plan for the Application Year

Increase Preventive Dental Services to Children

The burden of oral disease is not uniformly distributed throughout North Dakota (ND). Access to oral health services is an ongoing concern and challenge. Vulnerable and underserved populations face a variety of barriers to oral health care including transportation issues, lack of insurance or ability to pay for care, inability to take time off work to go to the dentist or transport their children, limited availability of providers accepting Medicaid and lack of understanding of the importance of good oral health and its impact on overall health. The limited oral public health infrastructure, particularly in rural counties and lower economically impacted state regions, provides limited options for families in need. The existing oral health safety-net facilities are overburdened and cannot take on more patients without expanding their infrastructure.

Disparities in oral health exist among specific population and age groups in ND. A significantly higher proportion of minority children have decay experience, untreated tooth decay and urgent dental needs. One in five (23%) Head Start children ages 2-4 need dental treatment (Program Information Report, 2014-2015). One in four (28%) third-grade students ages 8-11 assessed, has untreated caries. One fourth of children with an identified special need (23%) needed other dental care beyond a preventive dental visit (Basic Screening Survey, 2010).

Racial disparities in oral health present challenges to oral health providers. American Indian children in third grade experienced more dental caries (tooth decay) than white children (90.5% vs. 69.8%). They also had more untreated dental decay (51% vs. 23%). While 38.7 percent of American Indian children had dental sealants, rampant decay was almost two times more prevalent in American Indian children than in White children (56.6% vs. 27.5%) (Basic Screening Survey, 2015).

Third grade children in rural areas were more likely to have untreated tooth decay compared to children in urban areas (30.1% vs. 27.3%), although this difference was not statistically significant. Children in schools with greater than 50 percent of children on the free and reduced-fee lunch program were more likely to have rampant tooth decay (47.7% vs. 30%) and they were more likely to have untreated tooth decay (44.1% vs. 24.7%) compared to children in schools with less than 25 percent of children on the free and reduced-fee lunch program (Basic Screening Survey, 2015).

In 2007, the ND Legislature passed a law that allows fluoride varnish to be applied by medical professionals. Applications may be provided twice a year up to age 21 for those on ND Medicaid, up to age 18 for those Healthy Steps (State Children’s Health Insurance Program) and the Sanford Health Plan. In 2014, 54 medical clinics and 248 providers were trained on fluoride varnish applications. Efforts will continue to increase this number.

Seal!ND is a program established in 2008 designed to increase access to preventive dental care to underserved populations. The program has four temporary public health hygienists that are strategically located throughout the state. Services offered with this program include: oral health screenings, oral health education, dental sealants, and fluoride varnish. From 2008-2014, the Seal!ND program has provided preventive oral health services to 2,938 children. Collaboration and partnership with the Ronald McDonald Care Mobile and Bridging the Dental Gap (a safety net clinic) has been able to expand preventive oral health services, however, additional partnerships are needed to expand these services. Fluoride varnish and sealants are best practice strategies in reducing dental decay in children.

The State Oral Health Program (OHP) will collaborate with various partners to promote medical/dental collaboration and build the oral public health infrastructure to enhance the delivery of targeted clinical preventive services and health systems changes. The Smiles for Life curriculum will be incrementally implemented in medical and nursing schools across the state to increase oral health literacy. The focus will be on integrating oral health assessment,

referral, anticipatory guidance and application of fluoride varnish in public and private health care settings. The OHP is currently working on a special project to assess oral health literacy among chronic disease programs and also among medical professionals. The OHP is currently in the process of creating a new website that will be more user friendly and will help promote and provide oral health information to both professionals and the public. ND has strong community water fluoridation programs. The OHP works collaboratively with the North Dakota Department of Health's Community Water Fluoridation Program to sustain the community water fluoridation efforts and promote fluoridation as new water systems develop. Currently, 97 percent of ND's population receives optimally fluoridated water through community water systems. The Community Water Fluoridation Program will maintain its high percentage of the population receiving fluoridated water with greater emphasis placed on educating public health professionals, local fluoridation engineers and public officials/policy makers on the benefits of fluoridation and any new guidelines/recommendations released with the intent of avoiding fluoridation challenges and increasing the percentage of adjusted water systems that maintain optimal fluoridation levels. ND has a strong, broad-based Oral Health Coalition. Formed in 2005, the Oral Health Coalition is a chartered, collaborative, statewide coalition comprised of a variety of public and private agencies, organizations and individuals focusing on improving the oral health of North Dakotans. The Oral Health Coalition has been a strong advocacy group to enhance oral disease prevention efforts and policy and systems change in the state. The coalition also has many members dedicated to improving oral health in North Dakota, including dentists, dental hygienists, dental assistants, universities, local public health, medical systems, dental safety net clinics, third-party payers, etc. The ND OHP and the Oral Health Coalition also work closely with the ND Dental Foundation, which has recently received \$6.5 million to help increase access to care, and to create and sustain prevention and education programs. The OHP Director and the ND Dental Foundation Executive Director have been having frequent conversations on how to best integrate activities and priorities of the Dental Foundation and the Oral Health Coalition.

Increase Adequate Insurance Coverage to the MCH Population

According to the 2011/2012 National Survey of Children's Health (NSCH), 93.5 percent of North Dakota (ND) children were insured and 6.5 percent were uninsured. This is slightly less than the U.S., where 94.5 percent of children were insured and 5.5 percent were uninsured. Current insurance was inadequate for 23.8 percent of children (about one-fourth) and adequate for 76.2 percent of children. Those less adequately insured included older children 12-17 years, children with special health care needs, those with less education, and families at 100-199 percent of poverty. According to the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), 60.1 percent of CSHCN age 0 to 18 were in families who had adequate private and/or public insurance to pay for the services they needed. For children receiving services through the Division of Children's Special Health Services (CSHS), 92 percent of children served had a source of health care coverage in 2015. 2015 Federally Available Data (FAD) indicated that a higher percent of insured women had a preventive medical visit in the past year at 66.8 percent, compared to uninsured women at 59.5 percent.

Access to quality health care is essential to increase the likelihood of a healthy life for the maternal and child health (MCH) population. In addition to influencing overall physical, dental, mental, and social health status, access to quality health care impacts prevention, detection, and treatment of health conditions. In addition to efforts that reduce the number of uninsured, challenges remain with adequacy of coverage. Those who are inadequately insured are more likely to have delayed or forgone care, lack a medical home, are less likely to receive needed referrals and care coordination, and/or receive family-centered care. Problems with adequacy include cost-sharing requirements that are too high; benefit limitations, and inadequate coverage of needed services.

Efforts to address these issues focus on the following strategies and activities. Staff will continue to monitor the status of health care coverage for the MCH population using a variety of data sources. When available, this can be used to inform partners and stakeholders about the state's progress in addressing adequacy of insurance. Health systems advocacy will continue through partnerships between Title V and other departments or organizations involved in insurance, financing, and navigation support (e.g., ND Medicaid, ND Insurance Department, health system navigators, etc.). During the 2017 Legislative Session, new legislation will be tracked and changes in policies will be monitored that have the potential to impact health care coverage for the MCH population. Gap-filling coverage will be provided for necessary safety net services.

Efforts to inform and refer to health care coverage and other financing options available for the MCH population will continue. Primary activities include dissemination of information on insurance or other coverage options and providing referral training and education opportunities for families, local staff, and partners. In addition, benefits counseling and care coordination services will be provided for children with special health care needs and their families by state and county social service staff.

Additional critical partnerships/initiatives include collaboration with the following:

- Public coverage programs such as ND Medicaid and Healthy Steps (Children’s Health Insurance Program) - partnership with these important public coverage programs will continue (e.g., monitor legislation and changes in ND Medicaid or Healthy Steps programs and policies, coordinate on claims payments with use of the ND Health Enterprise MMIS, collaborate with Early Periodic Screening, Diagnosis, and Treatment Program, etc.)
- State Systems Development Initiative (SSDI) – SSDI will provide analytical and data needs to support the state action plan.
- State Title V and its partners such as Family Planning, Women, Infants and Children (WIC), families, school nurses, county social service staff, local public health, childcare providers, etc. will stay informed of current health insurance options for the MCH population and distribute information through a variety of strategies and make referrals as appropriate.

Implement all North Dakota State Mandates for the Maternal Child Health Population

Priorities are often influenced by state mandates, which in turn, are generally reflective of expressed need within the state over time. Inclusion of these mandates epitomizes the successful federal/state partnership by honoring a state’s unique priorities. North Dakota (ND) has several mandates addressing the health of the maternal and child health (MCH) population that direct Title V work efforts and require use of significant resources for successful implementation. A list of these mandates can be found in Supporting Document #02, Title V-MCH State Mandates and are discussed below.

Responsibilities of the North Dakota Department of Health (NDDOH) are addressed in ND Century Code (N.D.C.C.), Chapter 23-01. The State Health Officer (SHO) of the NDDoH is responsible for the administration of programs carried out with allotments made to the state by Title V. The NDDoH functions in compliance with Chapter 28-32, Administrative Agencies Practice Act, N.D.C.C. Programs funded by the federal-state Title V MCH Block Grant include: Children with Special Health Care Needs (CSHCN), child passenger safety, injury/violence prevention, newborn screening, MCH epidemiology, nutrition, breastfeeding, optimal pregnancy outcome, school nursing and sudden infant death syndrome.

Several mandates in N.D.C.C. address Title V children with special health care needs (CSHCN)-related responsibilities within the NDDoH. Chapter 23-01-34 includes program administration for CSHCN, including the provision of services and assistance to CSHCN and their families and the development and operation of clinics for the identification, screening, referral and treatment of CSHCN. Chapter 23-01-41 requires the establishment and administration of an autism spectrum disorder database. Chapter 23-41 mandates administrative duties of state and county agencies, confidential birth reports for newborns with visible congenital deformities, and services for individuals with Russell Silver Syndrome. Chapter 25-17-03 mandates treatment for individuals with phenylketonuria or maple syrup urine disease through the provision of medical food and low-protein modified food products.

Additional N.D.C.C. mandates distribution of materials relating to umbilical cord blood disposition and donation, and the development and distribution of materials as required in the Abortion Control Act (i.e., information about pregnancy and abortion, pregnancy support, adoption services). These mandates have been assigned to Title V staff.

To meet the requirements of North Dakota Century Code (N.D.C.C.) Chapter 14-02.1, Abortion Control Act, Section 14-02.1-02.1, Printed Information – Referral Service, the North Dakota Department of Health (NDDoH) developed and published an *Information About Pregnancy and Abortion* booklet: http://www.ndhealth.gov/familyhealth/Preg_Abortion_booklet_final.pdf. This publication consists of objective information on specific topics to include: information and resources on various agencies and services available to assist a pregnant woman through pregnancy; anatomical information along with colored photos of development of the unborn child at two-week gestational increments; information regarding the obligations of the father; and materials that describe various surgical and drug-induced methods of abortion as well as any risk factors associated with those methods. The booklet is free of charge to any person, facility or hospital in both hard copy and electronic versions. Research on the content of the booklet is a continuous process to ensure that the information is accurate,

up-to-date, and evidence-based. In addition to the required information, content was also added on the harmful efforts of tobacco use during and after pregnancy.

N.D.C.C. Chapter 23-45, Umbilical Cord Blood Disposition, Section 23-45-02. Umbilical cord blood - Information pamphlet – Distribution, requires the NDDoH to prepare a pamphlet that includes information on medical processes involved in the collection of umbilical cord blood; any risks of cord blood collection for both mother and baby; the current and potential future uses for the collected cord blood; the cost of cord blood donation; and options for ownership and future use of the donated material. The pamphlet must be available on the NDDoH's website and be distributed upon request at no charge. The NDDoH elected to use and disseminate the pamphlet from the Cord Blood Registry titled *Parent's Guide to Cord Blood Banking*. This pamphlet is free to patients, hospitals and other entities that choose to utilize the information. The Title V grant supports the costs associated with these unfunded, state mandates and the MCH Nurse Consultant has been assigned responsibility for both of these activities.

N.D.C.C. Chapters 23-01-03.1 and 25-17 mandates ND's Newborn Screening (NBS) Program. Newborn screening provides critical intervention to newborns who may be born with disorders that require immediate intervention. Currently, ND tests for 50 conditions. The panel of tests that is performed is periodically reviewed and new conditions are added as testing and follow-up methods become available. Conditions that are added to the panel are recommended by a national panel and are approved by the State Health Council. The screening and follow-up of newborns is performed in collaboration with the State Hygienic Lab and the University of Iowa Children's Hospital in Iowa, as well as Children's Special Health Services (CSHS). Intermediate and long-term follow up after NBS has primarily been addressed in CSHS by:

- providing follow-up contacts, resource information and care coordination for children with abnormal newborn screening results.
- providing assistance and resource information for all newborns that participate in the "Cardiac Care for Children Program" throughout the state.
- providing financial support for metabolic disorder clinics that result in coordinated disease management.
- providing no-cost or at-cost medical food and care coordination for newborns and individuals with phenylketonuria (PKU) and maple syrup urine disease (MSUD).
- providing diagnostic and treatment services for children birth to age 21 who meet medical and financial eligibility criteria.

Along with the follow-up calls for babies with abnormal newborn screening results, CSHS assists families with referrals for services, care coordination, and support. Information is provided regarding the CSHS diagnostic and treatment program as well as other state-wide resources (e.g., WIC, ND Medicaid, Early Intervention) to assist the family in meeting their needs, and to provide them support and direction during a time that can be very stressful and overwhelming. Financial eligibility for CSHS treatment services is legislatively mandated at 185 percent of the federal poverty level. All current NBS conditions are approved medical conditions for CSHS coverage. Title V supports staff to manage the NBS Program including a program director, nurse consultant, CSHS program administrator, and an administrative assistant. In addition, Title V funds support contracts for a medical director and metabolic disorder clinic. State funds have also been provided to the program to support medical consultation.

Federally, the Maternal and Child Health Block Grant enables the state to address the following on behalf of children with special health care needs and their families: 1) to provide and promote family-centered, community-based, coordinated care (including care coordination services) for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families, and 2) to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI, to the extent medical assistance for such services is not provided under title XIX. Specifics regarding the CSHS role in providing rehabilitation services is described below.

ND is a 209(b) state, which means Supplemental Security Income (SSI) beneficiaries under 16 years of age are not automatically eligible for ND Medicaid. If assets are an issue affecting ND Medicaid eligibility, children eligible for SSI can be covered under the children and family coverage groups where asset testing is not required. The state CSHCN program pays for or provides rehabilitative services for eligible children that are served by Title V to the extent services are not provided by ND Medicaid. State CSHCN program staff conduct outreach, information and

referral activities targeted to the SSI population. On a monthly basis, Disability Determination Services provides referrals electronically to the state CSHCN program. In response, state CSHCN staff provide a direct mailing to families notifying them about potential programs that could be of assistance. This assures that children are consistently being referred to the Title V program and that families receive information about program benefits and needed services.

The Title V and CSHCN Directors assure compliance for these state mandates and oversee staff assigned to carry out the roles and responsibilities related to the mandates. Title V staff share program accomplishments and challenges at bi-monthly Title V meetings. These meetings serve as an avenue for program updates, sharing and collaboration.

Cross-Cutting/Life Course - Annual Report

SPM 1

Priority Need Statement: *Form and strengthen partnerships with families, American Indians and underrepresented populations.*

Performance Measure: *The degree to which families and American Indians participate in Title V program and policy activities.*

The Centers for Disease Control and Prevention (CDC) emphasizes that collaboration with partners [can] “reduce the higher rates of poor outcomes experienced by some racial and ethnic groups...” Title V programs recognize that partner-based approaches in program planning are fundamental to impacting maternal and child health (MCH) outcomes and reducing health disparities, particularly among marginalized populations.

Adverse child and family experiences may have harmful health outcomes. Adverse childhood experiences (ACEs) can have profound effects on the lifelong health of adults. Many studies on ACEs have been retrospective in nature, asking adults to recall their childhood experiences and then examining the prevalence of various chronic conditions and economic outcomes. According to the 2011/2012 National Survey of Children’s Health, nearly half (43.7%) of ND children age 0 through 17 experienced one or more of the nine ACEs. The next survey data from the NSCH will not be available until 2017. Starting in 2016, the NSCH and the National Survey of Children with Special Health Care Needs will be combined and completed annually.

From 2000 to 2010, ND’s overall American Indian (AI) population grew 17 percent, from 31,329 to 36,591 people, accounting for 5.4 percent of ND’s population in the 2010 Census. Poverty rates for AI continued to be higher than for the state overall. One in four AI in the state are impoverished, including nearly half of AI children under the age of 18. Data from the 2011/2012 National Survey of Children’s Health indicated that half (50%) of ND AI children experienced at least two ACEs (3.2 times as many as white children), with exposure increasing by age (28% of AI children 0 through 9 and 74% of children 10 through 17). One-fourth of AI children experienced at least four ACEs (6.6 times as many as white children). Divorce/parental separation (37%) and living with someone who had an alcohol or drug problem (35%) were the most common ACEs among AI children. The study demonstrated considerably higher rates of ACE’s among AI children and previous research has demonstrated long-term health consequences of adverse experiences in childhood, including greater comorbidity in adulthood. Trauma-informed care and ACE treatment can reduce the long-term costs associated with negative outcomes resulting from ACE’s exposure. This has emphasized the importance of Title V/ MCH programs working in AI communities to understand ACE’s, resiliency, and trauma-informed care and how they impact health and community outcomes.

The ND Collaborative Improvement and Innovation Network to reduce Infant Mortality Initiative activity included strategies to educate individuals, providers and communities about ACE's, resiliency and trauma-informed care and has continued to work with American Indian Public Health Resource Center (AIPHRC) at North Dakota State University for targeted outreach with AI tribes in the state. Evidence-based maternal, infant and early childhood home visiting programs in the state have explored the use of the toolkit to assist home visitors in helping families understand how their lives have been impacted by ACE's and their capacity for resiliency and flourishing. These statistics highlighted the critical need for Title V programs to engage with disparate populations to achieve better health outcomes over the life course.

The data source for this measure is an assessment tool by which the Title V program staff have reported the degree of which families and American Indians have collaborated with their programs/coalitions based on the following program and policy planning activities: collaboration around education activities; programmatic services; advocacy and public policy; data and community mobilization; and representation on Title V-related committees, task forces, coalitions, etc.

Findings from the Federal Fiscal Year (FFY) 2014 survey evaluating AI and family participation in Title V activities indicated a 5 percent overall decrease from 57 percent in 2013 to 54 percent in 2014. Representation of families on committees, task forces and coalitions indicated a 9 percent decline in perceived participation. Perception of families' collaboration with Title V programs around advocacy and public policy had an approximate 2 percent improvement. Collaboration with AI around programmatic activities indicated a 5 percent decline. There was also an approximate 20 percent decrease in the perceived collaborations with AI around community mobilization. These decreases clearly indicate the need for continued emphasis and diligence to strengthen partnerships with families and the AI population.

Specific activities that occurred related to this measure included:

- A continued partnership with the AIPHRC on the Infant Mortality Collaborative for Improvement and Innovation Network (CollIN) initiative. In 2016, efforts will focus on tribal outreach and engagement; development of tribal resolutions/memorandums of understanding and data sharing agreements to conduct community needs assessments; coordination, analysis and dissemination of community needs assessments; and creation of a statewide or tribal specific coalition of key stakeholders to share strategies for addressing infant mortality in ND tribal communities.
- The Division of Children's Special Health Services (CSHS) assured that effective family partnerships were a priority within the division. Staff encouraged active family engagement in children with special health care needs (CSHCN) related meetings, committees, training opportunities, presentations, and work projects throughout the year. Representatives from Family Voices of ND, in particular, participated in many meetings led by CSHS staff. CSHS staff presented at family-led events such as a Family Voices topical call. Family/professional collaboration was encouraged and supported with many other committees and work groups (e.g., State Developmental Disabilities Council, Interagency Coordinating Council, Autism Spectrum Disorder Data Base, etc.).
- CSHS continued to support a ten-member Family Advisory Council. During this reporting period, three meetings were conducted. CSHS reimbursed Family Advisory Council members for mileage, meals and lodging and provided a \$75/day consultant's fee for meetings that were attended. A recommendation summary included as part of the meeting minutes documented division actions that were taken based on advice from the council. Members shared the value of CSHS through family stories and experiences. One such story has since been included on the CSHS website, disseminated at clinics, and in gift boxes for new families that have a baby born with a cleft lip/palate.
- CSHS sustained support services for children and youth with special health care needs and their families. Funding was provided to Family Voices of ND and ND Hands and Voices, two family-led organizations that

provide information/education, training, parent-to-parent programs, etc. for CSHCN and their families. Family Voices of ND is the state's family-to-family health information and education center and also houses a parent-to-parent program. ND Hands and Voices is dedicated to supporting families with children who are deaf or hard of hearing. CSHS promotes many other family support organizations in various outreach activities and through social media such as Facebook.

- CSHS staff assessed family partnerships and satisfaction in a variety of ways. Satisfaction with health information provided to families was assessed through a health information satisfaction survey, which evaluated family satisfaction, effectiveness of information, and referral efforts conducted or supported by CSHS. This survey was also available on the CSHS website homepage. Satisfaction was reported by local grantees who received funds from CSHS as part of their annual quality assurance reports.
- Title V staff analyzed the data from this performance measure's ranking tool to target areas for improvement among the Title V programs.
- Title V staff participated in a display opportunity at United Tribes Technical College for the first "The Earth, the Moon and the Sacred Stars" Maternal and Child Health Symposium sponsored by the AIPHRC. Title V funds supported several speakers for the symposium.
- CSHS provided funding for multidisciplinary developmental assessment clinics at Fort Totten and Turtle Mountain, two AI communities.

Other Programmatic Activities

Women/Maternal Health:

The Optimal Pregnancy Outcome Program (OPOP) serves an at-risk population of women throughout the state of North Dakota (ND). OPOP serves as an additional resource for pregnant women who may have poor social supports and/or are at risk for substance use/abuse. OPOP partners with March of Dimes, Women, Infant, and Children (WIC), and Text4baby to enhance prenatal health in pregnant women. There are currently four OPOP sites throughout the state that are supported through Title V funds. At the state level, Title V supports 20 percent of a nurse consultant position to provide leadership to OPOP.

Perinatal/Infant Health:

Working in conjunction with the North Dakota Department of Human Services (DHS), the ND Department of Health (NDDoH) developed a free magazine for new parents that cover important topics pertaining to the first year of a child's life. *Parenting The First Year* magazine provides beneficial information on topics such as crib safety, newborn screening, breastfeeding, appropriate car seat use, postpartum depression and developmental milestones, just to name a few. The magazine has a plethora of information for any new parent and includes many valuable resources. What's unique this magazine is that it contains specific contact information and resources available within the state. For example, the article on safe sleep contains contact information and a website link about the Cribs for Kids Program, a safe-sleep education and distribution program. Information on ND's Cribs for Kids Program can be found at: <http://www.ndhealth.gov/cribsforkids/>.

To ensure that information is up-to-date and pertinent, research on the content of the magazine is continually being conducted. The magazine is updated and reprinted every two years. Examples of partnerships with content expertise include Women, Infant, and Children (WIC), Children's Special Health Services (CSHS), NDQuits (tobacco program), Medicaid, newborn screening, and oral health. The magazine is widely distributed statewide to a variety of entities including local public health, clinics, and birthing centers. In the upcoming year, distribution will be expanded to include maternity stores, thrift stores, child care centers, etc. The Maternal and Child Health (MCH) Nurse Consultant provides leadership for this activity.

Another method of providing outreach to new birth families is through the ND Birth Review Program. This is considered an Early Intervention "ChildFind" activity that helps identify babies born with developmental risk factors or other special health care needs. The program fosters interagency partnerships to identify, inform, and refer at-risk newborn children and their families to designated services within ND. The target population includes all ND families who have had a child born within the state who have authorized receipt of health care information on the birth

certificate. Through information and referral efforts, the program promotes general child health and well-being and healthy pregnancies with optimal birth outcomes. A Program Administrator within the Division of Children with Special Health Services (CSHS) provides leadership for this activity.

ND's Early Hearing Detection and Intervention (EHDI) Program is administered by the ND Center for Persons with Disabilities (NDCPD) at Minot State University. NDCPD and CSHS have cooperative agreements in place that outline respective roles with implementation of EHDI in ND. A CSHS staff member functions as the State Implementation Coordinator. Since the program began, gains have been made in the percent of newborns in ND that have had their hearing screened before hospital discharge. Current grant efforts focus on reducing babies lost to follow-up as well as tracking, surveillance, and referral to early intervention services. Additional efforts have been made to implement quality improvement strategies to enhance efficiencies within the program. More information about ND's EHDI Program is available at: www.ndcpd.org/ehdi/ and on Form 4 of the application. Historically, NDCPD has been an important partner to the state CSHCN program, one that is successful in securing grant funding and supporting collaborative projects that improve the lives of individuals with disabilities.

Child Health:

School nurses play a vital role in the overall health and education of students in ND. With the steady increase of chronic diseases seen in schools, the role of the school nurse is becoming more diverse. Through education, assessment, treatment, and advocacy, school nurses embody a multitude of characteristics to ensure quality healthcare for students. Title V supports school nursing by funding a Maternal and Child Health (MCH)/State School Nurse Consultant who acts as a resource, consultant, advocate, and partner to school nurses. Title V fully funds this position.

The MCH/State School Nurse Consultant is a member of groups such as the National School Nurse Association, Children's Safety Network, the National Association of State School Nurse Consultants, and the National Network of State Adolescent Health Coordinators. Collaboration also occurs within the state with various partners such as the Department of Public Instruction (DPI), the North Dakota School Board Association (NDSBA), Healthy ND, and the North Dakota Board of Nursing (NDBON). The MCH/State School Nurse Consultant keeps up-to-date on current and emerging issues and communicates those to schools and school nurses throughout the state. The NDDoH maintains a state school nurse listserv that serves as a fast and efficient way to disseminate vital information to school nurses, public health nurses, and school administrators/staff. Specific areas of interest include combatting obesity, childhood safety, anti-bullying strategies, and medication administration. A resource for medication administration training for designated school staff was developed by the MCH/State School Nurse Consultant and is posted online for easy access: <http://www.ndhealth.gov/school-nursing/MedicationAdministration.htm>. Additional resources include: *Head Lice, A Lousy Problem*: <http://www.ndhealth.gov/head-lice/Publications/headlicebooklet.pdf>; *Health Guidelines for North Dakota Schools*; http://www.ndhealth.gov/csh/publications/School_Health_Guidelines_Final.pdf; and *Emergency Guidelines for North Dakota Schools* (not currently available on-line, but work is in progress to develop an electronic document).

In June 2016, the Title V Director, along with the CSHS Director, State Health Officer, President of the ND Chapter of the American Academy of Pediatrics, and three ND legislators attended the *Improving Quality and Access to Care in Maternal and Child Health* meeting in Colorado. As a result of this meeting, an action plan item includes exploring the option of braided funding to place a school nurse in a Regional Educational Association (REA). A REA is a group of school districts seeking to improve their educational programs and services through cooperation and pooling of resources. The State Title V Director will organize a meeting in the fall of 2016 to start work on this action plan item.

Another Title V partnership involves implementing physical activity and nutrition into early care and education. The State Maternal and Child Health (MCH) Nutritionist supports efforts to increase nutrition and physical activity in child care settings by serving as the co-facilitator of the Nutrition and Physical Activity in Early Child Care (NPAEC) Committee and distributing Companion Guides to the Early Learning Guidelines, specific to nutrition and physical activity.

The MCH Nutritionist also partners with the Preventive Health and Health Services Block Grant to support the work of the local MCH nutritionist, by acting as a clearinghouse for information, as well as coordinating a sustainability

training and annual meeting of public health nutritionists, allowing local and state staff to share progress and challenges in their community with obesity prevention effort.

Children with Special Health Care Needs:

The purpose of Children’s Special Health Services (CSHS) is to provide services for children with special health care needs (CSHCN) and their families and promote family-centered, community-based, coordinated services and systems of health-care. Programmatic efforts of the state CSHCN programs follow below. These programs provide essential public health services for the MCH population or fill critical gaps in the system of care for CSHCN and their families within the state. Many of the CSHCN programs also include state mandates, which can be found in the narrative for State Performance Measure #3 – Implement North Dakota state mandates delegated to the North Dakota Department of Health Title V/Maternal and Child Health Program.

Data Infrastructure:

State Systems Development Initiative (SSDI) – CSHS administers the SSDI grant. The purpose of SSDI in ND is to develop, enhance, and expand Title V’s Maternal and Child Health (MCH) data capacity, including efforts that support the state’s Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) initiative. Improved data capacity supports effective, efficient and quality programming for women, infants, children and youth, including children and youth with special health care needs.

Information Resource Center – CSHS provides health-care resource information to families and service providers free of charge. In addition, division staff carry out a variety of public information services (e.g., toll-free number; Supplemental Security Income (SSI) outreach mailings; resource development; presentations; training; display opportunities; electronic information dissemination strategies such as e-mail, website, and Facebook, etc.).

CSHCN Service System:

CSHCN Service System – CSHS supports initiatives that lead to a community-based system of services for all families, children and youth with special health-care needs. State-level CSHCN staff participate on numerous committees, advisory boards and task forces, which are actively working to improve children’s health. Funding is also provided to support projects that enhance the CSHCN service system. Several of the committees and projects focus on screening, transition, medical home, family partnership and satisfaction, adequate insurance, and community-based service systems.

Adolescent Health:

The Maternal and Child Health (MCH)/State School Nurse Consultant works in a variety of ways to promote adolescent health. The MCH/State School Nurse Consultant helps connect school nurses with information on topics such as binge drinking and drug use, tobacco, depression, reproductive health, obesity, proper exercise, and injury prevention.

The MCH/State School Nurse Consultant is an active member of the National Network of State Adolescent Health Coordinators, which allows for information, best practices and success stories to be shared. Pertinent information from this group, as well as other groups, is communicated to both internal and external partners that have a vested interest in adolescent health.

Additional information regarding school nursing services can be found under Child Health.

Cross-cutting/Life Course:

Title V funds 20 percent of the State Oral Health Program Director’s position. This funding has facilitated the development of an oral health infrastructure that serves as the “backbone” for oral health disease prevention in the state. Maintaining this infrastructure and continuing to build capacity is critical to sustaining current efforts to continue progress in preventing and reducing oral disease among the states most vulnerable populations.

Activities that do not fall into any of the population health domains:

Title V also provides a portion of funding to the vital services of information technology, contract and grant management, and epidemiological support that assist MCH staff with critical job functions.

II.F.2 MCH Workforce Development and Capacity

State Title V staff are able to avail themselves of various professional development opportunities in order to build their capacity as part of the maternal and child health (MCH) workforce. State staff have many strengths including passion, dedication and knowledge to ensure families receive high quality services; strong interpersonal abilities required for partnership building, collaboration and integration; and the capability to manage multiple priorities – just to name a few. To address specific training needs, state Title V staff create an individualized professional development plan that identifies training opportunities to enhance needed knowledge and skills as part of their annual performance review process.

Within the North Dakota Department of Health (NDDoH), a Professional and Leadership Development Program has been implemented. The program is divided into three phases: Professional Development, Leadership Development, and Mentoring. Phase I. Professional Development is open to all employees; topics covered include effective writing, public speaking, conducting successful meetings, customer service, phone etiquette, people skills, conflict management, media relations, and leadership. Phase I trainings have just started as of July 2016; several MCH staff are attending these sessions. Phase II. Leadership Development is for employees who wish to pursue department leadership opportunities. Upon Phase I completion, an employee desiring to continue on the leadership track is asked to complete a self/supervisor assessment. From the employees completing the assessment, up to six individuals are selected annually to take part in classes on leadership, supervisory management, dealing with difficult people, speaking to the media, legislative issues, and teamwork. This phase takes about six months to complete. Phase III. Mentoring is the “hands-on” phase of the program. Following completion of Phase II, employees will begin an approximate six-month period of working with a mentor. A flexible but targeted plan will be developed by which the employee can attain the skills necessary to meet core competencies identified for section leadership positions. Such a plan may consist of job-shadowing, participating in key meetings, cross-training among various divisions, undertaking a special project, additional training or courses, etc. Several MCH staff have voiced interest in continuing into Phases II and III.

Workforce development to advance the capacity of local staff is also important. To build capacity of the local workforce, State Title V staff provide technical assistance with program implementation on an ongoing basis. Periodic training opportunities are also conducted.

Although senior level management who serve in lead MCH-related positions have many years of administrative experience, almost 70 percent of Title V staff has less than five years of experience working in MCH programs at the state-level.

At the local level, the public health workforce is aging. Significant turnover within the next 5-10 year is expected, especially in key administrative staff.

For children with special health care needs (CSHCN), almost two-thirds of the 53 county social service assigned staff members who work with CSHS have less than five years' experience. These local staff members are often responsible for a variety of social service programs in addition to CSHS. Although about 80 percent are licensed social workers, many of these individuals do not stay in their position long enough to gain the needed expertise and on-the-job experience necessary to effectively carry out CSHS-required job functions such as eligibility determination and care coordination, especially for children with very complex health needs. With such high turnover (over 60% since November 2011), there is a significant need for ongoing technical assistance and training from state CSHCN staff.

Although a more formalized workforce development and training plan is needed, some of the critical workforce development and training needs of State Title V staff include:

- MCH/CSHCN leadership development

- Skill-building that prepares staff to lead through change, work effectively within integrated systems, and measure the quality and return on investment of current programs.
- Continued development of cultural and linguistic competence
- Continued development of programmatic content expertise
- Increased knowledge and understanding of health reform

Also refer to section II.B.2.b.iii. MCH Workforce Development and Capacity for additional information.

II.F.3. Family Consumer Partnership

The North Dakota (ND) Title V program is committed to building and strengthening family/consumer partnerships and promoting health equity for all MCH populations.

The Children's Special Health Services (CSHS) Division supports a ten-member Family Advisory Council that meets two to four times each year. Members are reimbursed mileage, meals and lodging and are paid a \$75.00 consultation fee for each meeting they attend. The CSHS Family Advisory Council assures family involvement in policy, program development, professional education and delivery of family-centered care for children with special health care needs and their families. Council members have the opportunity to provide input with development of the MCH Block Grant application and are encouraged and supported to attend the annual review.

North Dakota's Title V program has a strong partnership with several family-led organizations that provide leadership, support and advocacy for families. Four prominent organizations include Family Voices, Pathfinder Family Center, Federation of Families and Designer Genes. In the winter of 2015, these family-led support organizations published a resource entitled *Supporting Families in North Dakota: Through the Lens of Lived Experience*, which was used during the Legislative Session to educate policy-makers in the hopes of advancing family support across the state. This resource is available at: <http://fvnd.org/site/>.

Other organizations in the state also actively provide support to target populations such as families in the early intervention system and individuals with Down syndrome, autism or hearing loss, etc. The CSHS Division funds Family Voices of North Dakota to provide health information and education services in addition to parent-to-parent support for families.

Family representatives are actively involved in several other Title V program initiatives. Examples include the Newborn Screening Advisory Committee and the Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality. Family members attend conferences alongside state staff and are involved in the strategic and program planning activities that follow. In May 2016, the newborn screening program partnered with two families to develop videos to help educate the public on the importance of testing. In addition, a new infographics newborn screening brochure is being developed. Family members were asked for feedback and have provided valuable input in to the design and content for the new brochure. The NBS video can be viewed at: <https://www.youtube.com/watch?v=weJAz9o74Cw&feature=youtu.be>.

Efforts to engage families in quality improvement are ongoing. Programs that receive Title V funding assess family/consumer satisfaction on an ongoing basis (e.g., Family Planning). CSHS requires a description of specific quality assurance strategies, including client satisfaction assessments, in all of its service contracts and required annual reports.

Families are also involved in workforce and materials development. They routinely participate and present at CSHS training events for local staff and are involved alongside state staff in various conference planning activities (e.g., Autism and SCID conferences).

Families and consumers also review a wide array of educational materials that are developed by Title V program staff. The Family Planning Program supports an Information and Education Committee comprised of family and

youth representatives. CSHS routinely solicits family input with resource material development, and more recently, has engaged families in a “family story” messaging project.

Cultural and linguistic competence and the promotion of health equity continue to be a priority in the North Dakota Department of Health (NDDoH). With the growing Native American, immigrant, refugee and migrant populations, ND is developing a diverse society of extensive cultural, educational, economic, and language differences that may hamper the ability of some groups to participate in the improvements of health enjoyed by many in the state. To address disparities in the health and welfare of certain segments of the population, the NDDoH works collaboratively with the ND Indian Affairs Commission and the American Indian Public Health Resource Center at North Dakota State University.

The NDDoH has also developed policies and guidelines to support culturally competent approaches in its service delivery. In April 2015, the NDDoH revised the *Non-Discrimination to Applicants, Clients, and Other Beneficiaries* policy, which seeks to prevent and eliminate discrimination against individuals in employment and in the delivery of programs and services administered and supervised by the NDDoH and to make all programs and activities accessible to persons with disabilities.

In addition, the NDDoH completed a *Cultural and Linguistic Competence Policy Assessment*. Data from this assessment will be used: (1) to provide a summary of the strengths and areas for growth in training, policy development and administration, (2) for strategic planning, and (3) for quality improvement processes.

A NDDoH *Workforce Development Plan* was also finalized in June 2015. This document will assist in identifying gaps in knowledge, skills and abilities through the assessment of both organizational and individual needs, and address those gaps through targeted training and development opportunities. Cultural competency skills have been identified as one of the core competencies for the department. As a result of this plan, the Professional and Leadership Development Program has been implemented; information about this program can be found in II.F.2. MCH Workforce Development and Capacity. In addition, as part of the annual performance review process, all NDDoH employees create an individualized professional development plan.

Title V programs routinely collect, report and analyze data according to race and ethnicity in order to improve service delivery. Additional information regarding specific Title V efforts to form and strengthen partnerships with families, American Indians and other underrepresented populations is available in the 2015 annual report for SPM 1.

II.F.4. Health Reform

Title V programs in North Dakota (ND) have had an active role in providing consumer assistance services that help advance implementation of the Affordable Care Act (ACA) and the health insurance marketplace but a more limited role in activities that support overall health reform efforts such as collaboration with accountable care organizations or work with hospital organizations on community health needs assessments.

However, Title V programs do partner with others to address policy, reform and health systems advocacy. Examples include participation on the ND Department of Human Services (DHS) Medicaid Pediatric Task Force and other workgroups that address services for children with special health care needs (CSHCN) and monitoring legislation during legislative sessions or through interim legislative committees.

ND is one of 36 states that make up the Federally Facilitated Marketplace for the ACA. ND is also a Medicaid Expansion state. The Center for Medicare and Medicaid Services is currently funding three entities in ND to operate as Navigators including Family HealthCare Center, Great Plains Tribal Chairmen’s Health Board (GPTCHB), and Minot State University’s North Dakota Center for Persons with Disabilities (NDCPD). Family HealthCare is partnering with Southeast Community Action Agency and Valley Community Health Centers to reduce the number of uninsured in ND and provide outreach and education to seven northeastern and southeastern ND counties with focus

on new citizens/refugees, pregnant women/new mothers, American Indians (AI's), disabled, college students, and ND Medicaid-eligible individuals. GPTCHB served as a 2013 and 2014 Navigator grantee and provides enrollment assistance to AI's residing on and near the eight reservations in South Dakota and the four reservations and one Indian Service Area in ND and those residing in major urban areas served by Urban Indian Health Centers in these two states. NDCPD served as a 2013 and 2014 Navigator grantee and continues to work with their collaborative network of regional Navigators targeting those most at risk of being uninsured in ND, including people with mild disabilities, people with mental health disorders, farmers, young adults, AIs, small business persons, people who are unemployed, and people who are drug or alcohol addicted.

Title V programs monitor whether individuals served have a source of health care coverage and assess the "reach" of public insurance options. Located within the DHS, Healthy Steps and Medicaid have been effective public programs in reducing the number of uninsured, low-income children in the state. A toll-free resource line is available (1-877-KIDS-NOW) that helps uninsured families learn about low-cost and free health coverage programs. In addition, a seamless eligibility process for health coverage programs helps assure coverage for ND's children.

The ACA has added a layer of complexity in efforts to support families' access to insurance. Title V programs continue to conduct outreach services and provide families with information, referrals, linkages, and counseling aimed at increasing access to available sources of health care coverage and other assistance programs. Examples of outreach information that is provided to directly support local staff and families follow:

- New birth families in the state receive *Parenting the First Year* magazine, which includes information on health insurance and coverage options.
- Women, Infants and Children (WIC) State WIC staff share resources on the ACA with local WIC agency staff.
- Children's Special Health Services (CSHS) disseminates a *Health Care Coverage Options* brochure and financial and health care coverage information packets to families upon request.

Title V program staff make referrals and link families to services and resources at both the state and local level. More intensive care coordination services are also provided, especially for the children with special health care needs (CSHCN) population.

The CSHS division has also worked to build capacity in health benefits counseling through dissemination of resources that support families in making informed decisions regarding health insurance and other coverage options (e.g., Smart Choice Health Insurance workbook and a Medical Home Education in ND on-line curriculum).

There are still gaps that exist with the ACA in that some individuals need services that are not available through current benefit plans. Service limits also pose a challenge. Lower income families are not always able to afford a plan that covers their needs or the associated co-payments for services.

Title V is the payer of last resort for services that are not covered or reimbursed through another provider. Direct health care services for CSHCN's include claims payments to providers for gap-filling services for eligible children and purchase of formula and low-protein modified food products for the metabolic food program. Other local Title V grantees utilize a portion of Title V funds to provide pregnancy services, infant home visits, and dental care (screenings and fluoride varnish applications). State Title V also funds laboratory support for the Family Planning Program.

Additional information related to health reform is available in other sections of the application (e.g., overview of the state, Title V program capacity, family consumer partnership, annual report, budget narrative, etc.).

II.F.5. Emerging Issues

The North Dakota Department of Health (NDDoH) has put together a task force to address Zika virus. The objectives of the task force include:

1. Development of a communication plan to educate the public on Zika virus status.
2. Development of a communication plan to educate the provider community on Zika virus status.
3. Providing pregnancy reporting through **ArboNET** and Zika virus pregnancy registry (CDC reporting system).

The NDDoH's Women's Health Coordinator, who is directly supervised by the Title V Director, is representing the maternal and child health population at weekly taskforce meetings.

On February 10, 2016, NDDoH staff from the Division of Disease Control participated in a Grand Rounds presentation hosted by Bismarck **Catholic Health Initiatives** (CHI) St. Alexius to discuss the Zika virus. Efforts to produce additional informational videos for health professionals and the public are currently in production.

In addition, Zika virus information (e.g., facts, guidance, monitoring, reporting, precautions) is available on the Zika in North Dakota website and has been disseminated through press releases and through the ND Health Alert Network. The website can be viewed at: <http://www.ndhealth.gov/disease/zika/>.

Title V staff provided additional resource information to the task force for its future use (e.g., service-related information for families that have a baby born with a birth defect such as microcephaly).

All other emerging issues that are significant for understanding current or projected strengths and needs of the maternal and child health population in ND have been addressed in the State Overview and in the Five Year State Action Plans (e.g., substance abused newborns, human trafficking).

II.F.6. Public Input

Public input is an essential and integral part of North Dakota's (ND) Title V Maternal and Child Health (MCH) Block Grant Application and Annual Report during its development and after its transmittal.

Early in 2014, ND began planning the five-year needs assessment to select priorities for 2016-2020. The first step in the process to obtain public input was through a MCH survey of perceived needs that was deployed January through March 2014. The 11 question survey was sent to a large number of MCH stakeholders, who were asked to forward the survey to others that may be interested in participating. Links to MCH resources and data were provided at the start of the survey to assist stakeholders in understanding MCH Block Grant requirements. The questions in the survey were open ended to capture qualitative information to gather: specific recommendations for strengthening and improving the health of the MCH population; specific programs or aspects of the service system that are, and are not, working well; and what MCH populations in the state need additional supports. In addition, the survey asked respondents to list their major or emerging health concerns and the biggest needs that are not being met for the MCH population. There were a total of 149 stakeholders that responded to the survey.

On June 16, 2014, a MCH needs assessment meeting was held to engage state and local stakeholders in the needs assessment process. Save-the-date fliers that included the purpose of the meeting were emailed to the same large group of stakeholders as for the MCH survey. Once again, the stakeholders were asked to forward the survey to others that may be interested in participating. Approximately 75 stakeholders attended the meeting in person or by video and/or audio conference. Meeting objectives included: a presentation on MCH history, information about the needs assessment process, information about MCH 3.0 transformation, and a review of the results from the MCH Survey of Perceived Needs. The meeting was successful in the fact that it increased stakeholders' knowledge and understanding of MCH and ND's needs assessment process; improved communication channels; generated new ideas; and built and sustained relationships and partnerships.

In March 2015, another stakeholder survey was developed and distributed to obtain feedback on the selected state priorities – *Did we select the best MCH priorities for 2016-2020?* Information about the needs assessment process and rationale for why the priorities were selected were included in the survey. The purpose of this survey was to evaluate whether the state priorities and national priority areas selected represented the public perception of the needs in ND; and if not, what they felt should be included. The Title V and Children with Special Health Care Needs (CSHCN) directors sent out the survey via an email statewide to MCH partners and stakeholders. To further increase participation in the survey, state MCH staff distributed the survey to their partners and stakeholders, including committees, coalitions, and advisory groups. Collaboration with chronic disease programs assured that the survey was distributed to this group of critical partners and stakeholders as well. In addition, MCH leadership team

members individually presented information for feedback on the needs assessment process and state priorities to many entities (e.g., Family Voices of ND, local public health, ND State Council on Developmental Disabilities, Pathfinder Services of ND, and Family and Medical Advisory Councils for CSHCN). The link to the survey was included at each of these presentations. A total of 222 individuals completed the survey. The survey results were posted on the North Dakota Department of Health's (NDDoH) website.

As a result of this public input and through quantitative data analysis, the final ND MCH 2016-2020 state selected priorities and national priority areas were determined. Annually during the first week in July, a news release is sent to most major media outlets in the state. The press release is also posted on the NDDoH's Facebook page and Twitter account. The news release provides information about the state priority needs that had been identified for the MCH population through the statewide needs assessment and announces that the Title V/MCH Application and Annual Report is available for public comment. Copies of the application and annual report are provided to certain entities every year such as Family Voices of ND, and also provided to other entities and/or individuals as requested. Historically, questions about the grant and requests received for the application and annual report have been minimal. However, this year after the press release was sent out on July 5, 2016, a reporter contacted the NDDoH and interviewed the Title V and CSHCN Directors. The directors provided information on the history of the grant, funding levels, and priority needs. The story appeared on a local Bismarck television station <http://www.kfyrtv.com/content/news/ND-Department-of-Healths-federal-funding-to-be-used-for-maternal-child-health-activity-385743261.html>.

Besides the needs assessment process, public/stakeholder input is gathered on a regular basis throughout the year. The Title V and CSHCN directors provide updates on the MCH grant and grant application process to various groups (e.g., local public health, Children's Special Health Services Advisory Councils, ND State Council on Developmental Disabilities, Family Voices of ND, Coordinated Chronic Disease Partnership Committee, etc.). All of these groups have a broad range of representatives from throughout the state who provide input in directing public health efforts.

Additional efforts have been made this past year to increase awareness and gather input into the needs assessment process. The State System Development Initiative (SSDI) Coordinator and the MCH Epidemiologist gave a presentation on the MCH needs assessment process at the annual Dakota Conference on Rural and Public Health where close to 50 participants attended. Evaluations indicated that participants had an increased understanding of the MCH needs assessment after attending the session. In addition, an article was written outlining the MCH needs assessment for ND Compass. ND Compass is an on-line social indicators project that measures progress in the state and tracks trends in topic areas such as children and youth, economy, health, housing, and workforce. The project's goal is to reach policymakers, business and community leaders, and concerned individuals. The [article written on the needs assessment process for ND Compass can be viewed at: http://www.ndcompass.org/trends/ask-a-researcher/Child%20Health_Making%20Change%20Happen_Jan16.php#.V4WI7GZTGUK](http://www.ndcompass.org/trends/ask-a-researcher/Child%20Health_Making%20Change%20Happen_Jan16.php#.V4WI7GZTGUK).

The Title V Director sent out the MCH Women/Maternal and Perinatal/Infant action plans to the ND Infant Mortality Collaborative Improvement and Innovation Network (COLIN) state team for review and comment. One team member replied with supportive and positive comments regarding the selected strategies and activities.

II.F.7. Technical Assistance

North Dakota's (ND) Title V Program has identified the following potential areas of needed technical assistance:

- Development of evaluation criteria for local maternal and child health (MCH and CSHCN) grantees.
- Utilization of the Capacity Assessment for State Title V (CAST-5) tool to identify the ability of ND to carry out core MCH functions.
- Succession planning for future MCH leaders.
- Increasing access and utilization of ND Medicaid data using Advantage Suite, a web-based tool available to meet analytic and reporting needs with the goal of assuring access to quality data with the transition to the ND Health Enterprise MMIS.
- Enhancement of Autism Spectrum Disorder surveillance.

III. Budget Narrative

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$1,815,867	\$805,504	\$1,706,577	\$1,752,370
Unobligated Balance	\$601,300	\$601,300	\$605,289	\$0
State Funds	\$1,791,875	\$1,852,069	\$1,718,269	\$1,500,786
Local Funds	\$21,000	\$7,994	\$15,631	\$20,166
Other Funds	\$0	\$0	\$0	\$0
Program Funds	\$0	\$0	\$0	\$0
SubTotal	\$4,230,042	\$3,266,867	\$4,045,766	\$3,273,322
Other Federal Funds	\$2,034,506	\$2,133,463	\$2,152,938	
Total	\$6,264,548	\$5,400,330	\$6,198,704	\$3,273,322

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$1,727,404	\$1,164,312	\$1,733,640	
Unobligated Balance	\$569,203	\$0	\$0	
State Funds	\$1,711,780	\$2,189,117	\$1,280,231	
Local Funds	\$10,676	\$22,658	\$20,000	
Other Funds	\$0	\$0	\$0	
Program Funds	\$0	\$0	\$0	
SubTotal	\$4,019,063	\$3,376,087	\$3,033,871	
Other Federal Funds	\$1,908,672	\$1,869,081	\$1,898,313	
Total	\$5,927,735	\$5,245,168	\$4,932,184	

	2017	
	Budgeted	Expended
Federal Allocation	\$1,733,640	
Unobligated Balance	\$0	
State Funds	\$1,280,231	
Local Funds	\$38,133	
Other Funds	\$0	
Program Funds	\$0	
SubTotal	\$3,052,004	
Other Federal Funds	\$2,003,356	
Total	\$5,055,360	

III.A. Expenditures

Information on annual expenditures for FY 2015 is contained in Forms 2, 3a and 3b.

Title V has taken a conservative approach towards spending because of the uncertainty of final award amounts and fluctuating or decreased funding over the last several years. Historically, the budget has been developed based on the previous grant awards.

Form 2:

The FY 2015 award was \$1,734,089, which was just slightly more than the budgeted amount of \$1,727,404, an increase of \$6,685. The total FY 2015 Federal Allocation expenditure was \$1,164,312. The differential between the expended and budgeted amounts is attributed to additional general funds that were available, so less federal funds were expended. This differential is also reflected on Forms 3a and 3b.

State funds expended were more than budgeted (\$2,189,117 vs. \$1,711,780). This differential between the expended and budgeted amounts is attributed to additional general funds that were available.

Local Maternal and Child Health (MCH) funds expended are more than budgeted (\$22,658 vs. \$10,676). Local MCH funds include grantees other than local public health and social services that provide match. This increase between the budgeted and expended amounts is attributed to additional match provided from grantees.

Other federal funding expenditures were just slightly less than budgeted (\$1,869,081 vs. \$1,908,672).

Total funds expended for FY 2015 were \$5,245,168 vs. the budgeted amount of \$5,927,735.

Form 3a:

Federal and non-federal expenditures are reported separately by types of individuals served. Combined federal and non-federal expenditures include:

- Pregnancy women – \$454,107
- Infants < 1 year – \$555,019
- Children 1-22 years – \$894,152
- CSHCN – \$1,304,869
- All others – \$40,223

The Federal-State MCH Block Grant Partnership total is \$3,248,370, which includes \$1,117,433 in federal funds and \$2,130,937 in non-federal funds.

Form 3b:

Federal and non-federal expenditures are reported separately by types of services. Combined federal and non-federal expenditures for FY 2015 includes \$727,166 for direct services for the following population groups:

- a. Preventive and primary care services for all pregnant women, mothers, and infants up to age one – \$273,400
- b. Preventive and primary care services for children – \$140,843
- c. Services for CSHCNs – \$312,923

The expenditures for FY 2015 also include \$522,784 for enabling services, and \$2,126,137 for public health services and systems. The Federal-State Title V Block Grant Partnership Subtotal is \$3,376,087.

Direct services are broken out by the each of the three legislatively-defined MCH population groups: preventive and primary care services for all pregnant women, mothers, and infants up to age one; preventive and primary care services for children; and services for children with special health care needs (CSHCN).

Direct health care services for CSHCN's include claims payments to providers for gap-filling services for eligible children and purchase of formula and low-protein modified food products for the metabolic food program. Some local Title V grantees utilized a portion of Title V funds to provide pregnancy services, infant home visits, and dental care (screenings and fluoride varnish applications). State Title V also funded laboratory support for the Family Planning Program.

Direct service expenditures listed on Form 3b, Section 4 include combined federal and non-federal funds:

Pharmacy – \$43,641 for CSHCN's

Physician/Office Charges – \$105,279 for CSHCN's

Hospital Charges (includes inpatient and outpatient services) – \$31,533 for CSHCN's

Dental Care (does not include orthodontic services) – \$23,425 for CSHCN's

Durable Medical Equipment and Supplies – \$0

Laboratory Services – \$40,245 for primarily Family Planning Program laboratory support

Other – \$483,043 for CSHCN's claims, medical food, Optimal Pregnancy Outcome Program (pregnancy services), and infant home visits

Title V is the payer of last resort and the services listed above were not covered or reimbursed through another provider.

III.B. Budget

Budget information is contained in Forms 2, 3a and 3b.

In accordance with Section 505, the North Dakota (ND) Title V Program will use funds allocated under this title to meet the needs for preventive and primary care services for pregnant women, mothers, infants and children, including those with special health care needs. Allocation requirements for children (30%) and children with special health care needs (30%), administration (10%) and FY 1989 maintenance of effort (\$1,206,293) will be met.

As required in Sections 505(a)(5)(A), 505(a)(5)(D), 506(b)(1), the state will identify and apply a fair method to allocate funds to groups, localities, and individuals, and will apply guidelines for appropriate frequency and content of referrals and follow-up. The state will publish charges for services. If charges are imposed, they will be adjusted based on income and resources. At least every two years, the state will audit expenditures and submit a copy of the audit report.

Title V funds are allocated to a variety of local providers who serve families through local public health departments, Indian Reservations, health systems, schools, universities, etc. The majority of these agencies match federal dollars received with state or local funds. Title V assures that no charge will be made to "low-income" families. All agencies receiving funds must assure the state Title V Programs that if any charges are imposed for the provision of health services, such charges will not be imposed on services to low-income families and will be adjusted to reflect the income, resources and family size of the individual. No ND Title V Program will refuse services to anyone because of inability to pay. Some agencies may accept donations for services.

Form 2:

Title V has taken a conservative approach towards spending because of the uncertainty of final award amounts and fear of decreased funding over the last several years. Historically, the budget has been developed based on the previous final grant award.

FY 2017 Maternal and Child Health (MCH) federal allocation (\$1,733,640) is based on previous years funding awards. Population percentages, match, and maintenance of effort requirements are met. The budget allocates \$535,000 (30.9%) to preventive and primary care for children and \$577,822 (33.3%) for children with special health care needs (CSHCN's). Administrative costs budgeted at \$86,682 (5%) do not exceed 10 percent of the allocation. This amount based on projected indirect costs that are expected to be charged to the Title V Block Grant. The unobligated balance is \$0 as the full grant award is expected to be expended in the allotted time frame.

State MCH funds (\$1,280,231) meet the 4:3 match requirement. The budgeted amount is less than the expended amount as only the minimum amount of required match is included. However, additional state match historically has exceeded the minimum match requirement. In ND, local public health, schools, universities and county social services are considered entities of the state. The majority of these agencies match federal dollars received with state or local funds.

Local funds (\$38,133) also meet the 4:3 match requirement. Local MCH funds include grantees other than those listed above (e.g., non-profits, tribal).

Total state match is \$1,318,364, which exceeds the 1989 maintenance of effort requirement (\$1,206,293).

Other federal funds (\$2,003,356) are increased from the FY 2016 (\$1,898,311) budget due to increases in the State Abstinence Education Program and Health Resources and Services Administration Oral Health Workforce Grant (HRSA) Oral Health grants.

The state MCH budget total is \$5,055,360.

Form 3a (the following figures represent combined federal and non-federal funds by types of individuals served. Per grant guidance, these amounts do not include administrative costs.):

FY 2017 funds budgeted for pregnant women (\$499,709) support efforts such as the Optimal Pregnancy Outcome Program (OPOP), in addition to a variety of other state and local programs. Funds for infants under 1 year (\$505,821) support state and local programs such as infant mortality initiatives (Collaborative Improvement and Innovation Network (CollIN), infant and child death services, safe sleep activities, infant home visits, injury prevention, breastfeeding, and *Parenting the First Year* magazine. Funds for children ages 1 to 22 years (\$812,958) support state and local program such as school health, injury prevention, nutrition education, and physical activity initiatives. Budgeted figures for these population categories are based on a new funding allocation that aligns with state and national priorities areas, in addition to supporting state mandates.

Funding allocated for children with special health care needs (CSHCN's) (\$1,011,189) will support a variety of state and local programs such as diagnostic/treatment services, multidisciplinary clinics, metabolic food program, care coordination program, information resource center activities (e.g., family information and support services), and CSH system initiatives (e.g., medical home, transition). Budgeted figures for CSHCNs are based on past expenditures and efforts to realign activities with state and national priorities areas, in addition to supporting state mandates.

Funds for other populations (\$52,500) include state laboratory expenses to support the Family Planning Program.

The Federal-State MCH Block Grant Partnership total is \$2,882,177, which includes \$1,646,958 in federal funds and \$1,235,219 in non-federal funds.

Form 3b (the following figures represent combined federal and non-federal funds by types of services):

The budget for FY 2017 includes \$434,244 for direct services for the following population groups:

- a. Preventive and primary care services for all pregnant women, mothers, and infants up to age one – \$111,645
- b. Preventive and primary care services for children – \$79,914
- c. Services for CSHCNs – \$242,685

The budget for FY 2017 also includes \$787,920 for enabling services, and \$1,829,840 for public health services and systems. The Federal-State Title V Block Grant Partnership Subtotal is \$3,052,004. Budgeted figures for these population categories are based on state historical trend data for allocation of funds based on the pyramid level of services, and on a new funding allocation that aligns with state and national priorities areas.

Direct services are broken out by the each of the three legislatively-defined MCH population groups: preventive and primary care services for all pregnant women, mothers, and infants up to age one; preventive and primary care services for children; and services for children with special health care needs (CSHCN).

Direct health care services for CSHCN's include claims payments to providers for gap-filling services for eligible children and purchase of formula and low-protein modified food products for the metabolic food program. Local Title V grantees utilize a portion of Title V funds to provide pregnancy services (Optimal Pregnancy Outcome Program). State Title V also funds laboratory support for the Family Planning Program.

Enabling services for CSHCN's include service contracts for multidisciplinary clinics; family information, training, and support; and medical home projects. In addition, care coordination services are provided by county social service staff and reimbursed based on a random moment time study method of cost allocation. State and local Title V staff also provide referrals; transportation support; eligibility assistance; translation/interpretation assistance; health education f

individuals and families; environmental health risk reduction; health literacy; and outreach.

Public health services and systems include salary, fringe benefits, and operating expenses for state and local staff to carry out core public health functions and the 10 essential public health services. Examples include the MCH needs assessment; program planning, implementation and evaluation; policy development; quality assurance and improvement; workforce development; and population-based health promotion campaigns.

Additional detail relating to the types of services described above can be found throughout the grant application.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [IV. Title V-Medicaid IAA--MOU.pdf](#)

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [Ongoing Needs Assessment Findings.pdf](#)

Supporting Document #02 - [Title V-MCH State Mandates.pdf](#)

Supporting Document #03 - [MCH Workforce.pdf](#)

VI. Appendix

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Form 2
MCH Budget/Expenditure Details
State: North Dakota

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 1,733,640	
A. Preventive and Primary Care for Children	\$ 535,000	(30.9%)
B. Children with Special Health Care Needs	\$ 577,822	(33.3%)
C. Title V Administrative Costs	\$ 86,682	(5%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 1,280,231	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 38,133	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 1,318,364	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 1,206,293		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 3,052,004	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 2,003,356	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 5,055,360	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 100,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 90,145
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	\$ 340,600
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 1,032,400
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	\$ 440,211

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 1,727,404		\$ 1,164,312	
A. Preventive and Primary Care for Children	\$ 690,962	(40%)	\$ 379,471	(32.6%)
B. Children with Special Health Care Needs	\$ 575,744	(33.3%)	\$ 471,658	(40.5%)
C. Title V Administrative Costs	\$ 103,644	(6%)	\$ 46,879	(4%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 569,203		\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 1,711,780		\$ 2,189,117	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 10,676		\$ 22,658	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0		\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 1,722,456		\$ 2,211,775	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 1,206,293				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 4,019,063		\$ 3,376,087	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 1,908,672		\$ 1,869,081	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 5,927,735		\$ 5,245,168	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 97,462
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 28,876
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	\$ 313,559
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	\$ 366,980
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 1,062,204

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	Field Name:	Federal Allocation, A. Preventive and Primary Care for Children:
	Fiscal Year:	2015
	Column Name:	Annual Report Expended
	Field Note:	Additional general funds were available, so less federal funds were expended.
2.	Field Name:	Federal Allocation, B. Children with Special Health Care Needs:
	Fiscal Year:	2015
	Column Name:	Annual Report Expended
	Field Note:	Additional general funds were available, so less federal funds were expended.
3.	Field Name:	Federal Allocation, C. Title V Administrative Costs:
	Fiscal Year:	2015
	Column Name:	Annual Report Expended
	Field Note:	Administrative costs were lower than anticipated.
4.	Field Name:	2. UNOBLIGATED BALANCE
	Fiscal Year:	2015
	Column Name:	Annual Report Expended
	Field Note:	In the past, the amount entered for unobligated balance was the amount of carry over. Clarification was received from our project officer that if all funds from one year would be expended during the two year spending window, the unobligated balance should be \$0.
5.	Field Name:	3. STATE MCH FUNDS
	Fiscal Year:	2015
	Column Name:	Annual Report Expended
	Field Note:	Additional general funds were available which was directed to the state match.
6.	Field Name:	4. LOCAL MCH FUNDS
	Fiscal Year:	2015

Column Name: Annual Report Expended

Field Note:
Local match was more than anticipated.

7. **Field Name:** 1.FEDERAL ALLOCATION

Fiscal Year: 2015

Column Name: Annual Report Expended

Field Note:
Additional general funds were available, so less federal funds were expended.

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served
State: North Dakota

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	\$ 226,861	\$ 109,521
2. Infants < 1 year	\$ 277,275	\$ 133,858
3. Children 1-22 years	\$ 535,000	\$ 379,471
4. CSHCN	\$ 577,822	\$ 471,658
5. All Others	\$ 30,000	\$ 22,925
Federal Total of Individuals Served	\$ 1,646,958	\$ 1,117,433

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	\$ 272,848	\$ 344,586
2. Infants < 1 year	\$ 228,546	\$ 421,161
3. Children 1-22 years	\$ 277,958	\$ 514,681
4. CSHCN	\$ 433,367	\$ 833,211
5. All Others	\$ 22,500	\$ 17,298
Non Federal Total of Individuals Served	\$ 1,235,219	\$ 2,130,937
Federal State MCH Block Grant Partnership Total	\$ 2,882,177	\$ 3,248,370

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services
State: North Dakota

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	\$ 272,149	\$ 294,242
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 67,486	\$ 91,430
B. Preventive and Primary Care Services for Children	\$ 65,851	\$ 47,100
C. Services for CSHCN	\$ 138,812	\$ 155,712
2. Enabling Services	\$ 261,962	\$ 158,383
3. Public Health Services and Systems	\$ 1,199,529	\$ 711,687
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 24,875
Physician/Office Services		\$ 60,009
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 17,974
Dental Care (Does Not Include Orthodontic Services)		\$ 13,352
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 22,938
Other		
CSHCN claims, medical food, OPOP, home visits		\$ 155,094
Direct Services Line 4 Expended Total		\$ 294,242
Federal Total	\$ 1,733,640	\$ 1,164,312

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	\$ 162,095	\$ 432,924
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 44,159	\$ 181,970
B. Preventive and Primary Care Services for Children	\$ 14,063	\$ 93,743
C. Services for CSHCN	\$ 103,873	\$ 157,211
2. Enabling Services	\$ 525,958	\$ 364,401
3. Public Health Services and Systems	\$ 630,311	\$ 1,414,450
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 18,766
Physician/Office Services		\$ 45,270
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 13,559
Dental Care (Does Not Include Orthodontic Services)		\$ 10,073
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 17,307
Other		
CSHCN claims, medical food, OPOP, home visiting		\$ 327,949
Direct Services Line 4 Expended Total		\$ 432,924
Non-Federal Total	\$ 1,318,364	\$ 2,211,775

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated
State: North Dakota

Total Births by Occurrence: 12,842

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	12,832 (99.9%)	549	142	142 (100.0%)

Program Name(s)				
S, β -thalassemia	S,C disease	Biotinidase deficiency	Critical congenital heart disease	Cystic fibrosis
Classic galactosemia	S,S disease (Sickle cell anemia)	Congenital adrenal hyperplasia	Primary congenital hypothyroidism	Tyrosinemia, type I
Classic phenylketonuria	Homocystinuria	Maple syrup urine disease	Citrullinemia, type I	Argininosuccinic aciduria
Trifunctional protein deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Medium-chain acyl-CoA dehydrogenase deficiency	Carnitine uptake defect/carnitine transport defect
Glutaric acidemia type I	β -Ketothiolase deficiency	Holocarboxylase synthase deficiency	3-Hydroxy-3-methylglutaric aciduria	3-Methylcrotonyl-CoA carboxylase deficiency
Isovaleric acidemia	Methylmalonic acidemia (cobalamin disorders)	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Propionic acidemia	

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Early Hearing Detection and Intervention (EHDI)	12,594 (98.1%)	343	6	6 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Metabolic Newborn Screening - Long term follow-up activities by CSHS include the following: 1) care coordination for presumptive positive screens, 2) diagnostic and treatment services for eligible children with metabolic disorders, 3) multidisciplinary metabolic disorder clinics, and 4) medical food for individuals with PKU and MSUD .

Critical Congenital Heart Disease (CCHD) – Long term follow-up activities by CSHS include the following: 1) Cardiac Care for Children Program, and 2) diagnostic and treatment services for eligible children with cardiac conditions.

ND Early Hearing Detection & Intervention (EHDI) – EHDI staff provide short-term follow-up to ensure that hearing screening is performed on newborns prior to hospital discharge and that those with hearing loss are identified and receive early intervention as soon as possible. Long term follow-up activities by CSHS include diagnostic and treatment services for eligible children with hearing loss.

Form Notes for Form 4:

North Dakota does not have additional screening program data for children and women under Title V to report.

Field Level Notes for Form 4:

1.	Field Name:	Total Births by Occurrence
	Fiscal Year:	2015
	Column Name:	Total Births by Occurrence Notes
	Field Note:	CY 2015- This number of occurrent infant births in ND IN 2015.
2.	Field Name:	Core RUSP Conditions - Receiving At Lease One Screen
	Fiscal Year:	2015
	Column Name:	Core RUSP Conditions
	Field Note:	CY 2015-Number of initial specimens processed includes infants born in ND (resident births), as well as other states (occurrent births). This number excludes infants not screened. CCHD is a mandated screening in ND and is included on the newborn screening panel; however, there are no reporting requirements. The numbers reported in this form do not reflect any heart disease or defect found as a result of CCHD screening at birth.
3.	Field Name:	Core RUSP Conditions - Positive Screen
	Fiscal Year:	2015
	Column Name:	Core RUSP Conditions
	Field Note:	CY 2015-This number includes all infants who required any follow-up for a screen with an out-of-range result. This includes all reports of borderline, presumptive positive, possible, definite, carrier, or out-of-range results. Total number of cases detected: 549, number of true positive cases: 20, number of carriers detected: 122 (115 Hgb), number AMA/LTFU: 7 and number deceased (no final results): 13.
4.	Field Name:	Core RUSP Conditions - Confirmed Cases
	Fiscal Year:	2015
	Column Name:	Core RUSP Conditions
	Field Note:	CY2015-This number includes all infants who were confirmed to have a disorder or who were determined to be a carrier.
5.	Field Name:	Core RUSP Conditions - Referred For Treatment
	Fiscal Year:	2015

	Column Name:	Core RUSP Conditions
	Field Note:	CY 2015-The number of infants with a confirmed diagnosis who were referred to treatment.
6.	Field Name:	Early Hearing Detection and Intervention (EHDI) - Receiving At Least One Screen
	Fiscal Year:	2015
	Column Name:	Other Newborn
	Field Note:	CY-2015 -This is the number and percentage of occurrent births that received a hearing screen before hospital discharge.
7.	Field Name:	Early Hearing Detection and Intervention (EHDI) - Positive Screen
	Fiscal Year:	2015
	Column Name:	Other Newborn
	Field Note:	CY 2015-The source of the data for the number of presumed positives is obtained from the OZ eSP system via the North Dakota Early Hearing Detection and Intervention Program. This number is inclusive of both inpatient and outpatient screening results. The number does not include the number of "missed" screens, such as home births.
8.	Field Name:	Early Hearing Detection and Intervention (EHDI) - Confirmed Cases
	Fiscal Year:	2015
	Column Name:	Other Newborn
	Field Note:	CY 2015-The source of the data for the number of resident confirmed cases is obtained from the OZ eSP system via the North Dakota Early Hearing Detection and Intervention Program.
9.	Field Name:	Early Hearing Detection and Intervention (EHDI) - Referred For Treatment
	Fiscal Year:	2015
	Column Name:	Other Newborn
	Field Note:	CY 2015-The source of the data for infants referred for treatment is obtained from the OZ eSP system via the North Dakota Early Hearing Detection and Intervention Program. "Referred for Treatment" is defined as being referred to some type of Early Intervention service, not the obtainment of a hearing aid.

Data Alerts: None

**Form 5a
Unduplicated Count of Individuals Served under Title V**

State: North Dakota

Reporting Year 2015

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	12,842	24.3	0.0	70.8	2.3	2.6
2. Infants < 1 Year of Age	12,842	42.0	1.0	51.5	5.5	0.0
3. Children 1 to 22 Years of Age	55,497	23.9	2.1	67.9	6.1	0.0
4. Children with Special Health Care Needs	2,513	25.0	2.0	66.0	1.0	6.0
5. Others	10,023	5.4	0.0	40.2	42.9	11.5
Total	93,717					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2015
Field Note: 2015-Data Source: North Dakota Department of Health, Division of Vital Records. This number indicates occurrent births in the state. Primary Source of Coverage is derived from the payer status indicated in the Birth Certificate record.		

2.	Field Name:	Infants Less Than One YearTotal Served
	Fiscal Year:	2015
Field Note: 2015-Data Source: North Dakota Department of Health, Division of Vital Records. This number indicates occurrent births in the state. The following data sources were utilized to derive the percentage estimates for Primary Source of Coverage: Center for Medicare and Medicaid Form 416 (Title XIX); Healthy Steps Blue Cross/ Blue Shield and Advantage Suite web-based portal of the North Dakota Legacy Enterprise Medicaid Management Information System (Title XXI). The none/uninsured percentage was derived from the 2015 Current Population Survey. Private/Other insurance was estimated by back calculation. There was no method for estimating unknown.		

3.	Field Name:	Children 1 to 22 Years of Age
	Fiscal Year:	2015
Field Note: 2015-Data Source: January 1, 2015 through March 31, 2016 (15 months), North Dakota Department of Health, Program Reporting System (PRS). This number represents unduplicated number of children ages 1 to 22 seen at local Maternal and Child Health grantee entities. Payer status was from the following data sources: Center for Medicare and Medicaid Form 416 (Title XIX); Advantage Suite web-based portal of the North Dakota Legacy Enterprise Medicaid Management Information System (Title XXI). The none/uninsured percentage was derived from the 2015 American Community Survey. Private/Other insurance was estimated by back calculation. There was no method for estimating unknown.		

4.	Field Name:	Children with Special Health Care Needs
	Fiscal Year:	2015

Field Note:

2015-Data Sources: Division of Children's Special Health Services, North Dakota Department of Health. The sources of data are the 2015 Program Data Report and the Healthcare Coverage Report. These data reflect unduplicated counts of individuals receiving direct and enabling services served by Title V on line 8 of Form 2. The primary source of coverage for these individuals is for services that are not covered or fully reimbursed.

5. **Field Name:** **Others**

Fiscal Year: **2015**

Field Note:

2015-Data Sources: North Dakota Department of Health, Family Planning and Oral Health Program databases for State Fiscal Year 2014-2015. This number represents unduplicated counts of individuals receiving direct and enabling services through Title V and Family Planning and Oral Health Programs.

6. **Field Name:** **Total_TotalServed**

Fiscal Year: **2015**

Field Note:

2015-The data reflects unduplicated counts of individuals receiving direct and enabling services served by Title V on line 8 of Form 2.

Form 5b
Total Recipient Count of Individuals Served by Title V
State: North Dakota

Reporting Year 2015

Types Of Individuals Served	Total Served
1. Pregnant Women	23,543
2. Infants < 1 Year of Age	18,319
3. Children 1 to 22 Years of Age	89,358
4. Children with Special Health Care Needs	10,371
5. Others	20,793
Total	162,384

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women
	Fiscal Year:	2015
<hr/>		
Field Note: 2015-Data Source: North Dakota Department of Health, Division of Vital Records. This number indicates the number of pregnant women who delivered in the state in Calendar Year 2015 and the estimated number of pregnant women in the state with a delivery projected to be within the first 10 months of Calendar Year 2016. This number is an estimated reach from the Title V Parenting Magazine and multi-media reach of the Newborn Screening Program campaigns. This number represents individuals receiving a Title V service within the service levels of the MCH Pyramid excluding infrastructure building.		
<hr/>		
2.	Field Name:	Infants Less Than One Year
	Fiscal Year:	2015
<hr/>		
Field Note: 2015-Data Source: The source of this data is the North Dakota Department of Health, Division of Vital Records and the North Dakota Department of Health, Program Reporting System (PRS). The data represents total recipient count of occurrent births and the number of infants <1 year of age receiving a Title V service within the service levels of the MCH Pyramid excluding infrastructure building.		
<hr/>		
3.	Field Name:	Children 1 to 22 Year of Age
	Fiscal Year:	2015
<hr/>		
Field Note: 2015-Data Source: The North Dakota Department of Health, Program Reporting System (PRS), Title V Maternal and Child Health Block Grant Report (January 1, 2015-March 31, 2016). This number also includes the number of children served through the School Nursing Program in Calendar Year 2015 as reported in the Step Up and be counted School Nursing Survey. This number represents the count of children ages 1 to 22 receiving a Title V service within the service levels of the MCH Pyramid excluding infrastructure building.		
<hr/>		
4.	Field Name:	Children With Special Health Care Needs
	Fiscal Year:	2015

Field Note:

2015-Data Source: The North Dakota Department of Health, Division of Children's Special Health Services (CSHS). This number includes counts from the following data sources: unduplicated counts from the Program Data Report, local contract data from annual contract reports, follow-up of positive newborn screens, and communication/outreach strategies (CSHS toll free line, Division email, Facebook and website). This number represents individuals receiving a Title V service within the service levels of the MCH Pyramid excluding infrastructure building.

5. **Field Name:** **Others**

Fiscal Year: **2015**

Field Note:

2015-Data Source: The North Dakota Department of Health, Family Planning Program, Oral Health Program and the Injury Prevention Program's Poison Control Program count of individuals reached. This number represents individuals receiving a Title V service within the service levels of the MCH Pyramid excluding infrastructure building.

6. **Field Name:** **Total Served**

Fiscal Year: **2015**

Field Note:

This number represents the total individuals receiving a Title V service within the service levels of the MCH Pyramid excluding infrastructure building.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: North Dakota

Reporting Year 2015

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	12,842	10,438	627	1,013	275	34	0	455
Title V Served	12,842	10,438	627	1,013	275	34	0	455
Eligible for Title XIX	3,111	1,836	386	657	63	12	0	157
2. Total Infants in State	12,842	10,438	627	1,013	275	34	0	455
Title V Served	12,842	10,438	627	1,013	275	34	0	455
Eligible for Title XIX	7,604	4,920	981	1,448	193	32	0	30

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	11,999	667	176	12,842
Title V Served	11,999	667	176	12,842
Eligible for Title XIX	2,785	260	66	3,111
2. Total Infants in State	11,999	667	176	12,842
Title V Served	11,999	667	176	12,842

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
Eligible for Title XIX	6,766	398	440	7,604

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	Field Name:	1. Total Deliveries in State
	Fiscal Year:	2014
	Column Name:	Total All Races
	Field Note:	CY 2015-The source for this data is the North Dakota Department of Health -- Division of Vital Records.

2.	Field Name:	1. Title V Served
	Fiscal Year:	2014
	Column Name:	Total All Races
	Field Note:	CY 2015-The source for this data is the North Dakota Department of Health -- Division of Vital Records.

3.	Field Name:	1. Eligible for Title XIX
	Fiscal Year:	2014
	Column Name:	Total All Races
	Field Note:	CY 2015-The source for this data is the North Dakota Department of Health -- Division of Vital Records.

4.	Field Name:	2. Total Infants in State
	Fiscal Year:	2014
	Column Name:	Total All Races
	Field Note:	CY 2015-The source for this data is the North Dakota Department of Health -- Division of Vital Records.

5.	Field Name:	2. Title V Served
	Fiscal Year:	2014
	Column Name:	Total All Races
	Field Note:	CY 2015-The source for this data is the North Dakota Department of Health -- Division of Vital Records.

6.	Field Name:	2. Eligible for Title XIX
----	--------------------	----------------------------------

Fiscal Year: 2014

Column Name: Total All Races

Field Note:

CY 2015- The data is generated through an adhoc report using the Advantage Suite web-based tool of the Medicaid Management Information System (Legacy and the North Dakota Enterprise). These data are housed in the North Dakota Department of Human Services, Division of Medical Services.

There were 7,604 unique individuals eligible for Title XIX.

The number of individuals in more than one race are already included in their respective primary races, with potential for duplication in counts by primary race. Therefore the "More than One Race Reported" category count is excluded. In 2015, 284 individuals were reported in the "More than One Race Reported" category.

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: North Dakota

A. State MCH Toll-Free Telephone Lines	2017 Application Year	2015 Reporting Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 472-2286	(800) 472-2286
2. State MCH Toll-Free "Hotline" Name	CHS-East Toll-Free	CHS-East Toll-Free
3. Name of Contact Person for State MCH "Hotline"	Janet Lucas	Janet Lucas
4. Contact Person's Telephone Number	(701) 328-2496	(701) 328-2496
5. Number of Calls Received on the State MCH "Hotline"		1,653

B. Other Appropriate Methods	2017 Application Year	2015 Reporting Year
1. Other Toll-Free "Hotline" Names	CSHS Toll-Free Hotline	CSHS Toll-Free Hotline
2. Number of Calls on Other Toll-Free "Hotlines"		929
3. State Title V Program Website Address	http://www.ndhealth.gov/CSHS/	http://www.ndhealth.gov/CSHS/
4. Number of Hits to the State Title V Program Website		3,382
5. State Title V Social Media Websites		https://www.facebook.com/ndcshs/
6. Number of Hits to the State Title V Program Social Media Websites		167

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information
State: North Dakota

1. Title V Maternal and Child Health (MCH) Director	
Name	Kim Mertz, R.N., B.N.Sc.
Title	Director, Division of Family Health
Address 1	North Dakota Department of Health
Address 2	600 E. Boulevard Ave
City/State/Zip	Bismarck / ND / 58505
Telephone	(701) 328-2493
Extension	
Email	kmertz@nd.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Tamara Gallup Lelm, R.N., M.P.A.
Title	Director, Division of Children's Special Health Se
Address 1	North Dakota Department of Health
Address 2	600 E. Boulevard Ave
City/State/Zip	Bismarck / ND / 58505
Telephone	(701) 328-2436
Extension	
Email	tlelm@nd.gov

3. State Family or Youth Leader (Optional)

Name	Moe Schroeder
Title	Parent to Parent Coordinator, Family Voices of ND
Address 1	PO Box 164
Address 2	225 2nd Street W
City/State/Zip	Hunter / ND / 58048
Telephone	(701) 793-8339
Extension	
Email	melissa.schroeder@annecenter.org

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs
State: North Dakota

Application Year 2017

No.	Priority Need
1.	Reduce tobacco use in pregnant women.
2.	Increase the rate of breastfeeding at 6 months.
3.	Reduce disparities in infant mortality.
4.	Reduce fatal motor vehicle crash deaths to adolescents.
5.	Reduce overweight and obesity in children.
6.	Increase the utilization of medical home.
7.	Increase the number of children with special health care needs receiving transition support.
8.	Increase preventive dental services to children.

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Reduce tobacco use in pregnant women.	New	In ND, about 18 percent of women (1 in 5) reported smoking at any point during their pregnancy, compared to about 11 percent nationally (1 in 10). Smoking during pregnancy can cause a baby to be born too early, have low birth weight, and increases the risk of Sudden Infant Death Syndrome (SIDS).
2.	Increase the rate of breastfeeding at 6 months.	New	In ND, about 45 percent of women report having breastfed their infants at 6 months, compared to about 50 percent nationally. Breastfeeding is associated with a reduced risk of SIDS, reduces a child's risk of becoming overweight as a teen or adult and has been linked to decreased risk of breast and ovarian cancer in women.
3.	Reduce disparities in infant mortality.	New	In ND, the American Indian infant death rate (15 per 1,000) is about 4 times greater than that of the White infant death rate (4 per 1,000). Significant differences exist in infant deaths between races. Infants born to American Indian mothers are at much higher risk for poor birth outcomes, including being born too early, being born at low birth weight and to die in the first year of life.

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
4.	Reduce fatal motor vehicle crash deaths to adolescents.	New	In ND in the past three years, unintentional injuries among ages 15 through 24 due to motor vehicle crashes ranged from about 19 to 27 per 100,000. Motor vehicle crashes are the number one killer of teenagers; young drivers are twice as likely as adult drivers to be in a fatal crash. Motor vehicle crashes are preventable and proven strategies can improve the safety of young drivers on the road.
5.	Reduce overweight and obesity in children.	Continued	In ND, about 36 percent of children and teenagers between ages 10 through 17 are considered overweight to obese, compared to 31 percent nationally. There are many reasons for childhood obesity including poor food choices and reduced physical activity. Children that are overweight have an increased risk for heart disease, diabetes, asthma, and low-self-esteem.

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
6.	Increase the utilization of medical home.	Continued	<p>In ND, about 48 percent of families of children with special health care needs (less than half), ages 0 to 18, report having received coordinated, ongoing, comprehensive care within a medical home. A medical home means a child has a personal doctor or nurse as a usual source of care, gets needed referrals, receives effective care coordination, and assures families are actively involved in their child's care. Children with a medical home are more likely to receive preventive care, are less likely to be hospitalized, and are more likely to be diagnosed early for chronic or disabling conditions.</p>
7.	Increase the number of children with special health care needs receiving transition support.	New	<p>In ND, about 47 percent of parents of children with special healthcare needs (less than half) report having adequate resources for their child's transition into adulthood. Transition to adulthood is a critical developmental period. Children who do not receive transition services are more likely to have unmet health needs as adults. Transition includes discussions about adult doctors, changing health needs, health insurance, and appropriate self-care and management.</p>

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
8.	Increase preventative dental services to children.	New	<p>In ND, about 42 percent of Early Periodic Screening Diagnostic and Treatment-eligible children ages 6 through 9 (less than half) reported having received any dental services. Oral health is an important component of overall health throughout life and is a great unmet health need among certain population groups within the state. People with limited access to oral health care are at greater risk for chronic diseases.</p>

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

**Form 10a
National Outcome Measures (NOMs)**

State: North Dakota

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	76.7 %	0.4 %	8,396	10,950
2013	74.5 %	0.4 %	7,693	10,327
2012	73.2 %	0.5 %	7,193	9,822
2011	72.7 %	0.5 %	6,776	9,327
2010	74.3 %	0.5 %	6,528	8,792
2009	75.1 %	0.5 %	6,559	8,729

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	128.2	11.3 %	131	10,219
2012	121.4	11.0 %	123	10,133
2011	141.1	12.0 %	140	9,921

Legends:

- 📄 Indicator has a numerator ≤ 10 and is not reportable
- ⚡ Indicator has a numerator < 20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2010_2014	NR 	NR 	NR 	NR 
2009_2013	NR 	NR 	NR 	NR 
2008_2012	23.6 	7.1 % 	11 	46,676 

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.2 %	0.2 %	704	11,359
2013	6.4 %	0.2 %	679	10,597
2012	6.2 %	0.2 %	625	10,104
2011	6.7 %	0.3 %	637	9,523
2010	6.7 %	0.3 %	607	9,103
2009	6.4 %	0.3 %	572	9,000

Legends:

- 📄 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.1 - Notes:

None

Data Alerts: None

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.0 %	0.1 %	116	11,359
2013	1.2 %	0.1 %	126	10,597
2012	1.1 %	0.1 %	115	10,104
2011	1.1 %	0.1 %	105	9,523
2010	1.2 %	0.1 %	105	9,103
2009	1.2 %	0.1 %	112	9,000

Legends:

- 📄 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.2 - Notes:

None

Data Alerts: None

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.2 %	0.2 %	588	11,359
2013	5.2 %	0.2 %	553	10,597
2012	5.1 %	0.2 %	510	10,104
2011	5.6 %	0.2 %	532	9,523
2010	5.5 %	0.2 %	502	9,103
2009	5.1 %	0.2 %	460	9,000

Legends:

- 📄 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.3 - Notes:

None

Data Alerts: None

NOM 5.1 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	8.4 %	0.3 %	948	11,353
2013	8.5 %	0.3 %	902	10,593
2012	9.1 %	0.3 %	918	10,103
2011	8.5 %	0.3 %	805	9,526
2010	9.8 %	0.3 %	887	9,102
2009	9.2 %	0.3 %	826	8,997

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.1 - Notes:

None

Data Alerts: None

NOM 5.2 - Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	2.2 %	0.1 %	247	11,353
2013	2.4 %	0.2 %	249	10,593
2012	2.3 %	0.2 %	231	10,103
2011	2.4 %	0.2 %	229	9,526
2010	2.4 %	0.2 %	219	9,102
2009	2.4 %	0.2 %	214	8,997

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.2 - Notes:

None

Data Alerts: None

NOM 5.3 - Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.2 %	0.2 %	701	11,353
2013	6.2 %	0.2 %	653	10,593
2012	6.8 %	0.3 %	687	10,103
2011	6.1 %	0.2 %	576	9,526
2010	7.3 %	0.3 %	668	9,102
2009	6.8 %	0.3 %	612	8,997

Legends:

- 📄 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.3 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	23.0 %	0.4 %	2,605	11,353
2013	22.3 %	0.4 %	2,357	10,593
2012	24.8 %	0.4 %	2,500	10,103
2011	25.2 %	0.4 %	2,397	9,526
2010	26.6 %	0.5 %	2,424	9,102
2009	28.8 %	0.5 %	2,595	8,997

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	4.0 %			
2013/Q3-2014/Q2	4.0 %			
2013/Q2-2014/Q1	6.0 %			

Legends:
📅 Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.6	0.8 %	70	10,627
2012	5.5	0.7 %	56	10,136
2011	6.8	0.9 %	65	9,561
2010	7.2	0.9 %	66	9,133
2009	5.2	0.8 %	47	9,026

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.0	0.8 %	64	10,599
2012	6.3	0.8 %	64	10,106
2011	6.5	0.8 %	62	9,527
2010	6.8	0.9 %	62	9,104
2009	6.3	0.8 %	57	9,001

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.7	0.7 %	50	10,599
2012	3.3	0.6 %	33	10,106
2011	4.0	0.7 %	38	9,527
2010	5.1	0.8 %	46	9,104
2009	3.3	0.6 %	30	9,001

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.3 ⚡	0.4 % ⚡	14 ⚡	10,599 ⚡
2012	3.1	0.6 %	31	10,106
2011	2.5	0.5 %	24	9,527
2010	1.8 ⚡	0.4 % ⚡	16 ⚡	9,104 ⚡
2009	3.0	0.6 %	27	9,001

Legends:
 📌 Indicator has a numerator <10 and is not reportable
 ⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	235.9	47.2 %	25	10,599
2012	158.3 ⚡	39.6 % ⚡	16 ⚡	10,106 ⚡
2011	147.0 ⚡	39.3 % ⚡	14 ⚡	9,527 ⚡
2010	164.8 ⚡	42.6 % ⚡	15 ⚡	9,104 ⚡
2009	122.2 ⚡	36.9 % ⚡	11 ⚡	9,001 ⚡

Legends:
 📄 Indicator has a numerator <10 and is not reportable
 ⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	94.4 ⚡	29.9 % ⚡	10 ⚡	10,599 ⚡
2012	197.9	44.3 %	20	10,106
2011	167.9 ⚡	42.0 % ⚡	16 ⚡	9,527 ⚡
2010	109.8 ⚡	34.8 % ⚡	10 ⚡	9,104 ⚡
2009	166.7 ⚡	43.1 % ⚡	15 ⚡	9,001 ⚡

Legends:
 📄 Indicator has a numerator <10 and is not reportable
 ⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

FAD Not Available for this measure.

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	8.1	0.9 %	83	10,219
2012	5.1	0.7 %	52	10,133
2011	3.4	0.6 %	34	9,921

Legends:
 Indicator has a numerator ≤ 10 and is not reportable
 Indicator has a numerator < 20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	13.8 %	1.2 %	19,115	138,430

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	18.1 ⚡	4.5 % ⚡	16 ⚡	88,621 ⚡
2013	20.0 ⚡	4.8 % ⚡	17 ⚡	85,223 ⚡
2012	17.4 ⚡	4.7 % ⚡	14 ⚡	80,401 ⚡
2011	22.0 ⚡	5.3 % ⚡	17 ⚡	77,351 ⚡
2010	17.2 ⚡	4.8 % ⚡	13 ⚡	75,740 ⚡
2009	18.9 ⚡	5.1 % ⚡	14 ⚡	73,913 ⚡

Legends:
 📄 Indicator has a numerator <10 and is not reportable
 ⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	30.4	5.7 %	28	92,162
2013	39.8	6.6 %	36	90,573
2012	46.8	7.3 %	41	87,701
2011	44.5	7.1 %	39	87,706
2010	48.1	7.4 %	42	87,264
2009	50.0	7.5 %	44	88,015

Legends:
📄 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	22.7	3.9 %	33	145,625
2011_2013	26.3	4.3 %	38	144,479
2010_2012	26.6	4.3 %	38	143,039
2009_2011	24.4	4.1 %	35	143,509
2008_2010	24.3	4.1 %	35	144,259
2007_2009	30.1	4.5 %	44	146,356

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	20.6	3.8 %	30	145,625
2011_2013	19.4	3.7 %	28	144,479
2010_2012	21.7	3.9 %	31	143,039
2009_2011	24.4	4.1 %	35	143,509
2008_2010	20.8	3.8 %	30	144,259
2007_2009	16.4	3.4 %	24	146,356

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	18.2 %	1.4 %	27,441	150,969
2007	18.2 %	1.1 %	25,997	142,697
2003	16.7 %	1.0 %	24,466	146,143

Legends:

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	18.2 %	2.0 %	3,321	18,206

Legends:

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	1.1 %	0.4 %	1,385	122,025
2007	0.8 %	0.2 %	934	115,631

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	8.4 %	1.1 %	10,243	121,701
2007	6.9 %	0.8 %	8,024	115,703

Legends:

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	85.9 %	4.0 %	9,115	10,608
2007	73.1 %	4.9 %	6,283	8,595
2003	67.3 % ⚡	5.9 % ⚡	5,987 ⚡	8,901 ⚡

Legends:
 🚩 Indicator has an unweighted denominator <30 and is not reportable
 ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	91.4 %	1.0 %	137,914	150,969
2007	90.6 %	0.9 %	129,226	142,697
2003	90.8 %	0.8 %	132,651	146,143

Legends:

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	35.9 %	2.5 %	23,091	64,415
2007	25.7 %	1.7 %	16,479	64,127
2003	26.9 %	1.8 %	17,962	66,685

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	30.5 %	0.7 %	1,489	4,886

Legends:
 Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	28.6 %	1.2 %	8,429	29,490
2011	25.5 %	1.4 %	7,541	29,604
2009	24.4 %	1.1 %	7,414	30,430
2007	23.4 %	1.3 %	7,469	31,919
2005	23.9 %	1.3 %	7,797	32,686

Legends:

 Indicator has an unweighted denominator <100 and is not reportable

 Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.7 %	1.1 %	11,198	167,227
2013	7.7 %	1.2 %	12,249	160,051
2012	7.4 %	1.2 %	11,393	153,362
2011	7.6 %	1.1 %	11,464	151,192
2010	6.6 %	1.0 %	9,910	149,865
2009	6.3 %	0.9 %	8,879	142,087

Legends:

- 📄 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	71.3 %	3.6 %	10,474	14,686
2013	72.0 %	3.2 %	9,726	13,504
2012	72.2 %	3.7 %	9,299	12,880
2011	79.1 %	3.5 %	10,187	12,874
2010	65.8 %	3.2 %	8,384	12,752
2009	43.4 %	3.7 %	5,071	11,678

Legends:

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
-  Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2015	62.0 %	2.8 %	91,358	147,470
2013_2014	63.0 %	2.4 %	89,232	141,667
2012_2013	62.2 %	2.6 %	88,228	141,914
2011_2012	53.7 %	2.9 %	71,887	133,968
2010_2011	53.9 %	3.5 %	72,959	135,359
2009_2010	46.4 %	4.1 %	67,497	145,468

Legends:

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
-  Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	60.9 %	4.8 %	12,447	20,442
2013	57.6 %	4.8 %	11,517	20,013
2012	60.3 %	5.0 %	11,935	19,805
2011	51.2 % ⚡	6.4 % ⚡	10,632 ⚡	20,771 ⚡
2010	41.7 %	4.3 %	8,567	20,541
2009	45.1 %	4.8 %	9,087	20,147

Legends:
 🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
 ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	37.6 %	4.6 %	8,054	21,438
2013	36.1 %	4.7 %	7,554	20,947
2012	18.6 %	3.8 %	3,836	20,621
2011	NR 🚩	NR 🚩	NR 🚩	NR 🚩

Legends:
 🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
 ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	92.1 %	2.0 %	38,582	41,880
2013	95.0 %	1.5 %	38,912	40,960
2012	89.6 %	2.6 %	36,201	40,425
2011	87.5 %	3.1 %	37,250	42,592
2010	83.1 %	2.4 %	35,143	42,273
2009	71.7 %	3.0 %	29,669	41,411

Legends:

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
-  Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	91.8 %	1.7 %	38,445	41,880
2013	93.7 %	1.7 %	38,380	40,960
2012	88.1 %	2.5 %	35,608	40,425
2011	84.2 %	3.5 %	35,867	42,592
2010	76.8 %	2.6 %	32,448	42,273
2009	66.0 %	3.2 %	27,342	41,411

Legends:

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
-  Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)
State: North Dakota

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	65.0	67.0	68.0	70.0	72.0	74.0

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2014	65.7 %	2.3 %	84,849	129,167	
2013	63.3 %	2.0 %	77,756	122,881	
2012	61.9 %	2.3 %	73,568	118,853	
2011	61.0 %	2.2 %	71,296	116,806	
2010	67.4 %	2.4 %	75,079	111,459	
2009	68.0 %	2.4 %	76,095	111,856	

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** 2016

Field Note:

2014- The data source is Behavioral Risk Factor Surveillance System (BRFSS).

NPM 4 - A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	84.0	85.0	86.0	87.0	88.0	90.0

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	79.4 %	2.9 %	8,196	10,329
2011	82.4 %	2.7 %		
2010	85.9 %	2.6 %		
2009	75.7 %	3.4 %		
2008	72.5 %	2.8 %		
2007	75.2 %	2.8 %		

Legends:

-  Indicator has an unweighted denominator <50 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** 2016

Field Note:

2014- The data source is National Immunization Survey (NIS).

NPM 4 - B) Percent of infants breastfed exclusively through 6 months

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	23.0	24.0	25.0	26.0	27.0	28.0

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	21.0 %	2.9 %	2,090	9,977
2011	22.5 %	2.9 %		
2010	15.6 %	2.7 %		
2009	15.6 %	2.7 %		
2008	19.2 %	2.2 %		
2007	15.3 %	2.3 %		

Legends:

-  Indicator has an unweighted denominator <50 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2016
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Field Note:

2014- The data source is National Immunization Survey (NIS).

NPM 5 - Percent of infants placed to sleep on their backs

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	70.5	72.0	73.5	75.0	76.5	77.0

FAD not available for this measure.

Field Level Notes for Form 10a NPMs:

1. **Field Name:** 2016

Field Note:

2014- The data source is Pregnancy Risk Assessment Monitoring System (PRAMS).

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Adolescent Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	294.0	288.0	282.0	276.0	270.0	264.0

Data Source: State Inpatient Databases (SID) - ADOLESCENT

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	319.6	18.9 %	286	89,495
2012	350.2	19.1 %	335	95,649
2011	401.8	20.9 %	370	92,080

Legends:
 Indicator has a numerator ≤10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** 2016

Field Note:

2014-The data source is State Inpatient Databases (SID); and the U.S. Census Bureau.

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	40.0	41.0	42.0	43.0	44.0	45.0

Data Source: National Survey of Children's Health (NSCH) - CHILD

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	38.9 %	3.0 %	19,367	49,796
2007	35.7 %	2.6 %	15,248	42,662
2003	32.6 %	2.3 %	16,044	49,253

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2016
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Field Note:

2014- The data source is the National Survey of Children's Health (NSCH). The revised NSCH will capture physical activity of at least 60 minutes per day with baseline NSCH data reflecting at least 20 minutes per day.

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	50.0	52.0	54.0	56.0	58.0	60.0

Data Source: National Survey of Children's Health (NSCH) - CSHCN

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	48.6 %	4.1 %	13,294	27,361
2007	58.4 %	3.3 %	14,912	25,546

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	64.9 %	1.9 %	78,482	120,928
2007	65.2 %	1.5 %	73,190	112,208

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** 2016

Field Note:

2014- The data source is the National Survey of Children's Health (NSCH).

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	47.0	48.0	49.0	50.0	51.0	52.0

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	46.5 %	3.5 %	4,021	8,641
2005_2006	51.2 %	3.0 %	3,651	7,125

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** 2016

Field Note:

2014-North Dakota used data from the 2009-2010 National Survey of Children with Special Healthcare (Needs NS-CSHCN) as a baseline. The revised National Survey of Children's Health (NSCH) beginning in 2017 will provide future data for NPM12.

NPM 13 - A) Percent of women who had a dental visit during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

FAD not available for this measure.

Field Level Notes for Form 10a NPMs:

None

NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	76.5	78.5	80.5	82.5	84.5	86.5

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	74.6 %	1.6 %	103,221	138,391
2007	77.2 %	1.2 %	102,309	132,482

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)
State: North Dakota

SPM 1 - Decrease depressive symptoms in adolescents.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	23.0	21.0	19.0	17.0	15.0

Field Level Notes for Form 10a SPMs:

1.	Field Name:	2017
Field Note:		
2014-The source for this data is selected weighted CDC data from the North Dakota 2013 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of North Dakota high school students who answer "yes" to survey question #23 on the YRBS. The denominator is the total weighted number of high school students (grades 9-12) who completed the YRBS survey question #23.		

SPM 2 - Increase adequate insurance coverage to the MCH population.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	78.0	80.0	82.0	84.0	86.0

Field Level Notes for Form 10a SPMs:

1.	Field Name:	2017
Field Note:		
2014-The source of this data is the 2011/2012 National Survey of Children's Health (NSCH). The numerator is the weighted estimate of children, ages 0 through 17, who were reported to be adequately insured, based on 3 criteria: whether their children's insurance covers needed services and providers, and reasonably covers costs. If a parent answered "always" or "usually" The denominator is the weighted estimate of North Dakota children ages 0 through 17 years.		

SPM 3 - Implement North Dakota state mandates delegated to North Dakota Department of Health Title V / Maternal and Child Health Program.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a SPMs:

None

Form 10a
State Outcome Measures (SOMs)
State: North Dakota

SOM 1 - The ratio of the American Indian infant mortality rate to the White infant mortality rate per 1,000.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	3.8	3.7	3.6	3.5	3.4

Field Level Notes for Form 10a SOMs:

1. **Field Name:** 2017

Field Note:

2017-The source of the numerator and denominator is the North Dakota Department of Health, Division of Vital Statistics. The numerator is the three-year infant mortality rate per 1,000 of American Indian infants. The denominator is the three-year infant mortality rate per 1,000 of White infants. The data is expressed as a ratio.

Form 10a
Evidence-Based or-Informed Strategy Measures (ESMs)

State: North Dakota

ESM 1.1 - Number of partnerships established to assist with the integration of tobacco cessation and prevention activities for pregnant women and women of reproductive age.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	11.0	12.0	13.0	14.0

Field Level Notes for Form 10a ESMs:

-
1. **Field Name:** **2017**
-
- Field Note:**
Data Sources: North Dakota Department of Health, Smoking Cessation Partnership List – maintained by the Optimal Pregnancy Outcome Program Director
Data Limitations: Partner buy-in, funding, and program capacity.
-
2. **Field Name:** **2018**
-
- Field Note:**
Data Sources: North Dakota Department of Health, Smoking Cessation Partnership List – maintained by the Optimal Pregnancy Outcome Program Director
Data Limitations: Partner buy-in, funding, and program capacity.
-
3. **Field Name:** **2019**
-
- Field Note:**
Data Sources: North Dakota Department of Health, Smoking Cessation Partnership List – maintained by the Optimal Pregnancy Outcome Program Director
Data Limitations: Partner buy-in, funding, and program capacity.
-
4. **Field Name:** **2020**
-
- Field Note:**
Data Sources: North Dakota Department of Health, Smoking Cessation Partnership List – maintained by the Optimal Pregnancy Outcome Program Director
Data Limitations: Partner buy-in, funding, and program capacity.
-
5. **Field Name:** **2021**

Field Note:

Data Sources: North Dakota Department of Health, Smoking Cessation Partnership List – maintained by the Optimal Pregnancy Outcome Program Director

Data Limitations: Partner buy-in, funding, and program capacity.

ESM 4.1 - Number of North Dakota hospitals that are designated as North Dakota Breastfeeding-Friendly.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	6.0	8.0	10.0	12.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** 2017

Field Note:

Data Source: North Dakota Department of Health Breastfeeding website: North Dakota Breastfeeding Friendly Application: <http://www.ndhealth.gov/breastfeeding/?id=78>

2. **Field Name:** 2018

Field Note:

Data Source: North Dakota Department of Health Breastfeeding website: North Dakota Breastfeeding Friendly Application: <http://www.ndhealth.gov/breastfeeding/?id=78>

3. **Field Name:** 2019

Field Note:

Data Source: North Dakota Department of Health Breastfeeding website: North Dakota Breastfeeding Friendly Application: <http://www.ndhealth.gov/breastfeeding/?id=78>

4. **Field Name:** 2020

Field Note:

Data Source: North Dakota Department of Health Breastfeeding website: North Dakota Breastfeeding Friendly Application: <http://www.ndhealth.gov/breastfeeding/?id=78>

5. **Field Name:** 2021

Field Note:

Data Source: North Dakota Department of Health Breastfeeding website: North Dakota Breastfeeding Friendly Application: <http://www.ndhealth.gov/breastfeeding/?id=78>

ESM 5.1 - Number of hospitals that have implemented safe infant sleep polices.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	4.0	6.0	8.0	12.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2017			
	Field Note:	Data Source: North Dakota Department of Health – Survey of Birthing Hospitals Survey data maintained by the Infant and Child Death Services Program Director.			
2.	Field Name:	2018			
	Field Note:	.Data Source: North Dakota Department of Health – Survey of Birthing Hospitals Survey data maintained by the Infant and Child Death Services Program Director.			
3.	Field Name:	2019			
	Field Note:	Data Source: North Dakota Department of Health – Survey of Birthing Hospitals Survey data maintained by the Infant and Child Death Services Program Director.			
4.	Field Name:	2020			
	Field Note:	Data Source: North Dakota Department of Health – Survey of Birthing Hospitals Survey data maintained by the Infant and Child Death Services Program Director.			
5.	Field Name:	2021			
	Field Note:	Data Source: North Dakota Department of Health – Survey of Birthing Hospitals Survey data maintained by the Infant and Child Death Services Program Director.			

ESM 7.1 - Number of certified child passenger safety technician proxies in North Dakota.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	12.0	14.0	16.0	20.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2017
	Field Note:	Data Source: Safe Kids National CPS Certification Program: http://cert.safekids.org/
2.	Field Name:	2018
	Field Note:	Data Source: Safe Kids National CPS Certification Program: http://cert.safekids.org/
3.	Field Name:	2019
	Field Note:	Data Source: Safe Kids National CPS Certification Program: http://cert.safekids.org/
4.	Field Name:	2020
	Field Note:	Data Source: Safe Kids National CPS Certification Program: http://cert.safekids.org/
5.	Field Name:	2021
	Field Note:	Data Source: Safe Kids National CPS Certification Program: http://cert.safekids.org/

ESM 8.1 - Numbers of schools maternal and child health (MCH) grantees are working in to reduce overweight and obesity in North Dakota children.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	21.0	32.0	43.0	54.0	65.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2017
	Field Note:	Data Source: North Dakota Department of Health – Program Reporting System (Family Health – Title V Maternal and Child Health Block Grant)
2.	Field Name:	2018
	Field Note:	Data Source: North Dakota Department of Health – Program Reporting System (Family Health – Title V Maternal and Child Health Block Grant)
3.	Field Name:	2019

Field Note:

Data Source: North Dakota Department of Health – Program Reporting System (Family Health – Title V Maternal and Child Health Block Grant)

4. **Field Name:** 2020

Field Note:

Data Source: North Dakota Department of Health – Program Reporting System (Family Health – Title V Maternal and Child Health Block Grant)

5. **Field Name:** 2021

Field Note:

Data Source: North Dakota Department of Health – Program Reporting System (Family Health – Title V Maternal and Child Health Block Grant)

ESM 11.1 - Number of individuals who have received education and training on care coordination for CSHCN.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	30.0	35.0	40.0	45.0	50.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** 2017

Field Note:

Data Source: List of individuals who have attended CSHCN care coordination education and training opportunities.

2. **Field Name:** 2018

Field Note:

Data Source: List of individuals who have attended CSHCN care coordination education and training opportunities.

3. **Field Name:** 2019

Field Note:

Data Source: List of individuals who have attended CSHCN care coordination education and training opportunities.

4. **Field Name:** 2020

Field Note:

Data Source: List of individuals who have attended CSHCN care coordination education and training opportunities.

5. **Field Name:** **2021**

Field Note:

Data Source: List of individuals who have attended CSHCN care coordination education and training opportunities.

ESM 12.1 - Number of individuals who have received education and training on healthcare transition.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	30.0	35.0	40.0	45.0	50.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

Field Note:

Data Source: List of individuals who have attended care coordination education and training opportunities.

2. **Field Name:** **2018**

Field Note:

Data Source: List of individuals who have attended care coordination education and training opportunities.

3. **Field Name:** **2019**

Field Note:

Data Source: List of individuals who have attended care coordination education and training opportunities.

4. **Field Name:** **2020**

Field Note:

Data Source: List of individuals who have attended care coordination education and training opportunities.

5. **Field Name:** **2021**

Field Note:

Data Source: List of individuals who have attended care coordination education and training opportunities.

ESM 13.1 - Number of children that receive dental sealants per school year.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	1,595.0	1,695.0	1,795.0	1,895.0	1,995.0

Field Level Notes for Form 10a ESMs:

-
1. **Field Name:** 2017
-
- Field Note:**
Data Source: North Dakota Department of Health – Oral Health Program – Seal!ND School-based Sealant Program Database.
-
2. **Field Name:** 2018
-
- Field Note:**
Data Source: North Dakota Department of Health – Oral Health Program – Seal!ND School-based Sealant Program Database.
-
3. **Field Name:** 2019
-
- Field Note:**
Data Source: North Dakota Department of Health – Oral Health Program – Seal!ND School-based Sealant Program Database.
-
4. **Field Name:** 2020
-
- Field Note:**
Data Source: North Dakota Department of Health – Oral Health Program – Seal!ND School-based Sealant Program Database.
-
5. **Field Name:** 2021
-
- Field Note:**
Data Source: North Dakota Department of Health – Oral Health Program – Seal!ND School-based Sealant Program Database.

Form 10b
State Performance Measure (SPM) Detail Sheets
State: North Dakota

SPM 1 - Decrease depressive symptoms in adolescents.

Population Domain(s) – Adolescent Health

Goal:	Decrease depressive symptoms among adolescents by promoting optimal mental health and social-emotional development.								
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>The weighted number of high school students (grades 9 through 12) who answer “yes” to survey question QN#23 on YRBS (High School).</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Total weighted number of high school students (grades 9 through 12) who completed the YRBS (High School) survey question QN#23.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	The weighted number of high school students (grades 9 through 12) who answer “yes” to survey question QN#23 on YRBS (High School).	Denominator:	Total weighted number of high school students (grades 9 through 12) who completed the YRBS (High School) survey question QN#23.	Unit Type:	Percentage	Unit Number:	100
Numerator:	The weighted number of high school students (grades 9 through 12) who answer “yes” to survey question QN#23 on YRBS (High School).								
Denominator:	Total weighted number of high school students (grades 9 through 12) who completed the YRBS (High School) survey question QN#23.								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	<p>HP2020 Objective:</p> <p>MHMD-4.1 Reduce the proportion of adolescents aged 12 to 17 years who experience major depressive episodes (MDEs)</p>								
Data Sources and Data Issues:	North Dakota Youth Risk Behavior Survey (YRBS).								
Significance:	<p>One of the leading causes of depression is bullying. In ND, about 25% of adolescents (1 in 4) report having depressive symptoms (feeling sad and/or hopeless) and/or being bullied in the past 12 months. Mental/behavioral health conditions have been increasing among children. Bullying is a major public health problem that may contribute to depression, antisocial behavior, suicidal thoughts, poor school performance, etc.</p> <p>According to the 2011/ 2012 National Survey of Children's Health (NSCH), 86.3 percent of ND children (ages 2 through 17) requiring counseling received mental health care treatment or counseling in the past year compared to the U.S. which was at 60 percent. Early identification and intervention of mental health issues is critical in this population.</p>								

SPM 2 - Increase adequate insurance coverage to the MCH population.

Population Domain(s) – Cross-Cutting/Life Course

Goal:	To ensure access to needed health care services.									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of children, ages 0 through 17, who were reported in the NSCH to be adequately insured, based on 3 criteria: whether their children’s insurance covers needed services, providers, and reasonably covers costs.</td> </tr> <tr> <td>Denominator:</td> <td>Number of children, ages 0 through 17</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of children, ages 0 through 17, who were reported in the NSCH to be adequately insured, based on 3 criteria: whether their children’s insurance covers needed services, providers, and reasonably covers costs.	Denominator:	Number of children, ages 0 through 17	Unit Type:	Percentage	Unit Number:	100	
Numerator:	Number of children, ages 0 through 17, who were reported in the NSCH to be adequately insured, based on 3 criteria: whether their children’s insurance covers needed services, providers, and reasonably covers costs.									
Denominator:	Number of children, ages 0 through 17									
Unit Type:	Percentage									
Unit Number:	100									
Healthy People 2020 Objective:	<p>HP2020 Objectives: Access to Health Services (AHS) Objective 1: Increase the proportion of persons with health insurance Access to Health Services (AHS) Objective 6: Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines</p>									
Data Sources and Data Issues:	National Survey of Children's Health (NSCH)									
Significance:	<p>There is a well-documented benefit for children in having health insurance. Research has shown that children who acquire health insurance are more likely to have access to a usual source of care, receive well-child care and immunizations and have developmental milestones monitored. They are also more likely to receive prescription drugs and appropriate care for asthma and basic dental services. Additionally, serious childhood problems are more likely to be identified early in children with insurance, and insured children with special health care needs are more likely to have access to specialists. Insured children not only receive more timely diagnosis of serious health care conditions but experience fewer avoidable hospitalizations, improved asthma outcomes and fewer missed school days.</p> <p>Almost one-quarter of American children with continuous insurance coverage are not adequately insured. Inadequately insured children are more likely to have delayed or forgone care, lack a medical home, are less likely to receive needed referrals and care coordination, and/or receive family-centered care. The American Academy of Pediatrics highlighted the importance of this issue with a policy statement. The major problems cited were cost-sharing requirements that are too high, benefit limitations, and inadequate coverage of needed services.</p>									

SPM 3 - Implement North Dakota state mandates delegated to North Dakota Department of Health Title V / Maternal and Child Health Program.

Population Domain(s) – Cross-Cutting/Life Course

Goal:	North Dakota state mandates delegated to the North Dakota Department of Health Title V / Maternal and Child Health Program are implemented.									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>North Dakota Title V/Maternal Child Health mandates implemented.</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable</td> </tr> <tr> <td>Unit Type:</td> <td>Text</td> </tr> <tr> <td>Unit Number:</td> <td>Yes/No</td> </tr> </table>		Numerator:	North Dakota Title V/Maternal Child Health mandates implemented.	Denominator:	Not applicable	Unit Type:	Text	Unit Number:	Yes/No
Numerator:	North Dakota Title V/Maternal Child Health mandates implemented.									
Denominator:	Not applicable									
Unit Type:	Text									
Unit Number:	Yes/No									
Healthy People 2020 Objective:	<p>HP2020 Objectives:</p> <p>MICH-1.9 Reduce the rate of infant deaths from sudden unexpected infant deaths (includes SIDS, Unknown Cause, Accidental Suffocation, and Strangulation in Bed).</p> <p>MICH-26 Reduce the proportion of children diagnosed with a disorder through newborn blood spot screening who experience developmental delay requiring special education services.</p> <p>PHI-13 Increase the proportion of Tribal, State, and local public health agencies that provide or assure comprehensive epidemiology services to support essential public health services.</p> <p>MICH-31 Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems</p>									
Data Sources and Data Issues:	North Dakota Century Code, North Dakota Administrative Code for the North Dakota Department of Health, and the Title V/Maternal and Child Health Program.									
Significance:	<p>Priorities are often influenced by state mandates, which in turn, are generally reflective of expressed need within the state over time. Inclusion of these mandates epitomizes the successful federal/state partnership by honoring a state’s unique priorities. ND has several mandates addressing the health of the MCH population that direct Title V work efforts and require use of significant resources for successful implementation. A list of these mandates can be found in Supporting Document #02, Title V-MCH State Mandates.</p>									

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: North Dakota

SOM 1 - The ratio of the American Indian infant mortality rate to the White infant mortality rate per 1,000.
Population Domain(s) – Perinatal/Infant Health

Goal:	Decrease the infant mortality between American Indian infants and White infants.									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>The three-year infant mortality rate per 1,000 of American Indian infants.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>The three-year infant mortality rate per 1,000 of White infants.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Ratio</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>1</td> </tr> </table>		Numerator:	The three-year infant mortality rate per 1,000 of American Indian infants.	Denominator:	The three-year infant mortality rate per 1,000 of White infants.	Unit Type:	Ratio	Unit Number:	1
Numerator:	The three-year infant mortality rate per 1,000 of American Indian infants.									
Denominator:	The three-year infant mortality rate per 1,000 of White infants.									
Unit Type:	Ratio									
Unit Number:	1									
Healthy People 2020 Objective:	<p>HP2020 Objectives:</p> <p>MICH-1 Reduce the rate of fetal and infant deaths</p> <p>MICH-1.1 Reduce the rate of fetal deaths at 20 or more weeks of gestation</p> <p>MICH-1.2 Reduce the rate of fetal and infant deaths during perinatal period (28 weeks of gestation to 7 days after birth)</p> <p>MICH-1.3 Reduce the rate of all infant deaths (within 1 year)</p> <p>MICH-1.4 Reduce the rate of neonatal deaths (within the first 28 days of life)</p> <p>MICH-1.5 Reduce the rate of postneonatal deaths (between 28 days and 1 year)</p> <p>MICH-1.6 Reduce the rate of infant deaths related to birth defects (all birth defects)</p> <p>MICH-1.7 Reduce the rate of infant deaths related to birth defects (congenital heart defects)</p> <p>MICH-1.8 Reduce the rate of infant deaths from sudden infant death syndrome (SIDS)</p> <p>MICH-1.9 Reduce the rate of infant deaths from sudden unexpected infant deaths (includes SIDS, Unknown Cause, Accidental Suffocation, and Strangulation in Bed)</p>									
Data Sources and Data Issues:	The North Dakota Department of Health, Division of Vital Records. A 3-year rolling average was used to determine the numerator and denominator.									
Significance:	<p>The overall 3-year infant mortality rate for 2014 was 5 per 1,000. However, for every 1 White infant death, there are 3 American Indian infant deaths. The infant mortality rate per 1,000 within the American Indian population has been decreasing from 18 in 2011 to 13, per 1,000 in 2014, as has the White infant mortality rate per 1,000 which was 5.3 in 2011 and 4.1 in 2014.</p> <p>Health disparities are caused by an assortment of factors. Individual behavior is very important, but the social determinants of health framework recognizes that our social and physical environments also profoundly impact our ability to experience good health. The federal Healthy People 2020 initiative for improving population health</p>									



examines social determinants of health in five key areas: economic stability, education, social and community context, health and health care, and neighborhood and built environment.

Traumatic events during infancy and childhood, termed adverse childhood experiences, also contribute to health problems as an adult. Additionally, inter-generational impacts of historical trauma and disruption of cultural practices significantly influence the health of American Indians.

While disparities can occur at every stage of the life course, health disparities for many American Indians begin prenatally, and among the vast majority of infants who live past their first year, these disparities can have long-lasting implications.

Several risk factors have been identified which can increase the chances of infant mortality, including birth defects, preterm birth, low birth weight, maternal complications during pregnancy, and injuries. Risk factors associated with poor birth outcomes include inadequate prenatal care; being a young mother; smoking, alcohol, and drug use during pregnancy; and gestational diabetes.

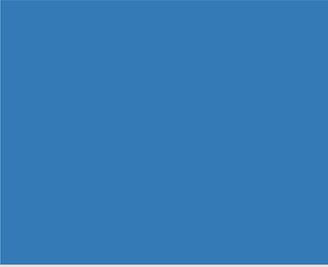
**Form 10c
Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheets**

State: North Dakota

ESM 1.1 - Number of partnerships established to assist with the integration of tobacco cessation and prevention activities for pregnant women and women of reproductive age.

NPM 1 – Percent of women with a past year preventive medical visit

Goal:	To decrease the number of pregnant women and women of reproductive age in North Dakota that use tobacco products.									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of current partners for the calendar year.</td> </tr> <tr> <td>Denominator:</td> <td>Expected number of partners by 2021</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>14</td> </tr> </table>		Numerator:	Number of current partners for the calendar year.	Denominator:	Expected number of partners by 2021	Unit Type:	Count	Unit Number:	14
Numerator:	Number of current partners for the calendar year.									
Denominator:	Expected number of partners by 2021									
Unit Type:	Count									
Unit Number:	14									
Data Sources and Data Issues:	<p>Data Sources: North Dakota Department of Health, Smoking Cessation Partnership List – maintained by the Optimal Pregnancy Outcome Program Director</p> <p>Data Limitations: Partner buy-in, funding, and program capacity</p>									
Significance:	<p>Partnerships between state programs, health care organizations, and public entities, as well as the public at large, are essential to reducing the rates of tobacco use in women of childbearing age. One important avenue for a woman to receive smoking cessation counseling includes well-woman or preconception visits. These visits provide a critical opportunity for women to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize her health before, between, and beyond potential pregnancies.</p> <p>A woman who is pregnant and smokes is more likely than other women to have a miscarriage, preterm birth, and a baby to be born with low birth weight. Birth weight is the single most important determinant of a newborn’s survival during the first year. Maternal smoking has been directly related to low birth weight. The risk of having a low-birth weight baby increases with the amount a woman smokes. In North Dakota in 2014, 89.3 percent of women abstained from smoking during pregnancy. The Healthy People 2020 goal is to have 98.6 percent of women abstaining from smoking while pregnant. American Indians (AI) are North Dakota’s largest minority population. An infant born to an American Indian mother (as compared to an infant born to a White mother) is 2.7 times more likely to be born to a mother who smoked.</p> <p>Smoking during and after pregnancy also increases the risk of an infant to die of Sudden Infant Death Syndrome. Babies born to women who smoke are also more</p>									



likely to have certain birth defects.

Increasing partnerships and sharing smoking cessation projects, strategies and programs, increases the ability to impact a larger number of women.

ESM 4.1 - Number of North Dakota hospitals that are designated as North Dakota Breastfeeding-Friendly. NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Goal:	To increase the number of North Dakota hospitals that are designated as North Dakota Breastfeeding-Friendly.									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of North Dakota birthing hospitals designated as Breastfeeding-Friendly.</td> </tr> <tr> <td>Denominator:</td> <td>Number of North Dakota birthing hospitals designated as Breastfeeding-Friendly by 2021.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>12</td> </tr> </table>	Numerator:	Number of North Dakota birthing hospitals designated as Breastfeeding-Friendly.	Denominator:	Number of North Dakota birthing hospitals designated as Breastfeeding-Friendly by 2021.	Unit Type:	Count	Unit Number:	12	
Numerator:	Number of North Dakota birthing hospitals designated as Breastfeeding-Friendly.									
Denominator:	Number of North Dakota birthing hospitals designated as Breastfeeding-Friendly by 2021.									
Unit Type:	Count									
Unit Number:	12									
Data Sources and Data Issues:	North Dakota Department of Health Breastfeeding website: North Dakota Breastfeeding Friendly Application: http://www.ndhealth.gov/breastfeeding/?id=78									
Significance:	<p>The advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Research demonstrates that breastfed children are less likely to die of sudden infant death syndrome (SIDS); may be less likely to develop juvenile diabetes; may have a lower risk of developing childhood obesity and asthma; and tend to have fewer dental cavities throughout life.</p> <p>Breastfeeding also has many positive effects for the mother as well, such as a lowered risk for breast and ovarian cancers, type 2 diabetes, and postpartum depression. Emotionally, mothers benefit from breastfeeding by forming a stronger bond with their baby.</p> <p>According to the National Immunization Survey, 20.95 percent of North Dakota (ND) mothers exclusively breastfed their infants at six months of age in 2012. The Healthy People (HP) 2020 goal for exclusively breastfed infants at 6 months is 25.5 percent.</p> <p>Supporting mothers in breastfeeding is an important strategy to increase breastfeeding rates. One resource proven to positively impact breastfeeding outcomes is The Ten Steps to Successful Breastfeeding for Hospitals, or Baby-Friendly Hospital Initiative. The “Ten Steps” are evidence-based practices which set the stage for success with breastfeeding. In 2014, the North Dakota Department of Health created the ND Breastfeeding-Friendly hospital designation to assist hospitals with implementing five of the ten Baby-Friendly Hospital steps.</p>									

ESM 5.1 - Number of hospitals that have implemented safe infant sleep policies.

NPM 5 – Percent of infants placed to sleep on their backs

Goal:	To increase the number of North Dakota hospitals that have implemented a safe infant sleep policy.									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of North Dakota hospitals that have a safe infant sleep policy in place.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Number of North Dakota hospitals with a safe infant sleep policy by 2021.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>12</td> </tr> </table>		Numerator:	Number of North Dakota hospitals that have a safe infant sleep policy in place.	Denominator:	Number of North Dakota hospitals with a safe infant sleep policy by 2021.	Unit Type:	Count	Unit Number:	12
Numerator:	Number of North Dakota hospitals that have a safe infant sleep policy in place.									
Denominator:	Number of North Dakota hospitals with a safe infant sleep policy by 2021.									
Unit Type:	Count									
Unit Number:	12									
Data Sources and Data Issues:	North Dakota Department of Health – Survey of Birthing Hospitals. Survey data maintained by the Infant and Child Death Services Program Director.									
Significance:	<p>Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position. However, in 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. Among others, additional higher-level recommendations include breastfeeding and avoiding smoke exposure during pregnancy and after birth. These expanded recommendations have formed the basis of the National Institute of Child Health and Development (NICHD) Safe to Sleep Campaign.</p> <p>Healthcare providers including hospital staff must role model implementation of safe sleep guidelines. It is essential that hospitals that provide care to mothers and infants institute strategies for education of hospital personnel and policies and procedures that promote safe infant sleep practices.</p>									

ESM 7.1 - Number of certified child passenger safety technician proxies in North Dakota.

NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Goal:	To increase the number of Certified Child Passenger Safety (CPS) technician proxies in North Dakota.									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of North Dakota CPS Technician Proxies.</td> </tr> <tr> <td>Denominator:</td> <td>Number of North Dakota CPS Technician Proxies by 2021.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>20</td> </tr> </table>		Numerator:	Number of North Dakota CPS Technician Proxies.	Denominator:	Number of North Dakota CPS Technician Proxies by 2021.	Unit Type:	Count	Unit Number:	20
Numerator:	Number of North Dakota CPS Technician Proxies.									
Denominator:	Number of North Dakota CPS Technician Proxies by 2021.									
Unit Type:	Count									
Unit Number:	20									
Data Sources and Data Issues:	Safe Kids National CPS Certification Program: http://cert.safekids.org/ Limitations: none									
Significance:	<p>Childhood injuries continue to be a leading cause of death to children in North Dakota (ND). In 2013, non-fatal injury hospitalization rates for children ages one through nine start at a high rate of 149.12 per 100,000 and increases as children get older and enter adolescence (ages 10-19) to 319.57 per 100,000. Motor vehicle crashes are the number one killer of teenagers; young drivers are twice as likely as adult drivers to be in a fatal crash. Motor vehicle crashes are preventable and proven strategies can improve the safety of young drivers on the road.</p> <p>ND has 231 nationally certified child passenger safety technicians throughout the state. In order to maintain the certification, child passenger safety technicians need to be observed by a qualified child passenger safety instructor or a proxy (a proxy can recertify technicians but they do not teach the certification curriculum). Currently, ND only has nine instructors and eight proxies. Access to these 17 professionals isn't always feasible; hence, the CPS Program plans to increase the number of CPS proxy's throughout the state in an effort to maintain the child passenger safety technician population and increase child passenger safety outreach.</p> <p>Providing ND communities' access to CPS Technicians through car seat checkups, child passenger safety presentations, and community resources will aid in decreasing car seat misuse and increase child restraint use. Beginning restraint use from birth consistently through seat belt use will increase the lifetime habit of buckling up. Increasing restraint use among adolescents will likely decrease the rates of non-fatal hospitalizations.</p>									

ESM 8.1 - Numbers of schools maternal and child health (MCH) grantees are working in to reduce overweight and obesity in North Dakota children.

NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	To increase the numbers of schools the MCH grantees are working with to reduce overweight and obesity in North Dakota children.									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of schools MCH grantees is working to reduce overweight and obesity in North Dakota children in the current year.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Number of schools MCH grantees is working to reduce overweight and obesity in North Dakota children in the current year.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>70</td> </tr> </table>		Numerator:	Number of schools MCH grantees is working to reduce overweight and obesity in North Dakota children in the current year.	Denominator:	Number of schools MCH grantees is working to reduce overweight and obesity in North Dakota children in the current year.	Unit Type:	Count	Unit Number:	70
Numerator:	Number of schools MCH grantees is working to reduce overweight and obesity in North Dakota children in the current year.									
Denominator:	Number of schools MCH grantees is working to reduce overweight and obesity in North Dakota children in the current year.									
Unit Type:	Count									
Unit Number:	70									
Data Sources and Data Issues:	North Dakota Department of Health – Program Reporting System (Family Health – Title V Maternal and Child Health Block Grant)									
Significance:	<p>A balanced diet and regular physical activity benefit the health of children and adults. Poor diet and physical inactivity contribute to many serious and costly health conditions including obesity, heart disease, diabetes, some types of cancer, unhealthy cholesterol and high blood pressure.</p> <p>According to the 2015 Youth Risk Behavior Survey (YRBS), 28.7 percent of North Dakota (ND) students in grades 9 through 12 had a body mass index (BMI) of 85 percent or greater (overweight and obese). This number has increased over time from 23.4 percent in 2007, to 24.4 percent in 2009, and 25.5 percent in 2011; however, was relatively unchanged from 2013 (28.6). The YRBS also indicated in 2015 that only 25.4 percent of ND students in grades 9 through 12 were physically active for a total of at least 60 minutes per day of the past seven days. Although low, this does represent a slight increase from the 2007 level of 21.8 percent. This number does increase when looking at the number of students in grades 9 through 12 that were physically active for at least 60 minutes per day for 5 or more days to 51.3 percent. The amount of time students are required to spend in a physical education (PE) course varies. In ND, elementary grades 1 through 6 must offer a minimum of 90 minutes of PE each week. Students in grades 9 through 12 must have at least one credit of PE, of which half can be health education.</p> <p>A strategy to reduce overweight and obesity in children is to provide targeted funding for the implementation of evidence-based strategies to reduce overweight and obesity in children by working within schools, child care facilities and communities.</p>									

ESM 11.1 - Number of individuals who have received education and training on care coordination for CSHCN.

NPM 11 – Percent of children with and without special health care needs having a medical home

Goal:	To increase the number of individuals who have received education and training on care coordination for CSHCN.									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of individuals who have received education and training on care coordination for CSHCN.</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>50</td> </tr> </table>		Numerator:	Number of individuals who have received education and training on care coordination for CSHCN.	Denominator:	Not applicable	Unit Type:	Count	Unit Number:	50
Numerator:	Number of individuals who have received education and training on care coordination for CSHCN.									
Denominator:	Not applicable									
Unit Type:	Count									
Unit Number:	50									
Data Sources and Data Issues:	<p>Data Source: List of individuals who have attended CSHCN care coordination education and training opportunities.</p> <p>Data Issues: None</p>									
Significance:	<p>Providing primary care to children in a “medical home” is the standard of practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The American Academy of Pediatrics (AAP) specifies seven qualities essential to a medical home, including care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective.</p>									

**ESM 12.1 - Number of individuals who have received education and training on healthcare transition.
 NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care**

Goal:	To increase the number of individuals (health professionals, youth/young adults, and families) who receive education and training on healthcare transition.									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of individuals who have received education and training on healthcare transition.</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>50</td> </tr> </table>		Numerator:	Number of individuals who have received education and training on healthcare transition.	Denominator:	Not applicable	Unit Type:	Count	Unit Number:	50
Numerator:	Number of individuals who have received education and training on healthcare transition.									
Denominator:	Not applicable									
Unit Type:	Count									
Unit Number:	50									
Data Sources and Data Issues:	<p>Data Source: List of individuals who have attended care coordination education and training opportunities.</p> <p>Data Issues: None</p>									
Significance:	<p>The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the American Academy of Pediatrics, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and healthcare are cited as two of the major barriers to making successful transitions.</p>									

ESM 13.1 - Number of children that receive dental sealants per school year.

NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Goal:	To increase the number of children receiving dental sealants through the school-based sealant program.									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of students receiving sealants per school year</td> </tr> <tr> <td>Denominator:</td> <td>Not Applicable</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>1,995</td> </tr> </table>		Numerator:	Number of students receiving sealants per school year	Denominator:	Not Applicable	Unit Type:	Count	Unit Number:	1,995
Numerator:	Number of students receiving sealants per school year									
Denominator:	Not Applicable									
Unit Type:	Count									
Unit Number:	1,995									
Data Sources and Data Issues:	North Dakota Department of Health – Oral Health Program – Seal!ND School-based Sealant Program Database.									
Significance:	<p>Oral health is a vital component of overall health. People with limited access to preventive oral health services are at greater risk for oral disease.</p> <p>The burden of oral disease is not uniformly distributed throughout North Dakota (ND). Access to oral health services is an ongoing concern and challenge. Vulnerable and underserved populations face a variety of barriers to oral health care including transportation issues, lack of insurance or ability to pay for care, inability to take time off work to go to the dentist or transport their children, limited availability of providers accepting Medicaid and lack of understanding of the importance of good oral health and its impact on overall health. The limited oral public health infrastructure, particularly in rural counties and lower economically impacted state regions, provides limited options for families in need. The existing oral health safety-net facilities are overburdened and cannot take on more patients without expanding their infrastructure.</p> <p>Sealants in childhood are cited as one of the most cost-effective evidence-based practices of reducing the likelihood of tooth decay later in life. The Seal!ND is a program was established in ND in 2008 to increase access to preventive dental care to underserved populations. Public Health Hygienists administer the program and provide oral health screenings, oral health education, dental sealants, and fluoride varnish. Between 2008 and 2015, the Seal!ND program provided preventive oral health services to 2,893 children. The program will continue to expand targeting schools with 40 percent or more students enrolled in a free and reduced-fee lunch program.</p>									

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: North Dakota

Form Notes for Form 10d NPMs and SPMs

None

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	12	17	12	14	14
Denominator	12	17	12	14	14
Data Source	See note field.				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The source for 2014 data is the Iowa Hygienic Laboratory and North Dakota Department of Health Newborn Screening Program. This data includes cases confirmed positive in calendar year 2014. The cut off date for the collection of this data is December 31st of the calendar year.

2. **Field Name:** **2014**

Field Note:

The source for 2014 data is the Iowa Hygienic Laboratory and North Dakota Department of Health Newborn Screening Program. This data includes cases confirmed positive in calendar year 2014. The cut off date for the collection of this data is December 31st of the calendar year.

3. **Field Name:** **2013**

Field Note:

The source for 2013 data is the Iowa Hygienic Laboratory and North Dakota Department of Health Newborn Screening Program. This data includes cases confirmed positive in calendar year 2013. The cut off date for the collection of this data is December 31st of the calendar year.

4. **Field Name:** 2012

Field Note:

2012-The source for 2012 data is the Iowa Hygienic Laboratory and North Dakota Department of Health Newborn Screening Program. This data includes cases confirmed positive in calendar year 2012. The cut off date for the collection of this data is December 31st of the calendar year.

5. **Field Name:** 2011

Field Note:

2011-The source for 2011 data is the Iowa Hygienic Laboratory and North Dakota Department of Health Newborn Screening Program. This data includes cases confirmed positive in calendar year 2011. The cut off date for the collection of this data is December 31st of the calendar year.

Data Alerts: None

NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

	2011	2012	2013	2014	2015
Annual Objective	63.5	75.5	76.0	76.5	77.0
Annual Indicator	75.0	75.0	75.0	75.0	75.0
Numerator	14,443	14,443	14,443	14,443	14,443
Denominator	19,262	19,262	19,262	19,262	19,262
Data Source	See note field.				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted in 2009-2010 by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:

For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted in 2009-2010 by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:

2012-For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:

2011-For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	53.0	50.0	50.5	51.0	51.5
Annual Indicator	47.8	47.8	47.8	47.8	47.8
Numerator	9,156	9,156	9,156	9,156	9,156
Denominator	19,170	19,170	19,170	19,170	19,170
Data Source	See note field.				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted in 2009-2010 by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010 surveys. Therefore, these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:

For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted in 2009-2010 by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010 surveys. Therefore, these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010 surveys. Therefore, these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:

2012- For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010 surveys. Therefore, these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:

2011-Final 2010 data was used as provisional data for 2011. For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	70.0	60.5	61.0	61.5	62.0
Annual Indicator	60.1	60.1	60.1	60.1	60.1
Numerator	11,707	11,707	11,707	11,707	11,707
Denominator	19,475	19,475	19,475	19,475	19,475
Data Source	See note field.				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted in 2009-2010 by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys so data is comparable across survey years. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:

For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted in 2009-2010 by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys so data is comparable across survey years. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:

2012- For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:

2011-For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	93.0	68.0	68.5	69.0	69.5
Annual Indicator	67.9	67.9	67.9	67.9	67.9
Numerator	13,149	13,149	13,149	13,149	13,149
Denominator	19,379	19,379	19,379	19,379	19,379
Data Source	See note field.	See note field	See note field	See note field	See note field
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

2015-Final 2014 data was used as provisional data for 2015. For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted in 2009-2010 by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the survey are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** 2014

Field Note:

For 2011-2014, indicator data came from the National Survey of Children with Special Health Care Needs (CSHCN), conducted in 2009-2010 by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the survey are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** 2013

Field Note:

For 2011-2014, indicator data come from the NS-CSHCN, conducted by the HRSA and CDC in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-2006 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:

2012-For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:

2011- For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2011	2012	2013	2014	2015
Annual Objective	52.0	47.0	47.5	48.0	48.5
Annual Indicator	46.5	46.5	46.5	46.5	46.5
Numerator	4,021	4,021	4,021	4,021	4,021
Denominator	8,642	8,642	8,642	8,642	8,642
Data Source	See note field.	See note field.	See note field	See note field	See note field
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:

2015-For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared. All estimates from the NSCSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistake

3. **Field Name:** 2013

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** 2012

Field Note:

2012- For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** 2011

Field Note:

2011- For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

	2011	2012	2013	2014	2015
Annual Objective	58.0	79.0	81.0	81.5	82.0
Annual Indicator	80.5	74.5	73.2	73.0	73.0
Numerator	10,363	9,710	10,100	10,638	10,638
Denominator	12,873	13,033	13,799	14,572	14,572
Data Source	See note field.	See note field.	See note field.	see note field	See note field.
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

2015-Final 2014 data was used as provisional data for 2015. 2014-Final 2014 data was used as provisional data for 2015. The sources for this data are the CDC National Immunization Survey and the U.S. Census Bureau. The numerator is derived from back calculation. The denominator is from the U.S. Census Bureau, Population Estimates 2014. Complete immunization status is generally considered to be: 4 DtaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B (4:3:1:3:3). The numerator for 2011 for North Dakota includes 4 DtaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B and 1 Varicella (4:3:1:3:3:1). Data for this measure from 2011 onwards includes immunization for Varicella in the current immunization series (4:3:1:3:3:1). In 2013, the CDC updated the series to 4:3:1:4:3:1 to include an additional dose of the Hib vaccine. North Dakota is using the new series for this measure (4:3:1:4:3:1). Caution: Data is not comparable between years due to respective changes in the vaccine series.

2. **Field Name:** 2014

Field Note:

2014-The sources for this data are the CDC National Immunization Survey and the U.S. Census Bureau. The numerator is derived from back calculation. The denominator is from the U.S. Census Bureau, Population Estimates 2014. Complete immunization status is generally considered to be: 4 DtaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B (4:3:1:3:3). The numerator for 2011 for North Dakota includes 4 DtaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B and 1 Varicella (4:3:1:3:3:1). Data for this measure from 2011 onwards includes immunization for Varicella in the current immunization series (4:3:1:3:3:1). In 2013, the CDC updated the series to 4:3:1:4:3:1 to include an additional dose of the Hib vaccine. North Dakota is using the new series for this measure (4:3:1:4:3:1). Caution: Data is not comparable between years due to respective changes in the vaccine series.

3. **Field Name:** 2013

Field Note:

The sources for this data are the CDC National Immunization Survey and the Bureau of Census. The numerator is derived from back calculation. The denominator is from the U.S. Census Bureau, Population Estimates 2013. Complete immunization status is generally considered to be: 4 DtaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B (4:3:1:3:3). Data for this measure from 2011 onwards includes immunization for Varicella in the current immunization series (4:3:1:3:3:1). In 2013, the CDC updated the series to 4:3:1:4:3:1 to include an additional dose of the Hib vaccine. North Dakota is using the new 4:3:1:4:3:1 series for this measure. Caution: Data is not comparable between years due to respective changes in vaccine series.

4. **Field Name:** **2012**

Field Note:

2012-Final 2012 data was used as provisional data for 2013. The sources for this data are the CDC National Immunization Survey and the Bureau of Census. The numerator is derived from back calculation. In 2009 the percent of 19 to 35-month-olds who received immunizations is lower due to shortage of Haemophilus influenzae type b (Hib) vaccine. The denominator is from the U.S. Census Bureau, Population Estimates 2012. Note: Prior to 2009, the source for denominator data was 2000 census. Note: Prior to CY 2010 the numerator is the number of resident children who have received the complete immunization schedule for DTP/DTAP, OPV, measles, mumps, rubella (MMR), H. influenza, and hepatitis B before their second birthday. Complete immunization status is generally considered to be: 4 DtaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B (4:3:1:3:3). The numerator for 2011 for North Dakota includes 4 DtaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B and 1 Varicella (4:3:1:3:3:1). Data in 2011 includes immunization for Varicella in the current immunization series (4:3:1:3:3:1). Data from 2009 and 2010 should not be compared with prior years because of changes in measurement for the vaccine series.

5. **Field Name:** **2011**

Field Note:

2011-The sources for this data are the CDC National Immunization Survey and the Bureau of Census. The numerator is derived from back calculation. In 2009 the percent of 19 to 35 month olds who received immunizations is lower due to shortage of Haemophilus influenzae type b (Hib) vaccine. The denominator is from the U.S. Census Bureau, Population Estimates 2011. Note: Prior to 2009, the source for denominator data was 2000 census. Note: Prior to CY 2010 the numerator is the number of resident children who have received the complete immunization schedule for DTP/DTAP, OPV, measles, mumps, rubella (MMR), H. influenza, and hepatitis B before their second birthday. Complete immunization status is generally considered to be: 4 DtaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B (4:3:1:3:3) . The numerator for 2011 for North Dakota includes 4 DtaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B and 1 Varicella (4:3:1:3:3: 1). Data in 2011 includes immunization for Varicella in the current immunization series (4:3:1:3:3: 1). Data from 2009 and 2010 should not be compared with prior years because of changes in measurement for the vaccine series. The annual indicator for the series 4:3:1:3:3 for the calendar year 2011 is 85 percent.

Data Alerts: None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	9.1	12.4	12.2	11.6	11.4
Annual Indicator	12.3	11.8	10.6	9.9	9.9
Numerator	453	433	391	374	374
Denominator	36,694	36,779	37,053	37,698	37,698
Data Source	See note field.				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The sources for this data are the North Dakota Department of Health -- Division of Vital Statistics and the U.S. Census Bureau, Population Division. The numerator is a three-year total. The source of the denominator is from the U.S. Census Bureau, Population Estimates 2014 for 15 through 17-year-old females in North Dakota. Note: Prior to 2009 the source for denominator data was the 2000 census. The denominator is the number of female teenagers 15 through 17 in North Dakota.

2. **Field Name:** **2014**

Field Note:

The sources for this data are the North Dakota Department of Health -- Division of Vital Statistics and the U.S. Census Bureau, Population Division. The numerator is a three-year total. The source of the denominator is from the U.S. Census Bureau, Population Estimates 2014 for 15 through 17-year-old females in North Dakota. Note: Prior to 2009 the source for denominator data was the 2000 census. The denominator is the number of female teenagers 15 through 17 in North Dakota.

3. **Field Name:** **2013**

Field Note:

The sources for this data are the North Dakota Department of Health -- Division of Vital Statistics and the U.S. Census Bureau, Population Division. The numerator is a three-year total. The source of the denominator is from the U.S. Census Bureau, Population Estimates 2013 for 15 through 17-year-old females in North Dakota. Note: Prior to 2009 the source for denominator data was 2000 census.

4. **Field Name:** **2012**

Field Note:

2012-The sources for this data are the North Dakota Department of Health -- Division of Vital Statistics and the U.S. Census Bureau, Population Division. The numerator is a three-year total. The source of the denominator is from the U.S. Census Bureau, Population Estimates 2012 for 15 through 17-year-old females in North Dakota. Note: Prior to 2009 the source for denominator data was 2000 census.

5. **Field Name:** 2011

Field Note:

2011- The sources for this data are the North Dakota Department of Health -- Division of Vital Statistics and the U.S. Census Bureau, Population Division. The numerator is a three-year total. The source of the denominator is from the U.S. Census Bureau, Population Estimates 2011 for 15 through 17-year-old females in North Dakota. Note: Prior to 2009 the source for denominator data was 2000 census. Note: The denominator is the number of female teenagers 15 through 17 in North Dakota.

Data Alerts: None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	61.0	61.5	62.0	65.0	70.0
Annual Indicator	60.4	60.4	60.4	53.0	53.0
Numerator	4,024	4,024	4,024	4,888	4,888
Denominator	6,662	6,662	6,662	9,222	9,222
Data Source	See note field.				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The source for this data is the North Dakota Department of Health Oral Health Basic Screening Survey for the 2014-2015 school year. The children screened for this performance measure are from a specific representative sample of third grade children in North Dakota. The denominator is the number of third grade children enrolled in North Dakota for the school year 2014-2015. The numerator is back calculated.

2. **Field Name:** **2014**

Field Note:

The source for this data is the North Dakota Department of Health Oral Health Basic Screening Survey for the 2014-2015 school year. The children screened for this performance measure are from a specific representative sample of third grade children in North Dakota. The denominator is the number of third grade children enrolled in North Dakota for the school year 2014-2015. The numerator is back calculated.

3. **Field Name:** **2013**

Field Note:

The source for this data is the North Dakota Department of Health Oral Health Basic Screening Survey for the 2009-2010 school year. The children screened for this performance measure are from a specific representative sample of third grade children in North Dakota. The denominator is the number of third grade children enrolled in North Dakota for the school year 2009-2010. The numerator is back calculated.

4. **Field Name:** **2012**

Field Note:

2012- The source for this data is the North Dakota Department of Health Oral Health Basic Screening Survey for the 2009-2010 school year. The children screened for this performance measure are from a specific representative sample of third grade children in North Dakota. The denominator is the number of third grade children enrolled in North Dakota for the school year 2009-2010. The numerator is back calculated.

5. **Field Name:** **2011**

Field Note:

2011- The source for this data is the North Dakota Department of Health Oral Health Basic Screening Survey for the 2009-2010 school year. The children screened for this performance measure are from a specific representative sample of third grade children in North Dakota. The denominator is the number of third grade children enrolled in North Dakota for the school year 2009-2010. The numerator is back calculated.

Data Alerts: None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	3.1	3.6	3.5	2.2	2.0
Annual Indicator	3.8	2.4	1.3	0.7	0.7
Numerator	14	9	5	3	3
Denominator	369,270	380,170	392,679	409,054	409,054
Data Source	See note field.				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. A three-year total was used to calculate the rate to avoid fluctuations. The data for the numerator is from the North Dakota Department of Health - - Division of Vital Statistics. The denominator is from the 2014 U.S. Census estimate from the U.S. Census Bureau, Population Division. Note: Prior to 2009 the source for denominator data was the 2000 census.

2. **Field Name:** **2014**

Field Note:

A three-year total was used to calculate the rate to avoid fluctuations. The data for the numerator is from the North Dakota Department of Health -- Division of Vital Statistics. The denominator is from the 2014 U.S. Census estimate from the U.S. Census Bureau, Population Division. Note: Prior to 2009 the source for denominator data was the 2000 census.

3. **Field Name:** **2013**

Field Note:

A three-year total was used to calculate the rate to avoid fluctuations. The data for the numerator is from the North Dakota Department of Health -- Division of Vital Statistics. The denominator is from the 2013 U.S. Census estimate from the U.S. Census Bureau, Population Division. Note: Prior to 2009 the source for denominator data was 2000 census.

4. **Field Name:** **2012**

Field Note:

2012- A three-year total was used to calculate the rate to avoid fluctuations. The data for the numerator is from the North Dakota Department of Health -- Division of Vital Statistics. The denominator is from the 2012 U.S. Census estimate from the U.S. Census Bureau, Population Division. Note: Prior to 2009 the source for denominator data was 2000 census.

5. **Field Name:** 2011

Field Note:

2011- A three-year total was used to calculate the rate to avoid fluctuations. The data for the numerator is from the North Dakota Department of Health -- Division of Vital Statistics. The denominator is from the 2011 U.S. Census estimate from the U.S. Census Bureau, Population Division. Note: Prior to 2009 the source for denominator data was 2000 census.

Data Alerts: None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	42.0	48.0	48.5	49.0	49.5
Annual Indicator	45.0	44.6	55.4	48.1	48.1
Numerator	4,155	4,492	5,867	5,460	5,460
Denominator	9,234	10,072	10,591	11,352	11,352
Data Source	See note field.				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The source for 2011 data is the 2012 Center for Disease Control and Prevention National Immunization Survey. The source for 2005, 2006 and 2007 data was the 2003 National Survey of Children's Health. The denominator used from 2008 onwards is the number of resident births in North Dakota. Note: The denominator for 2008 was changed from 30,670 reported in 2008 to 8,931. The source of the denominator from 2008 onwards is from the North Dakota Department of Health -- Division of Vital Statistics which represents the number of births for the calendar year. The numerator is derived from back calculation.

2. **Field Name:** **2014**

Field Note:

The source for 2011 data is the 2012 Center for Disease Control and Prevention National Immunization Survey. The source for 2005, 2006 and 2007 data was the 2003 National Survey of Children's Health. The denominator used from 2008 onwards is the number of resident births in North Dakota. Note: The denominator for 2008 was changed from 30,670 reported in 2008 to 8,931. The source of the denominator from 2008 onwards is from the North Dakota Department of Health -- Division of Vital Statistics which represents the number of births for the calendar year. The numerator is derived from back calculation.

3. **Field Name:** **2013**

Field Note:

The source for 2013 data is the Center for Disease Control and Prevention National Immunization Survey, provisional data, 2010 births. The source for 2005, 2006 and 2007 data was the 2003 National Survey of Children's Health. The denominator used from 2008 onwards is the number of resident births in North Dakota. Note: The denominator for 2008 was changed from 30,670 reported in 2008 to 8,931. The source of the denominator is from the North Dakota Department of Health -- Division of Vital Statistics which represents the number of births for the calendar year. The numerator is derived from back calculation.

4. **Field Name:** **2012**

Field Note:

2012-The source for 2012 data is the Center for Disease Control and Prevention National Immunization Survey, provisional data, 2010 births. The source for 2005, 2006 and 2007 data was the 2003 National Survey of Children's Health. The denominator used from 2008 forward is the number of resident births in North Dakota. Note: The denominator for 2008 was changed from 30,670 reported in 2008 to 8,931. The source of the denominator is from the North Dakota Department of Health -- Division of Vital Statistics which represents the number of births for the calendar year. The numerator is derived from back calculation.

5. **Field Name:** **2011**

Field Note:

2011-The source for 2011 data is the Center for Disease Control and Prevention National Immunization Survey, provisional data, 2009 births. The source for 2005, 2006 and 2007 data was the 2003 National Survey of Children's Health. The denominator used from 2008 forward is the number of resident births in North Dakota. Note: The denominator for 2008 was changed from 30,670 reported in 2008 to 8,931. The source of the denominator is from the North Dakota Department of Health -- Division of Vital Statistics which represents the number of births for the calendar year. The numerator is derived from back calculation.

Data Alerts: None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	98.0	98.1	98.6	98.8	99.0
Annual Indicator	98.5	98.6	98.2	98.5	98.5
Numerator	10,610	11,337	11,760	12,642	12,642
Denominator	10,777	11,503	11,978	12,840	12,840
Data Source	See note field.				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The data for the numerator is obtained from the OZ eSP system via the North Dakota Early Hearing Detection and Intervention Program. The denominator is the occurrent births in the state obtained from the North Dakota Department of Health--Division of Vital Statistics. Calendar year 2014 data was used for reporting.

2. **Field Name:** 2014

Field Note:

The data for the numerator is obtained from the OZ eSP system via the North Dakota Early Hearing Detection and Intervention Program. The denominator is the occurrent births in the state obtained from the North Dakota Department of Health--Division of Vital Statistics. Calendar year 2014 data was used for reporting.

3. **Field Name:** 2013

Field Note:

2014-Final 2013 data was used as provisional data for 2014. The data for the numerator is obtained from the OZ eSP system via the North Dakota Early Hearing Detection and Intervention Program. The denominator is the occurrent births in the state obtained from the North Dakota Department of Health--Division of Vital Statistics. Calendar year 2013 data was used for reporting.

4. **Field Name:** 2012

Field Note:

2012- The data for the numerator is obtained from the OZ eSP system via the North Dakota Early Hearing Detection and Intervention Program. The denominator is the occurrent births in the state obtained from the North Dakota Department of Health--Division of Vital Statistics. Calendar year 2012 data was used for reporting.

5. **Field Name:** 2011

Field Note:

2011- The data for the numerator is obtained from the OZ eSP system via the North Dakota Early Hearing Detection and Intervention Program. The denominator is the occurrent births in the state obtained from the North Dakota Department of Health--Division of Vital Statistics. The data was obtained from 2010 newborn hearing screening that was reported in 2011.

Data Alerts: None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	6.8	7.8	6.8	6.6	6.4
Annual Indicator	7.0	7.0	7.0	7.0	7.0
Numerator	10,581	10,823	11,388	11,797	11,797
Denominator	151,156	154,608	162,688	168,527	168,527
Data Source	See note field.	See note field.	See note field.	See note field	See note field
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The new 2014 data source for this measure is a Population Reference Bureau data analysis from the U.S. Census Bureau, 2008 - 2014 American Community Survey. The numerator is derived from a back calculation that applies the percent of children without health insurance from Kids Count to the denominator of children birth through 17 from the 2014 census estimate. In 2014, the Current Population Survey Annual Social and Economic Supplement (CPS ASEC) was redesigned. Due to these changes, data for the 2014 CPS ASEC are not comparable to data from earlier years. CPS-based health insurance tables on the KIDS COUNT Data Center were not updated this year. State-level tables require multi-year averaged data which are not possible given the break in comparability. KIDS COUNT reported a 3-year average previously. Note: Prior to 2009, the source for denominator data was the 2000 census.

2. **Field Name:** **2014**

Field Note:

2014-The new 2014 data source for this measure is a Population Reference Bureau data analysis from the U.S. Census Bureau, 2008 - 2014 American Community Survey. The numerator is derived from a back calculation that applies the percent of children without health insurance from Kids Count to the denominator of children birth through 17 from the 2014 census estimate. In 2014, the Current Population Survey Annual Social and Economic Supplement (CPS ASEC) was redesigned. Due to these changes, data for the 2014 CPS ASEC are not comparable to data from earlier years. CPS-based health insurance tables on the KIDS COUNT Data Center were not updated this year. State-level tables require multi-year averaged data which are not possible given the break in comparability. KIDS COUNT reported a 3-year average previously. Note: Prior to 2009, the source for denominator data was the 2000 census.

3. **Field Name:** **2013**

Field Note:

The new 2014 Data Source for this measure is: Population Reference Bureau, analysis of data from the U.S. Census Bureau, 2008-2012 American Community Survey. The numerator is derived from a back calculation that applies the percent of children without health insurance from Kids Count to the denominator of children birth through 17 from the 2013 census estimate. In 2014, the Current Population Survey Annual Social and Economic Supplement (CPS ASEC) was redesigned. Data for the 2013 CPS ASEC are not comparable to data from earlier years.

4. **Field Name:** **2012**

Field Note:

2012-The sources for this data are the 2012 Kids Count and the U.S. Census Bureau. The numerator is derived from a back calculation that applies the percent of children without health insurance from Kids Count to the denominator of children birth through 17 from the 2012 census estimate. The figures shown here are 3-year averages of data. Note: Prior to 2009, the source for denominator data was 2000 census. From 2009 onward, census estimates were used.

5. **Field Name:** **2011**

Field Note:

2011-The sources for this data are the 2011 Kids Count and the U.S. Census Bureau. The numerator is derived from a back calculation that applies the percent of children without health insurance from Kids Count to the denominator of children birth through 17 from the 2011 census estimate. The figures shown here are 3-year averages of data. Note: Prior to 2009, the source for denominator data was 2000 census. From 2009 onward, census estimates were used.

Data Alerts: None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	30.8	30.6	29.7	34.0	33.5
Annual Indicator	29.9	35.7	32.5	34.2	34.2
Numerator	2,001	2,867	2,795	2,717	2,717
Denominator	6,693	8,029	8,602	7,948	7,948
Data Source	See note field.				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The new source for 2014 data is the North Dakota WIC program. Queries were run for risk_113 and risk_114 for children 2 to 5 years old. Note: Prior to 2012, the source of the data was the Pediatric Nutrition Surveillance System (PedNSS).

2. **Field Name:** 2014

Field Note:

The new source for 2014 data is the North Dakota WIC program. Queries were run for risk_113 and risk_114 for children 2 to 5 years old. Note: Prior to 2012, the source of the data was the Pediatric Nutrition Surveillance System (PedNSS).

3. **Field Name:** 2013

Field Note:

The new source for 2013 data is the North Dakota WIC program, querying risk factor risk_113 and risk_114 for children 2 to 5 years old. Note: Prior to 2012, the source of the data was the Pediatric Nutrition Surveillance System (PedNSS).

4. **Field Name:** 2012

Field Note:

2012-The new source for 2012 data is the North Dakota WIC program, querying risk factor risk_113 and risk_114 for children 2 to 5 years old. Note: Prior to 2012, the source of the data was the Pediatric Nutrition Surveillance System (PedNSS).

5. **Field Name:** 2011

Field Note:

2011- The source for this data is from the 2011 Pediatric Nutrition Surveillance System (PedNSS), which is conducted every year.

Data Alerts: None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	12.8	12.6	12.4	12.2	12.0
Annual Indicator	12.7	12.3	11.2	10.7	10.7
Numerator	1,173	1,234	1,190	1,209	1,209
Denominator	9,234	10,072	10,591	11,352	11,352
Data Source	See note field.				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
2015-Final 2014 data was used as provisional data for 2015. The source for this data is the North Dakota Department of Health, Division of Vital Statistics.

2. **Field Name:** **2014**

Field Note:
The source for this data is the North Dakota Department of Health, Division of Vital Statistics.

3. **Field Name:** **2013**

Field Note:
The source for this data is the North Dakota Department of Health, Division of Vital Statistics.

4. **Field Name:** **2012**

Field Note:
2012-The source for this data is the North Dakota Department of Health, Division of Vital Statistics

5. **Field Name:** **2011**

Field Note:
2011- The source for this data is the North Dakota Department of Health, Division of Vital Statistics.

Data Alerts: None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	15.0	19.0	24.0	22.0	21.8
Annual Indicator	24.2	22.4	20.8	22.0	22.0
Numerator	35	32	30	32	32
Denominator	144,581	143,039	144,479	145,362	145,362
Data Source	See note field.	See note field.	See note field.	See note field	See note field
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The denominator is from the 2014 census estimates conducted by U.S. Census Bureau, Population Division. Note: Prior to 2009, the source for denominator data was the 2000 census. Please note corrections to 2003, 2004 and 2008 reporting: 2003 Annual Indicator: 8.7, Numerator: 14, Denominator: 160,854. 2004 Annual Indicator: 12.4, Numerator: 20, Denominator: 160,854. 2008 Annual Indicator: 14.9, Numerator: 24, Denominator: 160,854.

2. **Field Name:** 2014

Field Note:

The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The denominator is from the 2014 census estimates conducted by U.S. Census Bureau, Population Division. Note: Prior to 2009, the source for denominator data was the 2000 census. Please note corrections to 2003, 2004 and 2008 reporting: 2003 Annual Indicator: 8.7, Numerator: 14, Denominator: 160,854. 2004 Annual Indicator: 12.4, Numerator: 20, Denominator: 160,854. 2008 Annual Indicator: 14.9, Numerator: 24, Denominator: 160,854.

3. **Field Name:** 2013

Field Note:

The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The denominator is from the 2013 census estimates conducted by U.S. Census Bureau, Population Division. Note: Prior to 2009, the source for denominator data was 2000 census. Please note corrections to 2003, 2004 & 2008 reporting: 2003 Annual Indicator: 8.7, Numerator: 14, Denominator: 160,854. 2004 Annual Indicator: 12.4, Numerator: 20, Denominator: 160,854. 2008 Annual Indicator: 14.9, Numerator: 24, Denominator: 160,854.

4. **Field Name:** 2012

Field Note:

2012-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The denominator is from the 2012 census estimates conducted by U.S. Census Bureau, Population Division. Note: Prior to 2009, the source for denominator data was 2000 census. Please note corrections to 2003, 2004 & 2008 reporting: 2003 Annual Indicator: 8.7, Numerator: 14, Denominator: 160,854. 2004 Annual Indicator: 12.4, Numerator: 20, Denominator: 160,854. 2008 Annual Indicator: 14.9, Numerator: 24, Denominator: 160,854.

5. **Field Name:** 2011

Field Note:

2011- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The denominator is from the 2011 census estimates conducted by U.S. Census Bureau, Population Division. Note: Prior to 2009, the source for denominator data was 2000 census. Please note corrections to 2003, 2004 & 2008 reporting: 2003 Annual Indicator: 8.7, Numerator: 14, Denominator: 160,854. 2004 Annual Indicator: 12.4, Numerator: 20, Denominator: 160,854. 2008 Annual Indicator: 14.9, Numerator: 24, Denominator: 160,854.

Data Alerts: None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	52.0	52.5	62.0	64.0	64.5
Annual Indicator	61.5	63.8	74.6	62.4	62.4
Numerator	59	74	94	73	73
Denominator	96	116	126	117	117
Data Source	See note field.				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The Level 3 facilities in the state, based on self-report, are Sanford in Fargo, Essentia Health in Fargo, St. Alexius in Bismarck, Sanford in Bismarck and Altru in Grand Forks.

2. **Field Name:** 2014

Field Note:

The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The Level 3 facilities in the state, based on self-report, are Sanford in Fargo, Essentia Health in Fargo, St. Alexius in Bismarck, Sanford in Bismarck and Altru in Grand Forks.

3. **Field Name:** 2013

Field Note:

The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The Level 3 facilities in the state, based on self-report, are Sanford in Fargo, Essentia Health in Fargo, St. Alexius in Bismarck, Sanford in Bismarck and Altru in Grand Forks.

4. **Field Name:** 2012

Field Note:

2012- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The Level 3 facilities in the state, based on self-report, are Sanford in Fargo, Essentia Health in Fargo, St. Alexius in Bismarck, Sanford in Bismarck and Altru in Grand Forks.

5. **Field Name:** 2011

Field Note:

2011- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The Level 3 facilities in the state, based on self-report, are Sanford in Fargo, St. Alexius in Bismarck, Sanford in Bismarck and Altru in Grand Forks.

Data Alerts: None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	84.5	85.0	85.5	86.0	86.5
Annual Indicator	83.7	83.7	83.8	81.8	81.8
Numerator	7,726	8,431	8,876	9,284	9,284
Denominator	9,234	10,072	10,591	11,352	11,352
Data Source	See note field.	See note field.	See note field.	See note field	See note field
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015
Field Note:
2015-Final 2014 data was used as provisional data for 2015. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

2. **Field Name:** 2014
Field Note:
The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

3. **Field Name:** 2013
Field Note:
The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

4. **Field Name:** 2012
Field Note:
2012- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

5. **Field Name:** 2011
Field Note:
2011- The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Data Alerts: None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)
State: North Dakota

SPM 1 - The degree to which families and American Indians participate in Title V program and policy activities.

	2011	2012	2013	2014	2015
Annual Objective	3.0	3.0	53.0	54.0	55.0
Annual Indicator	52.0	53.0	58.0	56.0	56.0
Numerator	52	53	58	56	56
Denominator	100	100	100	100	100
Data Source	See note				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The source for this data is from the ND Department of Health (DoH)-Divisions of CSHS, FH, IPC, and NPA. This measure is based on an annual assessment by each of the Title V funded programs in the DoH which is used to assess efforts to form and strengthen partnerships with families and American Indians (AI's). An assessment tool was utilized to measure the degree to which families and AI's participated in Title V program and policy activities.. Note: In 2014, the numerator had an average score of 2.78, which was rounded to 2.8.

2. **Field Name:** **2014**

Field Note:

The source for this data is from the ND Department of Health (DoH)-Divisions of CSHS, FH, IPC, and NPA. This measure is based on an annual assessment by each of the Title V funded programs in the DoH which is used to assess efforts to form and strengthen partnerships with families and American Indians (AI's). An assessment tool was utilized to measure the degree to which families and AI's participated in Title V program and policy activities.. Note: In 2014, the numerator had an average score of 2.78, which was rounded to 2.8.

3. **Field Name:** **2013**

Field Note:

The source for this data is from the ND Department of Health (DoH)-Divisions of CSHS, FH, IPC, and NPA. This measure is based on an annual assessment by each of the Title V funded programs in the DoH which is used to assess efforts to form and strengthen partnerships with families and American Indians (AI's). An assessment tool was utilized to measure the degree to which families and AI's participated in Title V program and policy activities.. Note: In 2013, the numerator had an average score of 2.87, which was rounded to 2.9.

4. **Field Name:** 2012

Field Note:

2012-The source for this data is from the North Dakota Department of Health--Division of Children's Special Health Services, Division of Family Health, Division of Injury Prevention and Control, and Division of Nutrition and Physical Activity. This measure is based on an annual assessment by each of the Title V funded programs in the North Dakota Department of Health which is used to assess efforts to form and strengthen partnerships with families and American Indians. An assessment tool was developed that measures both collaboration efforts of Title V funded programs as well as representation and participation of families and American Indians on committees, task forces and coalitions to achieve health equality in the maternal and child population. It is based on a qualitative assessment of Title V funded programs and measures partnership involvement and collaboration in 6 key areas for both families and American Indians. The assessment tool utilizes a 5 point scale for each key area. The measure is an average of the scores from each of the Title V funded programs. The annual indicator is expressed as a percent. Note: In 2012, the numerator had an average score of 2.646, which was rounded to 2.6.

5. **Field Name:** 2011

Field Note:

2011-The source for this data is from the North Dakota Department of Health--Division of Children's Special Health Services, Division of Family Health, Division of Injury Prevention and Control, and Division of Nutrition and Physical Activity. This measure is based on an annual assessment by each of the Title V funded programs in the North Dakota Department of Health which is used to assess efforts to form and strengthen partnerships with families and American Indians. An assessment tool was developed that measures both collaboration efforts of Title V funded programs as well as representation and participation of families and American Indians on committees, task forces and coalitions to achieve health equality in the maternal and child population. It is based on a qualitative assessment of Title V funded programs and measures partnership involvement and collaboration in 6 key areas for both families and American Indians. The assessment tool utilizes a 5 point scale for each key area. The measure is an average of the scores from each of the Title V funded programs. The annual indicator is expressed as a percent. Note: In 2011, the numerator had an average score of 2.61 which was rounded to 2.6 (52%). Note: Each point of the scale has a value of 20 percent.

Data Alerts: None

SPM 2 - The percent of Medicaid enrollees receiving Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening services.

	2011	2012	2013	2014	2015
Annual Objective	67.0	68.0	69.0	70.0	71.0
Annual Indicator	58.9	57.0	58.0	57.7	57.7
Numerator	33,158	32,208	32,979	33,634	33,634
Denominator	56,275	56,481	56,840	58,325	58,325
Data Source	See note field.	See note field	See note field	See note field	See note field
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2015

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The source for this data is from the North Dakota Department of Human Services -- Medical Services Division, Health Tracks program (CMS 416 annual EPSDT Participation Report). The numerator is the total screens received and the denominator is the expected number of EPSDT screenings.

2. **Field Name:** 2014

Field Note:

2014-Final 2014 data was used as provisional data for 2015. The source for this data is from the North Dakota Department of Human Services -- Medical Services Division, Health Tracks program (CMS 416 annual EPSDT Participation Report). The numerator is the total screens received and the denominator is the expected number of EPSDT screenings.

3. **Field Name:** 2013

Field Note:

The source for this data is from the North Dakota Department of Human Services -- Medical Services Division Health Tracks program. (CMS 416 annual EPSDT Participation Report). The numerator is the total screens received and the denominator is the expected number of EPSDT screenings.

4. **Field Name:** 2012

Field Note:

2012- The source for this data is from the North Dakota Department of Human Services -- Medical Services Division Health Tracks program. (CMS 416 annual EPSDT Participation Report). The numerator is the total screens received and the denominator is the expected number of EPSDT screenings.

5. **Field Name:** 2011

Field Note:

2011- The source for this data is from the North Dakota Department of Human Services -- Medical Services Division Health Tracks program. (CMS 416 annual EPSDT Participation Report). The numerator is the total screens received and the denominator is the expected number of EPSDT screenings.

Data Alerts: None

SPM 3 - The percent of children age 0 through 17 receiving health care that meets the American Academy of Pediatrics (AAP) definition of medical home.

	2011	2012	2013	2014	2015
Annual Objective	64.5	65.0	62.5	63.0	63.5
Annual Indicator	61.9	61.9	61.9	61.9	61.9
Numerator	91,776	91,776	91,776	91,776	91,776
Denominator	148,289	148,289	148,289	148,289	148,289
Data Source	See note field.	See note field.	See note field.	See note field.	See note field
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2015

Field Note:

2015-2014 data was used as provisional data for 2015. The source of this data is the 2011/2012 National Survey of Children's Health (NSCH). The numerator is the weighted estimate of North Dakota children 0 through 17 who met the criteria for having a medical home. The denominator is the weighted estimate of North Dakota children ages 0 through 17 years.

2. **Field Name:** 2014

Field Note:

The source of this data is the 2011/2012 National Survey of Children's Health (NSCH). The numerator is the weighted estimate of North Dakota children 0 through 17 who met the criteria for having a medical home. The denominator is the weighted estimate of North Dakota children ages 0 through 17 years.

3. **Field Name:** 2013

Field Note:

The source of this data is the 2011/2012 National Survey of Children's Health (NSCH). The numerator is the weighted estimate of North Dakota children 0 through 17 who meet the criteria for having a medical home. The denominator is the weighted estimate of North Dakota children ages 0 through 17 years.

4. **Field Name:** 2012

Field Note:

2012-The source of this data is the 2011/2012 National Survey of Children's Health (NSCH). The numerator is the weighted estimate of North Dakota children 0 through 17 who meet the criteria for having a medical home. The denominator is the weighted estimate of North Dakota children ages 0 through 17 years.

5. **Field Name:** 2011

Field Note:

2011-The source of this data is the 2011/2012 National Survey of Children's Health (NSCH). The numerator is the weighted estimate of North Dakota children 0 through 17 who meet the criteria for having a medical home. The denominator is the weighted estimate of North Dakota children ages 0 through 17 years.

Data Alerts: None

SPM 4 - The percent of parents who reported that they usually or always got the specific information they needed from their child's doctor and other health care providers during the past 12 months.

	2011	2012	2013	2014	2015
Annual Objective	87.0	87.5	89.0	89.5	90.0
Annual Indicator	88.4	88.4	88.4	88.4	88.4
Numerator	125,987	125,987	125,987	125,987	125,987
Denominator	142,596	142,596	142,596	142,596	142,596
Data Source	See note field.	See note field.	See note field.	See note field.	See note field
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The source of this data is the 2011/2012 National Survey of Children's Health (NSCH). The numerator is the weighted estimate of North Dakota parents reporting on the NSCH survey that they usually or always got specific information they needed from their child's doctors and other health care providers during the past 12 months. The denominator is the weighted estimate of total North Dakota parents responding to the NSCH survey question K5Q43.

2. **Field Name:** **2014**

Field Note:

The source of this data is the 2011/2012 National Survey of Children's Health (NSCH). The numerator is the weighted estimate of North Dakota parents reporting on the NSCH survey that they usually or always got specific information they needed from their child's doctors and other health care providers during the past 12 months. The denominator is the weighted estimate of total North Dakota parents responding to the NSCH survey question K5Q43.

3. **Field Name:** **2013**

Field Note:

The source of this data is the 2011-2012 National Survey of Children's Health (NSCH). The numerator is the weighted estimate of North Dakota parents reporting on the NSCH survey that they usually or always got specific information they needed from their child's doctors and other health care providers during the past 12 months. The denominator is the weighted estimate of total North Dakota parents responding to the NSCH survey question K5Q43.

4. **Field Name:** **2012**

Field Note:

2012-The source of this data is the 2011-2012 National Survey of Children's Health (NSCH). The numerator is the weighted estimate of North Dakota parents reporting on the NSCH survey that they usually or always got specific information they needed from their child's doctors and other health care providers during the past 12 months. The denominator is the weighted estimate of total North Dakota parents responding to the NSCH survey question K5Q43.

5. **Field Name:** **2011**

Field Note:

2011- The source of this data is the 2011/2012 National Survey of Children's Health (NSCH). The numerator is the weighted estimate of North Dakota parents reporting on the NSCH survey that they usually or always got specific information they needed from their child's doctors and other health care providers during the past 12 months. The denominator is the weighted estimate of total North Dakota parents responding to the NSCH survey question K5Q43.

Data Alerts: None

SPM 5 - Increase the number of children ages 0 to 2 served by an evidenced-based home visiting program.

	2011	2012	2013	2014	2015
Annual Objective	16.0	17.4	17.5	17.6	17.7
Annual Indicator	20.8	18.1	15.8	16.7	16.7
Numerator	373	331	316	353	353
Denominator	17,925	18,335	20,043	21,188	21,188
Data Source	See note field.	See note field.	See note field.	See note field	See note field
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The numerator is the total number of North Dakota children ages 0 to 2 served by an evidenced-based home visiting program. The data does not include prenatal referrals. The sources for the numerator are Nurse Family Partnership in Fargo, the FACE program using parents as teachers model at the UTTC in Bismarck, Healthy Families of Grand Forks, Healthy Families of Bismarck and the ND MIECHV project working with the Turtle Mountain tribe and the Spirit Lake tribe serving Rolette, Benson, and Ramsey counties. The denominator is from the U.S. Census Bureau, Population Division, 2014 estimates. The rate is calculated per 1,000. Please note corrections for data reported in 2008. The numerator was reported as 279 with a rate of 15.8. The corrected data is 260 for the numerator with a rate of 14.8.

2. **Field Name:** **2014**

Field Note:

The numerator is the total number of North Dakota children ages 0 to 2 served by an evidenced-based home visiting program. The data does not include prenatal referrals. The sources for the numerator are Nurse Family Partnership in Fargo, the FACE program using parents as teachers model at the UTTC in Bismarck, Healthy Families of Grand Forks, Healthy Families of Bismarck and the ND MIECHV project working with the Turtle Mountain tribe and the Spirit Lake tribe serving Rolette, Benson, and Ramsey counties. The denominator is from the U.S. Census Bureau, Population Division, 2014 estimates. The rate is calculated per 1,000. Please note corrections for data reported in 2008. The numerator was reported as 279 with a rate of 15.8. The corrected data is 260 for the numerator with a rate of 14.8.

3. **Field Name:** **2013**

Field Note:

The numerator is the total number of North Dakota children ages 0 to 2 served by an evidenced-based home visiting program. The data does not include prenatal referrals. The sources for the numerator are Nurse Family Partnership in Fargo, the FACE program using parents as teachers model at the UTTC in Bismarck, Healthy Families of Grand Forks, Healthy Families of Bismarck and the ND MIECHV project in Turtle Mountain and Devils Lake. The denominator is from the U.S. Census Bureau, Population Division, 2013 estimates. The rate is calculated per 1,000. Please note corrections for data reported in 2008. The numerator was reported as 279 with a rate of 15.8. The corrected data is 260 for the numerator with a rate of 14.8.

4. **Field Name:** **2012**

Field Note:

2012-The numerator is the total number of North Dakota children ages 0 to 2 served by an evidenced-based home visiting program. The data does not include prenatal referrals. The sources for the numerator are Nurse Family Partnership in Fargo, the FACE program using parents as teachers model at the UTTC in Bismarck, Healthy Families of Grand Forks and Healthy Families of Bismarck. The denominator is from the U.S. Census Bureau, Population Division, 2012 estimates. The rate is calculated per 1,000. Please note corrections for data reported in 2008. The numerator was reported as 279 with a rate of 15.8. The corrected data is 260 for the numerator with a rate of 14.8.

5. **Field Name:** **2011**

Field Note:

2011-The numerator is the total number of North Dakota children ages 0 to 2 served by an evidenced-based home visiting program. The data does not include prenatal referrals. The sources for the numerator are Nurse Family Partnership in Fargo, the FACE program using parents as teachers model at the UTTC in Bismarck, Healthy Families of Grand Forks and Healthy Families of Bismarck. The denominator is from the U.S. Census Bureau, Population Division, 2011 estimates. The rate is calculated per 1,000. Please note corrections for data reported in 2008. The numerator was reported as 279 with a rate of 15.8. The corrected data is 260 for the numerator with a rate of 14.8.

Data Alerts: None

SPM 6 - Decrease the percent of students who reported feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.

	2011	2012	2013	2014	2015
Annual Objective	22.0	21.0	20.0	19.0	18.0
Annual Indicator	23.8	23.8	25.4	27.2	27.2
Numerator	7,170	7,170	7,642	8,207	8,207
Denominator	30,135	30,135	30,059	30,163	30,163
Data Source	See note field.				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The source for this data is selected weighted CDC data from the North Dakota 2015 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of North Dakota high school students who answered "yes" to survey question #23 on the YRBS. The denominator is the total weighted number of high school students (grades 9-12) who completed the YRBS survey question #23.

2. **Field Name:** **2014**

Field Note:

The source for this data is selected weighted CDC data from the North Dakota 2015 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of North Dakota high school students who answered "yes" to survey question #23 on the YRBS. The denominator is the total weighted number of high school students (grades 9-12) who completed the YRBS survey question #23.

3. **Field Name:** **2013**

Field Note:

The source for this data is selected weighted CDC data from the North Dakota 2013 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of North Dakota high school students who answer "yes" to survey question #23 on the YRBS. The denominator is the total weighted number of high school students (grades 9-12) who completed the YRBS survey question #23

4. **Field Name:** **2012**

Field Note:

2012- The source for this data is selected weighted CDC data from the North Dakota 2011 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of North Dakota high school students who answer "yes" to survey question #23 on the YRBS. The denominator is the total weighted number of high school students (grades 9-12) who completed the YRBS survey question #23.

5. **Field Name:** **2011**

Field Note:

2011- The source for this data is selected weighted CDC data from the North Dakota 2011 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of North Dakota high school students who answer "yes" to survey question #23 on the YRBS. The denominator is the total weighted number of high school students (grades 9-12) who completed the YRBS survey question #23.

Data Alerts: None

SPM 7 - The ratio of students per school nursing FTE.

	2011	2012	2013	2014	2015
Annual Objective	4,300.0	4,250.0	2,000.0	1,950.0	1,900.0
Annual Indicator	2,057.9	2,057.9	1,477.6	1,477.6	1,477.6
Numerator	58,444	58,444	62,354	62,354	62,354
Denominator	28	28	42	42	42
Data Source	see note field.	see note field.	see note field.	see note field	see note field
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The numerator is the self-reported number of enrolled students in schools that responded to the ND school nurse survey. The denominator is the current number of school nursing RN FTEs, which is calculated from the school nurse survey. The denominator is calculated by taking the number of hours of reported RN nursing hours, divided by 120 (6 hours/day x 20 school days/month = 1 FTE. The indicator is a ratio. This survey indicated that there were approximately 42.2 school nurse FTEs for this population in CY 2014. Note: A similar method was used in calculating data for CY 2011.

2. **Field Name:** **2014**

Field Note:

The numerator is the self-reported number of enrolled students in schools that responded to the ND school nurse survey. The denominator is the current number of school nursing RN FTEs, which is calculated from the school nurse survey. The denominator is calculated by taking the number of hours of reported RN nursing hours, divided by 120 (6 hours/day x 20 school days/month = 1 FTE. The indicator is a ratio. This survey indicated that there were approximately 42.2 school nurse FTEs for this population in CY 2014. Note: A similar method was used in calculating data for CY 2011.

3. **Field Name:** **2013**

Field Note:

The numerator is the self-reported number of enrolled students in schools that responded to the ND school nurse survey. The denominator is the current number of school nursing RN FTEs, which are calculated from the school nurse survey. The denominator is calculated by taking the number of hours of reported RN nursing hours, divided by 120 (6 hours/day x 20 school days/month = 1 FTE. The indicator is a ratio. This survey indicated that there were approximately 42.2 school nurse FTEs for this population in CY 2014. Note: A similar method was used in calculating data for CY 2011 and was maintained for CY 2014.

4. **Field Name:** **2012**

Field Note:

2012-The numerator is the self-reported number of enrolled students in schools that responded to the ND school nurse survey. The denominator is the current number of school nursing RN FTEs, which are calculated from the school nurse survey. The denominator is calculated by taking the number of hours of reported RN nursing hours, divided by 120 (6 hours/day x 20 school days/month = 1 FTE. The indicator is a ratio. This survey indicated that there were approximately 28.4 school nurse FTEs for this population in CY 2011. Note: A new method was used in calculating data for CY 2011.

5. **Field Name:** **2011**

Field Note:

2011- The numerator is the self-reported number of enrolled students in schools that responded to the ND school nurse survey. The denominator is the current number of school nursing RN FTEs, which are calculated from the school nurse survey. The denominator is calculated by taking the number of hours of reported RN nursing hours, divided by 120 (6 hours/day x 20 school days/month = 1 FTE. The indicator is a ratio. This survey indicated that there were approximately 28.4 school nurse FTEs for this population in CY 2011. Note: A new method was used in calculating data for CY 2011.

Data Alerts: None

SPM 8 - Reduce the percent of students who were bullied on school property during the past 12 months.

	2011	2012	2013	2014	2015
Annual Objective	20.5	20.0	19.5	19.0	18.5
Annual Indicator	24.9	24.9	25.4	24.0	24.0
Numerator	7,503	7,503	7,660	7,241	7,241
Denominator	30,157	30,157	30,122	30,162	30,162
Data Source	See note field.				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The source for this data is selected weighted CDC data from the North Dakota 2015 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of students in grades 9 through 12 that responded "yes" to the YRBS question, indicating that they had been bullied on school property during the past 12 months. The denominator is the weighted number of students in grades 9 through 12 that responded to the question.

2. **Field Name:** **2014**

Field Note:

The source for this data is selected weighted CDC data from the North Dakota 2015 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of students in grades 9 through 12 that responded "yes" to the YRBS question, indicating that they had been bullied on school property during the past 12 months. The denominator is the weighted number of students in grades 9 through 12 that responded to the question.

3. **Field Name:** **2013**

Field Note:

The source for this data is selected weighted CDC data from the North Dakota 2013 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of students in grades 9 through 12 that responded "yes" to the YRBS question, indicating that they had been bullied on school property during the past 12 months. The denominator is the weighted number of students in grades 9 through 12 that responded to the question.

4. **Field Name:** **2012**

Field Note:

2012-The source for this data is selected weighted CDC data from the North Dakota 2011 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of students in grades 9 through 12 that responded "yes" to the YRBS question, indicating that they had been bullied on school property during the past 12 months. The denominator is the weighted number of students in grades 9 through 12 that responded to the question.

5. **Field Name:** **2011**

Field Note:

2011-The source for this data is selected weighted CDC data from the North Dakota 2011 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of students in grades 9 through 12 that responded "yes" to the YRBS question, indicating that they had been bullied on school property during the past 12 months. The denominator is the weighted number of students in grades 9 through 12 that responded to the question.

Data Alerts: None

SPM 9 - The rate of deaths to individuals ages 1 through 24 caused by intentional and unintentional injuries per 100,000 individuals.

	2011	2012	2013	2014	2015
Annual Objective	29.0	28.0	27.0	26.0	25.0
Annual Indicator	37.6	31.3	31.7	31.2	31.2
Numerator	85	73	81	81	81
Denominator	226,106	232,879	255,390	259,672	259,672
Data Source	See note field.				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The source for the numerator is the North Dakota Department of Health, Division of Vital Statistics. The denominator is from the U.S. Census Bureau, Population Division, 2014 U.S. population estimates. The numerator is the total number of deaths to individuals ages 1 through 24 due to intentional and unintentional injuries within the calendar year. The denominator is the estimated number of individuals ages 1 through 24 for the specific calendar year. The rate is calculated per 100,000.

2. **Field Name:** **2014**

Field Note:

The source for the numerator is the North Dakota Department of Health, Division of Vital Statistics. The denominator is from the U.S. Census Bureau, Population Division, 2014 U.S. population estimates. The numerator is the total number of deaths to individuals ages 1 through 24 due to intentional and unintentional injuries within the calendar year. The denominator is the estimated number of individuals ages 1 through 24 for the specific calendar year. The rate is calculated per 100,000.

3. **Field Name:** **2013**

Field Note:

The source for the numerator is the North Dakota Department of Health, Division of Vital Statistics. The denominator is from the U.S. Census Bureau, Population Division, 2013 U.S. population estimates. The numerator is the total number of deaths to individuals ages 1 through 24 due to intentional and unintentional injuries within the calendar year. The denominator is the estimated number of individuals ages 1 through 24 for the specific calendar year. The rate is calculated per 100,000.

4. **Field Name:** **2012**

Field Note:

2012-The source for the numerator is the North Dakota Department of Health, Division of Vital Statistics. The denominator is from the U.S. Census Bureau, Population Division, 2012 U.S. population estimates. The numerator is the total number of deaths to individuals ages 1 through 24 due to intentional and unintentional injuries within the calendar year. The denominator is the estimated number of individuals ages 1 through 24 for the specific calendar year. The rate is calculated per 100,000.

5. **Field Name:** **2011**

Field Note:

2011-The source for the numerator is the North Dakota Department of Health, Division of Vital Statistics. The denominator is from the U.S. Census Bureau, Population Division, 2011 U.S. population estimates. The numerator is the total number of deaths to individuals ages 1 through 24 due to intentional and unintentional injuries within the calendar year. The denominator is the estimated number of individuals ages 1 through 24 for the specific calendar year. The rate is calculated per 100,000.

Data Alerts: None

SPM 10 - The percent of healthy weight among adults ages 18 through 44.

	2011	2012	2013	2014	2015
Annual Objective	37.0	40.3	40.4	40.5	40.6
Annual Indicator	39.5	38.8	36.6	35.4	35.4
Numerator	97,053	89,080	91,433	92,347	92,347
Denominator	245,531	229,573	249,561	261,021	261,021
Data Source	See note field.	See note field.	See note field.	See note field	See note field
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:

2015-Final 2014 data was used as provisional data for 2015. The data for percent of healthy weight among adults from age 18 through 44 was collected from the 2014 Behavioral Risk Factor Surveillance Survey (BRFSS). Both the numerator and denominator are weighted estimates. The numerator is the weighted number of respondents ages 18 through 44 with body mass index (BMI) greater or equal to 18.5 and < 25.0. The denominator is the weighted number of respondents ages 18 through 44 providing height and weight information in the BRFSS. Note: The 2011 data was corrected as follows: The numerator was changed from 97,053 to 97,212. The denominator was changed from 245,531 to 229,624 and the Percent was changed from 39.5 to 42.3.

2. **Field Name:** **2014**

Field Note:

The data for percent of healthy weight among adults from age 18 through 44 was collected from the 2014 Behavioral Risk Factor Surveillance Survey (BRFSS). Both the numerator and denominator are weighted estimates. The numerator is the weighted number of respondents ages 18 through 44 with body mass index (BMI) greater or equal to 18.5 and < 25.0. The denominator is the weighted number of respondents ages 18 through 44 providing height and weight information in the BRFSS. Note: The 2011 data was corrected as follows: The numerator was changed from 97,053 to 97,212. The denominator was changed from 245,531 to 229,624 and the Percent was changed from 39.5 to 42.3.

3. **Field Name:** **2013**

Field Note:

The data for percent of healthy weight among adults from age 18 through 44 was collected from the 2013 Behavioral Risk Factor Surveillance Survey (BRFSS). Both the numerator and denominator are weighted estimates. The numerator is the weighted number of respondents ages 18 through 44 with body mass index (BMI) greater or equal to 18.5 and < 25.0. The denominator is the weighted number of respondents ages 18 through 44 providing height and weight information in the BRFSS. Note: The 2011 data was corrected as follows: The numerator was changed from 97,053 to 97,212. The denominator was changed from 245,531 to 229,624 and the Percent was changed from 39.5 to 42.3.

4. **Field Name:** 2012

Field Note:

2012-The data for percent of healthy weight among adults from age 18 through 44 was collected from the 2012 Behavioral Risk Factor Surveillance Survey (BRFSS). Both the numerator and denominator are weighted estimates. The numerator is the weighted number of respondents ages 18 through 44 with body mass index (BMI) greater or equal to 18.5 and < 25.0. The denominator is the weighted number of respondents ages 18 through 44 providing height and weight information in the BRFSS. Note: The 2011 data was corrected as follows: The numerator was changed from 97,053 to 97,212. The denominator was changed from 245,531 to 229,624 and the Percent was changed from 39.5 to 42.3.

5. **Field Name:** 2011

Field Note:

2011-The data for percent of healthy weight among adults from age 18 through 44 was collected from the 2011 Behavioral Risk Factor Surveillance Survey (BRFSS). Both the numerator and denominator are weighted estimates. The numerator is the weighted number of respondents ages 18 through 44 with body mass index (BMI) greater or equal to 18.5 and < 25.0. The denominator is the weighted number of respondents ages 18 through 44 providing height and weight information in the BRFSS.

Data Alerts: None

Form 11
Other State Data
State: North Dakota

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the current application/annual report.

State Action Plan Table

State: North Dakota

Please click the link below to download a PDF of the full version of the State Action Plan Table.

[State Action Plan Table](#)

Abbreviated State Action Plan Table

State: North Dakota

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce tobacco use in pregnant women.	NPM 1 - Well-Woman Visit	ESM 1.1	

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Increase the rate of breastfeeding at 6 months.	NPM 4 - Breastfeeding	ESM 4.1	
Reduce disparities in infant mortality.	NPM 5 - Safe Sleep	ESM 5.1	

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce overweight and obesity in children.	NPM 8 - Physical Activity	ESM 8.1	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce fatal motor vehicle crash deaths to adolescents.	NPM 7 - Injury Hospitalization	ESM 7.1	
			SPM 1

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Increase the utilization of medical home.	NPM 11 - Medical Home	ESM 11.1	
Increase the number of children with special health care needs receiving transition support.	NPM 12 - Transition	ESM 12.1	

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Increase preventive dental services to children.	NPM 13 - Preventive Dental Visit	ESM 13.1	
			SPM 2
			SPM 3