



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

**State Narrative for  
North Dakota**

**Application for 2009  
Annual Report for 2007**



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## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.

***An attachment is included in this section.***

### **B. Face Sheet**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. Assurances and Certifications**

Signed assurances and certifications will be maintained on file in the North Dakota Department of Health, Division of Family Health. As required in Section 502(a)(3), funds will only be used for the purposes specified. As required in Section 505(a)(5)(B), funds will only be used to carry out the purposes of this title.

***An attachment is included in this section.***

### **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; expires May 31, 2009.

### **E. Public Input**

In fall 2004, a Title V five-year needs assessment planning retreat was held with over 40 individuals representing each of the three MCH population groups. Needs assessment data was presented, and with the help of a facilitator, health needs were prioritized and intervention strategies and partner opportunities discussed. Input obtained at the retreat was used in subsequent planning for the FY 2006-2010 applications.

Annual updates on the MCH application activities are provided to the CSHS Advisory Councils and Community Health Section Advisory Committee. All of these groups have a broad range of representatives from throughout the state who provide input in directing public health efforts. Members of the CSHS Family Advisory Council also participated in the ranking to assess family participation in the State CSHCN program.

On July 3, 2008, a news release was sent to most major media outlets in the state. The release provided information about priority needs that had been identified for the MCH population through the statewide needs assessment and announced that the Title V application would be available for public comment on July 7, 2008.

## **II. Needs Assessment**

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

### **C. Needs Assessment Summary**

#### ***/2009/ ND Behavioral Risk Factor Surveillance System (NDBRFSS)***

***ND has been collecting BRFSS data since 1984. The data collected in ND is used to develop health policy, design and evaluate public health programs, monitor the health risks and health status of ND residents, determine the attitudes and beliefs of North Dakotans about important health issues, and meet data needs for researchers both in the state and nationwide. NDBRFSS data can be viewed at: <http://www.ndhealth.gov/brfss/>.***

#### ***ND Oral Health Surveillance Plan***

***The ND Oral Health Surveillance Plan 2007-2103 was released in fall 2007. The purpose of the plan is to monitor the oral health status and trends and use the information to guide program actions to improve the oral health of ND citizens. The data will be used for program planning, implementation and evaluation; policy planning and advocacy; and improvement of program accountability. The document can be viewed at: <http://www.ndhealth.gov/oralhealth/publications/ND%20Oral%20Health%20Surveillance%20Plan.pdf>.***

#### ***ND Position Paper on Collecting Heights and Weights***

***In March 2007, the ND Healthy Weight Council (HWC) released Guidelines for Collecting Heights and Weights on Children and Adolescents in School Settings and Implications of Measuring Height and Weight in Schools. The HWC addresses issues that encompass the promotion of healthy weight. HWC members include more than 60 dietitians, nutritionists, nurses, physical activity educators, physicians and other health professionals who work in health-care institutions, schools, state agencies, nonprofit health-advocacy groups and private industry.***

***The position of the HWC supports the physical and emotional well-being of all students and recommends that schools measure heights and weights only under special circumstances: 1) the school is involved in a research project approved by an institutional review board for which height and weight measures are needed, 2) the school is involved in measuring heights and weights for surveillance to justify a program or grant; reporting only aggregate data, 3) the school is part of a health program in which policies and procedures are in place to provide adequate referrals, and/or 4) the students are involved in activities where weight is monitored and dehydration is a concern. The position paper can be viewed at: <http://www.ndhealth.gov/nutrphyact/PositionPaper10-07.pdf>.***

#### ***ND 2006 Profiles***

***2006 ND School Health Profiles - School Health Questions Answered was released in 2007. This document combines Profiles survey results with YRBS results to provide information on school health policies and activities and the prevalence of health risk behaviors among youth. Survey results can be viewed at: <http://www.dpi.state.nd.us/health/educprof/SchHlthBrochure.pdf>.***

#### ***ND Youth Risk Behavior Survey (YRBS)***

***During the spring of 2007, the ND Department of Public Instruction and the NDDoH conducted the eighth biennial YRBS. Weighted data was obtained from 2,091 seventh and eighth grade students and students in grades nine through 12. These results can be used to make important inferences about all ND students in grades seven through 12 due to the***

*random, research-based selection process. State and local programs use this data to target youth based- interventions. Survey results can be viewed at: <http://www.dpi.state.nd.us/health/YRBS/2007/middle/index.shtm>.*

**National Survey of Children with Special Health Care Needs (NS-CSHCN)**  
*Major findings from the 2005-2006 NS-CSHCN became available December 2007. This telephone survey was conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention. More information can be found at: <http://cshcndata.org/content/Default.aspx>.*

#### **ND Disability Health Project**

*In July 2007, the ND Center for Persons with Disabilities at Minot State University was awarded funding from CDC to implement the ND Disability Health Project, the purpose of which was to promote the health and wellness of ND citizens with disabilities and to prevent or lessen the effects of secondary conditions associated with disabilities. Two reports prepared by the project present an initial picture of ND's health situation for persons with disabilities. They can be viewed at: [www.ndcpd.org/health](http://www.ndcpd.org/health). For the combined years of 2001 to 2006, 16.7 percent of ND adults, or one in six persons, were defined as having a disability (ND BRFSS, 2001-2006). Health disparities were noted between people with and without disabilities in ND. Issues that negatively impacted the quality of life for people with disabilities were identified.*

#### **ND Autism Initiative**

*Special Congressional Initiative funding was awarded to the ND Center for Persons with Disabilities at Minot State University to support the Great Plains Autism Spectrum Disorders Treatment Program (GPAST). An assessment was conducted in conjunction with this initiative where many needs were identified. More information about GPAST is available at: [www.ndcpd.org/Autism/](http://www.ndcpd.org/Autism/).*

#### **Genetics State Plan**

*In 2008, a five-year ND State Genetics Plan was released. The plan stemmed from a needs assessment and planning process that was conducted over a 21-month period from October 2005 to July 2007. The goal of the needs assessment was to identify and define genetic health service priorities for ND. The needs assessment process collected both qualitative and quantitative data using a variety of formats. A full report is available at: [www.medicine.nodak.edu/genetics](http://www.medicine.nodak.edu/genetics).*

#### **Transition**

*A ND Transition follow-up study is conducted each year to monitor perceptions and outcomes of students with disabilities as they leave the public education system. According to the spring 2008 ND Transition Follow-up Annual Report, 65.5 percent of students in Special Education had health insurance compared to 87.7 percent of students in General Education one year after exit. The full report is available at: [www.dpi.state.nd.us/transitn/publicatns.shtm](http://www.dpi.state.nd.us/transitn/publicatns.shtm).*

#### **ND Kids Count**

*ND Kids Count produced a report entitled 2006 Overview of Children's Well-Being in North Dakota. The report's focus was on American Indian Children, the state's largest racial minority group. American Indian children are an important, diverse part of the state's population and vital to the future of ND. The overview details a portrait of American Indian children with respect to their demographic traits, family composition, economic condition, education, health, and at-risk indicators. Further information is available at: [www.ndkidscount.org](http://www.ndkidscount.org). //2009//*

### **III. State Overview**

#### **A. Overview**

North Dakota (ND) is a large state on the northern edge of the Great Plains abutting the Canadian provinces of Saskatchewan and Manitoba. It is positioned neatly between Montana and Minnesota and sits on the northern border of South Dakota. The state is 212 by 360 miles and occupies a landmass equivalent to that of New York, New Jersey, Massachusetts and Connecticut (70,704 square miles) with a mere fraction of the population of these more urban states. It is 17th in the nation for size and 47th in the nation for population. The average population density for the United States is 79.6 persons per square mile compared to ND's 9.3 persons per square mile.

The relative isolation of ND's rural population is demonstrated by the fact that nearly 68% of the landmass in the state is considered frontier, with a population density less than six persons per square mile. This means a wide dispersion of the rural population and significant distances from rural to more populous areas. Travel to population centers for health care or for other purposes often entails significant amounts of time and effort for rural residents. Compounding this issue is the virtually non-existent mass transportation system. The automobile is the primary means of transportation for most rural and urban residents. While a number of mini-bus services have been developed over the years for the elderly and disabled residents, the services are regional and usually client-specific. There is limited Greyhound bus service and Amtrak service is only available through the northern tier of the state. This leaves most rural residents to rely on private automobiles for their primary transportation to access goods and services. Obviously, this is a significant problem for adolescents and low-income rural population groups.

The problem of isolation and travel difficulties for many ND rural residents is complicated by weather conditions in the state. As a state located in the geographic center of North America, the weather patterns can be extreme. Meteorologists point out that the farther an area is from oceans, the more variation there will be in the climate. ND is as far from oceans as any state in the nation. Temperatures range from highs of 109 degrees [with heat indexes up to 125 degrees] in the summer to lows of -43 degrees [with wind chills of -100 degrees] in the winter. Winter conditions are perhaps of more concern due to the more immediate jeopardy to human life that it can present. The absolute cold of winter compounded by the wind chill factors can freeze unprotected human flesh in less than one minute. Frequently, blowing snow makes travel hazardous and at times impossible.

This is not to say that ND is a forbidding place to live. It is a beautiful state with many extraordinary geographical features and is populated by hardy residents who understand the difficulties and the hazards of winter travel. Travel for many rural ND residents takes more planning and coordination in order to access health care services than for their counterparts in many other states in the nation.

There are several hard demographic truths about the future in ND: 1) population consolidation, 2) loss of young adults/families, 3) aging population, and 4) shifting labor force.

ND lost 1.6% of its population between 1980 and 2000, but not all counties lost population. Population growth was concentrated in Cass, Grand Forks and Burleigh counties. Smaller levels of growth were experienced in Sioux, Mercer, Ward and Rolette counties. All other counties lost population. Although adjacent and remote counties lost a significant share of their populations, the metro areas grew by 17.3% from 1980-2000.

Rural-Urban Population Distribution  
ND, 1900-2000 (see attachment)

Less than four percent of the United States population lives in frontier areas spread over more

than half of the country's land mass. However, over 21% of the ND population resides in the 36 counties designated as frontier. Frontier counties are categorized as persistent poverty counties. Economic characteristics of frontier areas impacting women and children include occupational hazards, poverty, lack of health insurance and lack of health care resources. Economic stress is also highly correlated with clinical depression and family stress.

One of the most significant issues faced by rural ND communities and health care providers is the out migration of the state's rural population. The effect of this demographic trend is profound. It influences all aspects of life in rural ND. The decline is associated with reductions in rural tax bases, business enterprises, social activities and bears heavily on the difficulty in sustaining local educational institutions and health care facilities, personnel and programs. The decline is not a recent phenomenon. It began over 50 years ago and will likely continue into the foreseeable future. To complicate matters, the decline is not uniformly distributed across all age groups. It is primarily associated with "working age" people (20-50 years old) who move from rural areas to secure employment or other opportunities out of state or in the population centers of ND. The net effect of this population trend is continued reduction in the number of people that live in most ND counties and a general "aging" of the population that remains in rural areas. However, that does not relieve public health programs from the responsibility of providing services to North Dakotans in these remote areas. This population trend presents a significant challenge to providing health care in rural ND.

As is characteristic of rural states, the annual per capita personal income is below the national average. It may be noted that, when controlling for inflation, ND compared to the United States and the three surrounding states, but still lags behind the national average [only 85% of the U.S. average] and two of the three bordering states ranking 39th nationally. All but one county within ND has per capita income lower than the national average. Forty-six of the 53 counties have per capita incomes lower than the state average. Per capita income stands at \$17,769 for ND compared to the national average of \$21,587.

Considering that agriculture comprises a significant portion of the state gross product, it is understandable that there can appear to be significant fluctuations in the per capita income from year to year. The boom/bust phenomenon in the energy industry in years past has had a significant impact on the economic status of North Dakotans in the western part of the state. Due to the problems in these two major industries, the ability of individuals to purchase health care services has decreased since the more basic needs of shelter and food have become the priority in their lives.

The 2000 Census indicates that 11.9% of the population lives in poverty. Statistics for 2001 indicate that the proportion has risen to 13.8%. This represents a fairly equal rise in both the number of males and females below the poverty level. However, 15.8% of all females are below poverty as compared to 13.0% of all males. This trend has not significantly changed over the intervening years leading to the year 2000 Census.

The state population of 638,800 is primarily Caucasian - 593,181 or 92.4% of the citizens fall into this category. Minority populations comprise 49,019 or 7.6% of North Dakotans. American Indians are the most significant minority group in ND totaling 31,329 individuals. Members of this ethnic group may be found either on one of the five reservations within ND or scattered across the state in the major cities. They are also the ethnic group with the most significant health care problems, but also the most difficult to reach and provide services to due to their cultural considerations.

American Indians living on the reservation have access to Indian Health Service (IHS) as well as Tribal Health Services (THS) for their health care services. There has been continued collaboration between the five tribes in ND, the DoH and the DHS in addressing health issues. The more difficult population of American Indians to reach are those residing in the major cities of ND. They have more limited access to IHS and THS for health care services and are less likely to be able to afford unsubsidized care.

## State and Departmental Priorities and Initiatives

Initiatives of Governor John Hoeven's Administration focus on the following six pillars: education, economic development, agriculture, energy, technology and quality of life. In Governor Hoeven's 2002 State of the State address, he announced a new public health initiative, Healthy North Dakota, which focuses on improving the health of every North Dakotan. First Lady Mikey L. Hoeven has been deeply committed to addressing women and children's issues in the state of ND. She is especially active in women's health, the prevention of underage drinking, and is the official spokesperson for Healthy North Dakota. More information is available at: <http://www.firstlady.state.nd.us>

Healthy North Dakota is a statewide initiative whose goal is to improve the health of every North Dakotan by inspiring people to establish personal behaviors and support policies that improve health and reduce the burden of health care costs. Healthy North Dakota works through innovative statewide partnerships to support North Dakotans in their efforts to make healthy choices - in schools, workplaces, senior centers, homes and anywhere people live, work and play. At an August 2002 Healthy North Dakota Summit, 130 people representing more than 75 organizations met to define wellness and identify priorities for ND. The input gathered at the summit provided the framework for a statewide wellness plan. The following topics have been identified as priorities for ND: 1) tobacco use, 2) substance abuse/mental health, 3) healthy weight/nutrition, 4) healthy weight/physical activity, 5) health disparities, 6) worksite wellness, 7) community engagement, 8) third-party payers/insurance, 9) oral health, 10) cancer, 11) early childhood, 12) school health, 13) aging, 14) immunizations, 15) cardiovascular health, 16) injury prevention and control, and 17) diabetes.

/2007/ Environmental quality has been added as a topic area. Healthy North Dakota also completed a strategic assessment in 2005-06. As a result of this assessment, the Healthy North Dakota Advisory Committee members agreed to move forward with the following recommendations: (1) Designate two focus areas for Healthy North Dakota and prioritize Healthy North Dakota resources accordingly; (2) Develop written role and function description, etc., for Coordinating, Advisory and Executive Committees for Healthy North Dakota; (3) Develop legislative priorities for the 2007-2009 biennium; and, (4) Identify best place for Healthy North Dakota. With regard to recommendation #4, it was heavily favored to house administration of Healthy North Dakota in the DoH with backing from the State Health Officer and the Governor's office. Potential areas of emphasis discussed include cardiovascular health, diabetes, obesity and cancer.//2007//

/2008/ In 2006, a group of leaders from the private and public sectors initiated a voluntary, self-funded collaborative effort to explore innovative, statewide approaches to improving the health status of North Dakotans. Results from this effort include a vision for the healthcare system in ND and a strategic map which outlines key initiatives to be undertaken.//2008//

***/2009/ The Statewide Vision and Strategy group identified priorities, including Healthy Kids/Healthy Weight and Worksite Wellness.//2009//***

The DoH is dedicated to ensuring that ND is a healthy place to live and that each person has an equal opportunity to enjoy good health. The Department is committed to the promotion of healthy lifestyles, the protection and enhancement of health and the environment, and the provision of quality health care services for the people of ND by networking, facilitating local efforts, collaborating with partners and stakeholders and providing expertise in developing creative public health solutions.

/2007/ In December 2005, the DoH started a strategic planning process through a funding partnership with the Association of State and Territorial Health Officers. The outcome of this process is the development of a strategic map that identifies the Department's mission, strategic initiatives, key objectives and indicators that will assist the Department in communicating with partners, setting direction, motivating employees, making decisions, determining priorities and budgets and monitoring progress and impact. It is anticipated that the strategic plan will be completed in fall 2006. The Title V director has been an active participant in this process.//2007//

/2008/ A Strategic Map containing the Department's mission, goals and key objectives has been completed. Indicators with state determined targets have been developed for all key objectives.//2008//

**/2009/ Strategies for achieving key objectives are being developed. A DoH Business Plan has also been written. Five subcommittees have been formed that are working on action plan development. The five subcommittees include programmatic effectiveness, workforce education and development, quality staff, department visibility, and employee health and wellness.//2009//**

The DHS is an umbrella agency with the mission to provide quality efficient and effective human services, which improve the lives of people. An Executive Director who is appointed by the governor heads the department. Broad-based goals of upper management are: 1) to focus attention on the Department's mission, 2) to improve teamwork across the department, 3) to improve innovation/creativity within the department, 4) to establish performance measures and accountability, and 5) to develop a proactive legislative agenda.

The department last underwent a strategic planning process in 2004. Plans that were developed as a result of that process continue to serve as a basis for evaluating achievements and include measures to ascertain the quality, efficiency and effectiveness of DHS programs.

/2007/ The DHS invited clients, the public, advocates, and providers to stakeholder meetings in January and February 2006, which took place in Bismarck, Devils Lake, Dickinson, Fargo, Grand Forks, Jamestown, Minot, and Williston. The meetings were organized to engage stakeholders in a discussion about community needs, service capacity, and resources in order to identify broad areas of interest and to seek ideas and recommendations from the department's partners. While comments varied, listed below are some common themes and concerns that emerged.

- \* Capacity issues exist at the State Hospital, the regional human service centers, and in the private sector for both mental health and substance abuse services.
- \* Concerns about the ability to meet the needs of ND's aging population and individuals with physical disabilities.
- \* ND's guardianship system (court system) needs more resources; access is an issue for vulnerable adults and children.
- \* Efficiency issues.
- \* Role of the Developmental Center and the plan for moving residents to community placements.
- \* Concerns about unfunded mandates.
- \* Shortage of family foster care homes and access to other appropriate placements.
- \* Transportation impacts access to services for rural and low-income residents -- outreach is limited.
- \* Issues regarding serving the Corrections population once they are no longer incarcerated.
- \* Homelessness and a shortage of housing options for vulnerable people exists in every region
- \* Medicaid Recipient Liability.
- \* Developmental disabilities providers report they are experiencing staffing issues.
- \* Access to treatment services is limited for sexual perpetrators who are minors or children.//2007//

**/2009/ Fall 2007, the ND Department of Human Services held public stakeholder meetings in eight locations throughout the state. The following themes were identified:**

- \* **ND's aging population is impacting service capacity**
- \* **Child welfare services are stressed in many regions**
- \* **Capacity issues exist across the system to appropriately serve youth transitioning into adult services**
- \* **Transportation is an issue across the state**
- \* **Workforce concerns exist across the entire service delivery system from direct**

**care workers to clinical specialists**

- \* **Capacity issues exist across the state's mental health system**
- \* **Concerns exist about gaps in the public substance abuse treatment system**
- \* **Support exists for technology solutions and more technical assistance**
- \* **Relationships and collaboration remain strong.//2009//**

ND's Title V statewide needs assessment process for FY's 2006-2011 began in 2003 and continued through March 2005. After an initial planning and data collection phase, a statewide meeting of key stakeholders was convened to assist in the selection of priority needs. Further work concluded the process by setting performance measure targets, identifying activities and allocating resources. The following ten priorities were identified through the statewide needs assessment process: 1) to increase physical activity and healthy weight among women, 2) to increase the initiation and duration of breastfeeding, 3) to increase access to dental services for low-income women, 4) to increase access to preventive health services for women, 5) to reduce the rate of intentional and unintentional injuries among children and adolescents, 6) to increase physical activity among pre-school and school-age children, 7) to increase the percent of healthy weight among children and adolescents, 8) to reduce the impact of chronic health conditions on children, 9) to improve geographic access to pediatric specialty care providers, and 10) to increase information and awareness about available services.

Title V resources are directed towards these ten priority areas. Many of these priority areas are also being addressed through Healthy North Dakota workgroups, in which MCH program staff are active members.

In April 2001, ND received a three-year, point-in-time Pregnancy Risk Assessment Monitoring System (PRAMS) grant. The first two years of the grant involved selection of a contractor, development of the survey tool, determination of sampling strategy, initiating the survey and the start of data analysis. Year three concluded in March 2005 with the release of "North Dakota PRAMS -- 2002 Survey Results." The report is available online at <http://www.ndsu.edu/sdc/data/ndprams.htm>. Data from this survey was instrumental in the state's five-year needs assessment.

/2007/ In January 2006, ND applied for the competitive, five-year PRAMS grant. In April 2006, ND was notified that the application was not selected for funding. Although many strengths were identified, the lack of an electronic registration system, no dedicated FTE to the project and no proposed over sampling to high-risk subpopulations (e.g., American Indians, Medicaid recipients) were cited as weaknesses. The ND State Data Center has made a commitment to develop and distribute PRAMS fact sheets from the 2002 point-in-time PRAMS. The DoH will collaborate with this project by serving as content reviewers and assisting with distribution. The Title V Director and Maternal/Infant Nurse Consultant provided a letter of support to the South Dakota Tribal PRAMS project; which did receive funding.//2007//

/2008/ The ND State Data Center has begun work on the PRAMS fact sheets "PRAMS-O-GRAMS." Topics will include current birth trends, pregnancy intendedness, maternal health and oral health services utilization, etc.//2008//

**//2009/ Five of nine PRAM-O-GRAM fact sheets have been completed. The PRAM-O-GRAM fact sheets can be viewed online at: <http://www.ndhealth.gov/familyhealth>.//2009//**

The 59th Legislative Assembly organized December 6-8, 2004, and met in regular session from Tuesday, January 4, 2005, through Saturday, April 23, 2005 and consisted of a Senate with 47 senators and a House of Representatives with 94 representatives. There were 944 bills (531 in the House and 413 in the Senate), 100 concurrent resolutions (60 in the House and 40 in the Senate), and two memorial resolutions introduced during the regular session. Of the total 1,046 bills and resolutions introduced, 333 House bills, 282 Senate bills, 42 House concurrent resolutions, 32 Senate concurrent resolutions, and one House and one Senate memorial resolution passed. The Governor signed 612 bills into law. He vetoed six bills, all of which were sustained. Three vetoes were item vetoes and did not affect the entire bill. Thus, 612 of the 615 bills have or will become law.

The Healthy North Dakota collaborative representing more than 400 North Dakotans and more than 150 different agencies, organizations and businesses provided leadership in identifying legislative strategies necessary to build a Healthy North Dakota. Healthy North Dakota partners worked collectively to identify key prevention policies prior to the legislative session, and as a result, a cohesive approach to raising the visibility of prevention was achieved. Through the Healthy North Dakota collaborative, silos are softening, which is leading the state to a cohesive, consistent approach to prevention.

Numerous bills relating to the maternal and child population were considered by the Legislature. Those most significantly related to the MCH population include:

HB 1101: Relating to personal flotation devices for children on vessels. (Failed)

HB 1012: An Act to provide an appropriation for defraying the expenses of the DHS; to provide an exception; to provide for a legislative council study; to provide an appropriation to the DoH; to provide for a transfer to the general fund; to provide for the transfer of appropriation authority; to create and enact a new section to chapter 25-18 of the ND Century Code, relating to providing services to medically fragile children; to amend and reenact subsection 10 of section 54.44.8-01 of the North Dakota Century Code (NDCC), relating to telecommunications equipment; and to declare an emergency. (Passed)

Some of the areas where additional funding will positively impact the DHS follows below:

- \* DHS will be able to replace the Medicaid Management Information System (MMIS).
- \* Funding was included to address a decrease in the federal match for Medicaid (FMAP).
- \* Funding was included to help some people with developmental disabilities to transition from the Developmental Center to community-based care settings.
- \* Uniform inflationary increases for various provider groups were included in the DHS appropriation bill.

HB 1048: Relating to required high schools units. This bill decreased the required units offered in physical education and health. (Passed)

HB 1148: Relating to personal care services for eligible medical assistance recipients who are residing in their own homes. Makes permanent the personal care option for individuals eligible for the Medicaid Program. It also requires the department to submit a waiver that would permit disabled and elderly individuals to direct their own care. (Passed)

HB 1227: Relating to the protection of a preborn child and the duty of physicians; and to provide a penalty. (Failed)

HB 1206: Relating to provider appeals of medical assistance reimbursement denials; and to amend and reenact section 50-24.1-15 of the NDCC, relating to pre-hospital emergency medical services. Establishes an appeal process for providers who do not agree with the payment decision made by staff of the Medicaid Program. The provider can appeal a decision to the Department and an individual who was not involved in the original decision must complete the review process. If the provider does not prevail, he then could appeal directly to the district court. (Passed)

HB 1320: Relating to recess for elementary students. (Failed)

HB 1342: Relating to all terrain vehicles. (Passed)

HB 1383: Relating to definitions for the purpose of sale and consumption of alcoholic beverages. (Passed)

HB 1412: Relating to passengers on all-terrain vehicles. (Passed)

HB 1456: Relating to employers' responsibilities for nursing mothers. (Failed)

HB 1459: Relating to creation of a prescription drug monitoring program and medical assistance program management; to provide for reports to the legislative council; to provide for a legislative council study; to provide legislative intent. Establishes a drug-monitoring program contingent on the availability of federal funds to implement the program. Establishes a disease management program for Medicaid recipients with a concentration given to individuals with high medical costs. It also requires the Department to report to the Legislative Council on various issues relating to the operation of the Medicaid Program and recommends a study of the Medicaid reimbursement system. (Passed)

HCR 3013: A concurrent resolution directing the Legislative Council to study the causes of and factors that reduce the severity of motor vehicle crashes. (Passed)

HCR 3017: Urging Congress to pass a human life amendment to the Constitution of the United States. (Passed)

HCR 3022: A concurrent resolution directing the Legislative Council to study data regarding cervical cancer and human papillomavirus, evaluate current methods of public education and access to regular cervical cancer screening, and consider options for increasing screening accuracy. (Passed)

HCR 3034: A concurrent resolution urging school districts to provide a midmorning and midafternoon recess to all students in kindergarten through grade six. (Passed)

HCR 3046: A concurrent resolution directing the Legislative Council to study the feasibility and desirability of implementing early childhood education programs. (Failed)

HCR 3051: A concurrent resolution directing the Legislative Council to study ways in which state agencies can join with health care professionals, school districts, schools and parents to promote understanding regarding the interplay of health and educational success and to improve the health and well-being of elementary and high school students in this state. (Failed)

HCR 3054: A concurrent resolution directing the Legislative Council to study state programs providing services to children with special health care needs to determine whether the programs are effective in meeting these special health care needs, whether there are gaps in the state's system for providing services to children with special health care needs, and whether there are significant unmet special health care needs of children which should be addressed. (Passed and selected as an interim legislative study)

SB 2004: An Act to provide an appropriation for defraying the expenses of the DoH relating to the state health officer's duty to establish an environmental review process for commercial buildings; relating to licensure of food vending machines, beverage sales, food and lodging establishments, assisted living facilities, pushcarts, mobile food units, salvaged food distributors, bed and breakfasts, mobile home parks, trailer parks, and campgrounds; relating to license fee amounts for beverage sales, food and lodging establishments, mobile food units, pushcarts, bed and breakfasts, mobile home parks, trailer parks, and campgrounds; to provide for a report to the legislative council; to provide legislative intent; and to provide for a legislative council study. (Passed)

Some of the areas that will positively impact the DoH follow below:

- \* One new FTE for the Division of Tobacco Prevention and Control (funded by the tobacco settlement dollars)

- \* Authority to spend \$220,000 for abstinence education programs.

- \* Authority to spend \$135,000 for worksite wellness pilot.

- \* Legislative Council study on the costs and benefits of adopting a comprehensive Healthy North Dakota and workplace wellness program.

SB 2067: Relating to the use of alcohol by a person under twenty-one years of age. (Passed)

SB 2163: Relating to student's possession and self-administration of medication for the treatment of asthma and anaphylaxis. (Passed)

SB 2185: Relating to buy-in of medical assistance for individuals with disabilities. Makes permanent the workers with disability program including clarifying the allowance of an additional \$10,000 in assets for this group. (Passed)

SB 2205: Relating to snowmobile registration and snowmobile operation by an individual who is at least twelve years of age. (Passed)

SB 2208: Relating to motor vehicle child restraint systems. (Passed)

SB 2223: Relating to the distribution of tobacco settlement moneys and tobacco tax revenue; and to provide a continuing appropriation. (Failed)

SB 2261: Relating to legal protection to moms who breastfed in public. (Failed)

SB 2300: Relating to smoke free environments, relating to smoking area signage; and to provide a penalty. (Passed)

SB 2308: Relating to consent for certain health care services provided to minors. (Failed)

SB 2328: Relating to a limitation on the sale of certain beverages on school property. (Failed)

SB 2380: Relating to the use of safety belts: relating to secondary enforcement of safety belt violations. (Failed)

SB 2395: Relating to a DHS treatment program for children with Russell-Silver syndrome; to amend and reenact subsection 12 of section 50-10-06 of the NDCC, relating to income eligibility for Russell-Silver syndrome treatment and services; to direct the DHS to apply for a medical waiver; to provide for a legislative council study; to provide for a report to the legislative council; to provide an appropriation; and to declare an emergency. (Passed)

SB 2409: Relating to the establishment of an alternatives-to-abortion services program; to provide for reports to the legislative council; to provide an appropriation; and to provide an expiration date. (Passed)

/2007/ During the 59th Legislative Assembly (2005 Session), the DoH received authority to spend \$135,000 for worksite wellness pilots. The DoH in partnership with Healthy North Dakota, secured funding from the Dakota Medical Foundation to conduct three worksite wellness pilot projects. Dakota Medical Foundation contracted with Altru Health Systems to facilitate the pilot projects. Preliminary results of these pilots will be available by December 2006. Additionally, the DoH in partnership with the Healthy North Dakota worksite wellness consultants, conducted initial pilot projects; this data will also be available by December 2006.//2007//

/2008/ North Dakota State University evaluated Healthy North Dakota's (HND) three worksite wellness pilots. The results showed that 80% of all employees scored poor to fair in the overall Personal Wellness Profile.//2008//

**/2009/ Evaluation data for one of the worksite wellness pilots demonstrated the positive impact comprehensive worksite wellness has made after one year:**

- **65% maintained their overall wellness score of 74 (doing well/excellent) or higher**
- **20% decrease in cancer risk**
- **16% improvement in nutritional changes**
- **15% improvement in fitness activities**
- **9% decrease in coronary risk**
- **5% decrease in above recommended weight range//2009//**

/2007/ The Legislative Council is studying the costs and benefits of adopting a comprehensive healthy ND and workplace wellness program in collaboration with the DoH, health insurers and other third-party payers, Workforce Safety and Insurance, interested nonprofit health-related agencies, and others who have an interest in establishing accident and disease prevention programs were addressed by the Budget Committee on Human Services. Healthy North Dakota members provided a general overview of Healthy North Dakota including its concepts and purpose, status of planning and some early results of the initiative. Testimony was also provided on the effectiveness of tobacco cessation efforts across the state. Representatives of the Public Employees Retirement System reported on its cessation and workplace wellness programs. Additionally, preliminary results of the Healthy North Dakota strategic assessment and proposals for the future of Healthy North Dakota were presented.//2007//

/2008/ Testimony related to HND and worksite wellness was provided to the Interim Budget Committee on Human Services, thus providing education to the committee about HND and the benefits of worksite wellness.//2008//

**/2009/ The study was conducted and the results were reported. No further action was taken.//2009//**

/2007/ Two bills relating to the CSHCN population were addressed by the interim Budget Committee on Human Services. The first was House Concurrent Resolution No. 3054, which directed the Legislative Council to study state programs providing services to children with special health care needs to determine program effectiveness, system gaps, and unmet health care needs. The second was Senate Bill No. 2395. This bill created a program for children with Russell Silver Syndrome and directed the DHS to apply for a waiver to provide in-home services to children with extraordinary medical needs who otherwise require hospitalization or nursing facility care. CSHS staff provided testimony at numerous committee meetings during the year. Legislative direction related to the child health study is as yet unknown. The Department anticipates submission of the new waiver application by December 2006.//2007//

/2007/ Passage of the Family Opportunity Act as part of the overall federal Deficit Reduction Act of 2005, opened the door for states to establish Medicaid buy-in programs for children with disabilities if their family income was less than 300% of the Federal Poverty Level. As part of its budget planning process for the 2007-2009 biennium, the DHS developed a fiscal analysis that included estimated enrollment and program costs just such a Medicaid buy-in program in ND.//2007//

/2007/ For the upcoming 2007 Legislative Assembly, the ND School Nurse Organization (NDSNO) is requesting a \$5,000,000 general fund appropriation to the DoH, Community Health Section, Division of Family Health, for the purposes of providing for the provision of school health and wellness services in schools. Utilizing the Joint Powers of Agreements model of service delivery, grants will be awarded for school health and wellness services through a Request for Proposal (RFP) process to schools in partnership with local public health units. A match requirement will be established, but has not been determined at this time. The funding amount includes one Full Time Equivalent (FTE) to manage the Program. This FTE will be located in the DoH, Division of Family Health. The remaining funds will be awarded in grants.//2007//

/2008/ The 60th Legislative Assembly met in regular session from January 3, 2007, through April 25, 2007. Numerous bills relating to the maternal and child population were considered by the Legislature.

HB 1004: DoH Appropriation Bill. The DoH's budget is \$172,112,310. Funding for the Division of Children's Special Health Needs is included in this amount (transferred from DHS to DoH). (Passed)

HB 1047: Relating to the eligibility requirements for the children's health insurance program. (Failed)

HB 1194: Relating to graduation requirements (physical education requirements would be reduced to 1/2 unit for grades 9-12). (Failed)

HB 1232: Relating to umbilical cord blood donation. (Passed)

HB 1246: Relating to dental medical assistance reimbursement; and to provide an appropriation. This Bill provides additional funds to DHS to enhance the dental fee schedule for children's dental services through the medical assistance program. (Passed)

HB 1254: Relating to the use of seat belts; and to repeal secondary enforcement of safety belt requirements. (Failed)

HB 1293: Relating to the application of topical fluoride varnish and exemptions to the regulation of dentists. This law will allow the application of fluoride varnish by medical professionals who have successfully completed an approved training program. (Passed)

HB 1320: Relating to the establishment of pre-kindergarten programs. (Passed)

HB 1423: Relating to youth operation of off-highway vehicles. (Failed)

HB 1445: Relating to equipment and operation of registered off-highway vehicles. (Passed)

HB 1451: Relating to the prohibition on the sale of carbonated beverages on school property. (Failed)

HB 1463: Relating to medical assistance eligibility for minors and eligibility under the state children's health insurance program; and to provide a contingent appropriation. This Bill allows for expansion of Medicaid eligibility for individuals from birth through age 18 at 133% of the federal poverty level and SCHIP (Healthy Steps) eligibility at a net income of 150% of the poverty line, but is contingent upon federal changes during SCHIP reauthorization. (Passed)

HB 1464: Relating to the use of abortion-inducing drugs. If this bill had passed, the DoH would not have been able to apply for family planning funds. (Failed)

HB 1466: Relating to the prohibition of the performance of abortions, except to save the life of the mother. (Passed; however, Roe vs. Wade will have to be overturned before this law would go into effect.)

HB 1471: Relating to state department of health programs to educate about the human papillomavirus virus. (Passed)

HB 1512: An Act to provide for a frontier and rural medical access grant program to provide primary health care to the uninsured and underinsured in rural areas of the state. (Failed)

HCR 3046: A concurrent resolution directing the Legislative council to study ways in which

various public and private entities can cooperate to promote healthy lifestyles for children and create awareness about the interplay of healthy lifestyle choices and educational success.

(Passed)

SB 2012: An Act to provide an appropriation for defraying the expenses of the DHS. Highlights impacting children include the transfer of responsibility for the administration of the Title V program for children with special health care needs from DHS to the DoH, 12-month continuous eligibility for categorically needy children, and funding to sustain outreach efforts for the SCHIP. Also included is a study of the state's Infant Development Programs. (Passed)

SB 2024: Relating to defraying the expenses of the DHS for a Medicaid management information system. This Bill allows DHS to move forward with the design, development, and installation of a new MMIS with a scheduled implementation date of July 2009. The Title V CSHCN program utilizes this system for claims payment activities. (Passed)

SB 2069: Relating to determination of self-employment income for eligibility for the SCHIP. This Bill allows averaging of the previous three years of adjusted gross income or loss when determining self-employment income for eligibility for SCHIP. (Passed)

SB 2103: Relating to the cost of forensic medical examinations for victims of sexual assault. (Passed)

SB 2152: Relating to selection criteria and eligibility for loan repayment by dentists. (Passed)

SB 2181: Relating to consent for prenatal care and other pregnancy care services provided to minors. (Failed)

SB 2186: Relating to early childhood care workforce development and department of human services establishment of a quality rating system for early childhood facilities. (Passed)

SB 2302: Relating to the provision on an appropriation to the state department of health for providing grants to local domestic violence sexual assault organizations. (Failed)

SB 2312: Relating to alternatives to abortion services program. (Passed)

SB 2313: Relating to the purchase and distribution of automated external defibrillators. (Passed)

SB 2326: Relating to medical assistance and other health coverage for families of children with disabilities. This Bill establishes a new eligibility category, a Medicaid buy-in program for families that have children with disabilities whose net income does not exceed 200% of the federal poverty line. It also appropriates funding to DHS to implement a new waiver for children with extraordinary medical needs who would otherwise require hospitalization or nursing facility care. (Passed)

SB 2354: Relating to instruction on physical education. This bill requires school districts to make available 1/2 unit of physical education during each school year. (Passed)

SB 2377: Relating to obstetrical services provided by laypeople. (Failed)

SB 2385: Relating to a school district or nonpublic school nursing services grant program. (Failed)

SB 2412: Relating to health care insurance for children and to taxes imposed on oil and gas. (Failed)

SCR 4032: A concurrent resolution directing the Legislative council to study ways in which schools and school districts can better identify high-risk students and provide programs designed to reduce the incidences of high-risk behaviors that can lead to suicide attempts. (Passed)//2008//

***/2009/ Updates to 2007 legislation:***

***HB 1232 -- A fact sheet has been developed explaining the process for umbilical cord blood donation.***

***HB 1293 -- Fluoride varnish training has been provided to medical professionals throughout the state.***

***HB 1463 -- Eligibility changes did not occur as hoped with SCHIP reauthorization as Congress only approved a continuation. However, the state opted to implement continuous Medicaid eligibility for pregnant women and children to age 19 effective 6/1/2008 and to expand the SCHIP program from 140% to 150% of poverty effective 10/1/2008.***

***HB 1471 -- The DoH received \$50,000 to provide HPV education. Educational materials have been purchased and distributed.***

***HCR 3046 -- Coordinated School Health (CSH) Program staff continues to present at the***

***Education Interim Committee meetings and has received initial support for the legislative requirement for health education for grades 9-12 pending cost estimations.***

***SB 2012 -- The Human Services Committee conducted an Infant Development Program study. Testimony focused on the increasing number of children served, program funding, and equity of the current retrospective rate-setting process.***

***SB 2024 -- DHS has progressed from design to development of a new Medicaid Management Information System that has a scheduled implementation date of July 2009.***

***SB 2103 -- The Domestic Violence/Rape Crisis Program partnered with the ND Council on Abused Women's Services and the ND Office of Attorney General's to receive funding to participate as a pilot site with the Violence Against Women Act Forensic Compliance Project. A survey is being done of all hospitals in the state regarding services provided to victims of sexual assault entering their health care system, payment of those services, and compliance with the Violence Against Women Act.***

***SB 2152 -- The application relating to the selection criteria and eligibility for loan repayment by dentists has been updated in accordance to the law which includes preference to dentists who will work in rural communities.***

***SB 2313 -- 398 AEDs and 360 cabinets were distributed to ND public and private schools.***

***SB 2326 -- Effective April 1, 2008, medical assistance is now provided through the Children with Disabilities Medicaid Coverage (buy-in program) to qualifying children under age 19 with a disability for families with incomes up to 200 percent of poverty. Effective June 1, 2008, ND implemented a new Medicaid waiver program to help families care for their medically fragile children at home. The program will serve up to 15 children at a time that would otherwise require care in a nursing home, hospital, or other institutional setting.***

***SB 2354 -- The CSH Program developed a fact sheet for ND educators on the concept based fitness requirement of the new law and provided training to PE teachers in March 2007./2009//***

#### Health Care Coverage

ND has been funded by HRSA for a second year of funding under the State Planning Grant Program. The current grant period, 8/1/04 to 8/31/05, includes \$162,196. ND has received a total amount of \$944,085 during fiscal years 2003 and 2004 through this program. The purpose of the grant program is to study health insurance coverage in the state and to develop options and plans for expanding health insurance coverage for the uninsured. Forty-six states have received funding through the State Planning Grant Program. Dr. John R. Baird, state medical officer, oversees the grant and coordinates the Governor's Health Insurance Advisory Committee (GHIAC). The Center for Rural Health, University of North Dakota (UND) School of Medicine and Health Sciences, coordinates the research component. A household phone survey, four household focus groups, an uninsured focus group and four employer focus groups have been conducted. In addition, health insurance questions have been added to a ND Job Service survey that was distributed to ND employers during May 2005 to identify opportunities and barriers that employers encounter pertaining to providing and/or offering health insurance coverage for their employees. The GHIAC has examined the experience of other states and reviewed ND's medical marketplace. Governor Hoeven requested that the GHIAC's policy recommendations be budget neutral. Overall, 8.2% of North Dakotans do not have health insurance. Of the approximately 51,900 North Dakotans who are uninsured, most uninsured tend to have lower incomes, and work in small firms that have 10 or fewer employees. American Indians are the most likely population in ND to be uninsured with almost 32% of American Indians reporting they are uninsured compared to 6.9% of the Caucasian population. A report will be filed with the Secretary of Health and Human Services (HHS) by the end of September 2005 that includes the 2005 research findings and policy options. In addition, an application for a one-year continuation grant of up to \$207,617 has been submitted to the Human Resources and Services Administration (HRSA) to conduct a study of ND's American Indians to determine if there are unique opportunities within this population to decrease the percentage of uninsured. Other proposed grant activities include developing policy options and building consensus around improving access to health care.

/2007/ ND was awarded a continuation grant of \$207,617 to fund an evaluation of the health insurance coverage of Native Americans in ND. A report will be filed with the Secretary of Health and Human Services by the end of September 2006 that includes the 2006 research findings and policy options. ND has received a total amount of \$1,151,702 during fiscal years 2003, 2004 and 2005 through this program.//2007//

It is estimated that nearly 11,000 children in ND are uninsured and approximately 7,000 children are eligible for Medicaid, Healthy Steps or the Caring Program. In late 2002, the Dakota Medical Foundation (DMF), an independent grant making organization that invests in projects designed to improve health and health care access, received a \$700,000 four-year grant from the Robert Wood Johnson Foundation to join the nationwide Covering Kids & Families Initiative. The goal is to connect all eligible children to existing low-cost or free health care coverage programs offered within the state. DMF provided \$577,000 in additional funding and resources to add to the success of the ND Covering Kids & Families project. The Covering Kids and Families project is a comprehensive, outcome-based structure for reducing the number of uninsured children in ND by increasing enrollment in Medicaid, SCHIP and the Caring Program. There are three major components of this proposal: 1) Statewide Project, 2) Enrollment Assistance Project, and 3) Enrollment Incentive Project.

This four-year ND initiative will enroll children in existing health coverage programs: Medicaid, the State Children's Health Insurance Program (SCHIP) and the Caring Program for Children. These programs offer free or low-cost health care coverage to eligible children. Eligibility is based on family size and household income. Benefits may include primary physician care, hospitalization, drug costs, dental and vision.

The Statewide Covering Kids and Family Advisory Board operates under a proven governance structure to be an effective independent voice for children in need of health care coverage. The ND State Title V Director is a member of this Board.

/2007/ In August of 2005, the position staffing the 1-877 KIDS NOW help line that connects families to information, assistance and applications for three low-cost/free health coverage programs transferred from the Covering Kids and Families office in Fargo to the DHS. The position is funded through the Covering Kids and Families grant through 6/30/07. The Covering Kids and Families Coalition is in the process of forming a comprehensive sustainability plan that addresses diversified funding, goals and strategies, demonstrated results, leadership, a sound infrastructure, key stakeholders, active partners, and community awareness. A statewide Covering Kids and Families office would continue to address the goal of enrolling eligible families into Medicaid, SCHIP and Caring for Children. The strategies of simplification and coordination of processes and outreach to communities and families will continue with a sustained statewide effort.//2007//

/2008/ The Covering Kids and Families (CKF) grant ended in March 2007. A sustainability plan was developed that includes: continued support from ND Blue Cross and Blue Shield/Caring Program; continued outreach efforts through the ND Department of Public Instruction, DoH and the Insurance Commissioner; sustainability of the CKF Coalition and outreach funding through the NDDHS; and media and meeting support through the Dakota Medical Foundation.//2008//

From January 2003 to March 2005, the number of children enrolled in coverage programs increased by 1,747, a 6% statewide increase. Caring Program enrollment increased from 625 to 685, Healthy Steps, the state children's health insurance program, increased from 2,111 to 2,314, and Medicaid increased from 25,575 to 27,059.

/2007/ From January 2003 to March 2006, the number of children enrolled in coverage programs increased by 2,570, a 9% statewide increase. Caring Program enrollment increased from 625 to 732, Healthy Steps, the state children's health insurance program, increased from 2,111 to 3,482.//2007//

/2008/ Throughout the four year initiative, enrollment in all programs combined saw a 6 % increase.//2008//

ND Medicaid pays for health services for qualifying families with children, and people who are pregnant, elderly or disabled. Eligibility requirements are at 133% of the Federal poverty level for pregnant women and children to age six. Eligibility requirements are at 100% of the Federal poverty level for children ages 6-19. The number of Medicaid-eligible individuals for the last 12 months ranged from about 52,000 to over 53,000. Approximately 50% of those eligible are under the age of 21, 16% are disabled and 13% are classified as aged. As of March 2005, 27,059 children were enrolled in Medicaid. Currently, there is no asset limit for children, families or pregnant women in the children and families coverage group. Due to an improving economy, ND's Federal Medical Assistance Percent (FMAP) is decreasing. In 2004, the DHS conducted a Medicaid enrollee survey. Results of this study are available at:  
<http://www.nd.gov/dhs/info/pubs/docs/medical-recipientsurvey-results-detailed2004.pdf>

/2007/ As of March 2006, 26,667 children were enrolled in Medicaid.//2007//  
/2008/ As of March 2007, 25,284 children were enrolled in Medicaid.//2008//  
**/2009/ In SFY 2007, there were 41,376 Medicaid recipients age 0 through 20. In the month of May 2008, 28,113 children were eligible for Medicaid with a 12 month average of 27,539 children. Continuous Medicaid eligibility for pregnant women, children under 19, and caretaker relatives went into effect 6/1/2008.//2009//**

In 2004, 43,893 individuals were eligible for Health Tracks, ND's EPSDT program. Screening ratios in the Health Tracks program increased from 50% in FY 2003 to 60% in FY 2004.

Healthy Steps, ND's State Children's Health Insurance Plan, provides premium-free, comprehensive health coverage to uninsured children up to 19 years old in qualifying families. Eligibility requirements are at 140% of the Federal poverty level. Modest co-payments apply for certain services, which are waived for American Indian children. As of March 2005, 2,314 individuals were eligible for Healthy Steps. Children continue to receive medical, dental and vision benefit coverage. A joint application for Medicaid and Healthy Steps has been available for some time. Recently, Healthy Steps and Medicaid began to use a combined computerized eligibility system. With this change, the state expects to add 600 to 1,000 children to Healthy Steps. A seamless eligibility process for three low cost and free health coverage programs will soon be a reality.

/2007/ As of March 2006, 3,482 individuals were enrolled in Healthy Steps.//2007//  
/2008/ As of March 2007, 3,815 individuals were enrolled in Healthy Steps.//2008//  
**/2009/ As of May 2008, 4,067 individuals 0 to 19 were enrolled in Healthy Steps. The 12 month average was 3,950 children. Effective 10/1/2008, SCHIP will expand eligibility to 150% of poverty.//2009//**

The Caring Program for Children provides free health and dental care for children up to age 19 years old who are not covered by or eligible for Medicaid, other health insurance, or accepted by Healthy Steps. Eligibility requirements are at 200% of the Federal poverty level. As of March 2005, 685 children were enrolled in the Caring Program.

/2007/ Effective 12/1/2005, changes were made to the Caring for Children eligibility guidelines to streamline enrollment processes and provide less confusion to enrollees. Eligibility requirements are now at 170% net of the Federal poverty level. Citizenship requirements now mirror those of Healthy Steps with the exception that non-citizens who were currently enrolled were able to continue participation. The crowd out policy of Healthy Steps was adopted. Families with comprehensive medical coverage who dropped insurance of their own volition are now ineligible to participate for six months from the date the coverage was terminated. Lastly, full-time student status continues as an eligibility requirement for children enrolled in the program. As of March 2006, 732 children were enrolled in the Caring Program. When enrollment reaches 740, the Program will have met its cap and a waiting list will be established. //2007//  
/2008/ As of March 2007, 737 children were enrolled in the Caring Program.//2008//  
**/2009/ As of May 2008, 650 children 0 to 19 were enrolled in the Caring Program. The Caring Program increased eligibility to 180% of poverty effective 5/1/2008.//2009//**

The Medicaid program administers a managed care plan, which is contracted through Noridian. Noridian utilizes the AltruCare Plan for care and care management in Grand Forks, Walsh and Pembina counties. In addition, Medicaid continues to manage the Primary Care Provider Program, which was initially implemented in January 1994. The only other known Health Maintenance Organization (HMO) is Heart of America, which provides services around Rugby ND. This HMO has been in existence for a number of years.

/2007/ The Medicaid program administers a managed care plan through a contract with North Dakota Blue Cross Blue Shield (NDBCBS). NDBCBS subcontracts with Altru Health System to operate the AltruCare Plan for health care and care management of Medicaid recipients in Grand Forks, Walsh and Pembina counties. In addition, Medicaid continues to operate a statewide primary care case management (PCCM) program, which was initially implemented in January 1994. There are only two other known Health Maintenance Organizations (HMO) in the state; Heart of America, which provides services in and around Rugby, N.D. in a 13 county service area and Medica, which operates in 25 counties throughout the state.//2007//

/2008/ Altru Health System notified the NDDHS that it would no longer serve as a managed care organization through the ND Medicaid Program after October 31, 2006. The change affected about 800 low-income residents of Grand Forks, Pembina, and Walsh counties who qualified for Medicaid that voluntarily participated in the Altru managed care plan. Affected individuals were transitioned to the statewide primary care case management program.//2008//

/2007/ The Medicaid Managed Care Program will implement a chronic disease management program by December 31, 2006. The program will serve Recipients with asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and diabetes with a goal of increasing the Recipient's self-management of their disease. The program will operate on a statewide basis through a contract with a Disease Management Organization (DMO) that will provide services through a primary care nurse model. Chronic disease management services will be provided both face-to-face and telephonically and will be provided in cooperation with the Recipient's primary care provider.//2007//

/2008/ The State Plan and Waiver have been approved by CMS for the disease management program. A July 1, 2007 implementation date is expected. Local nurses will be hired on a regional basis to: 1) provide care management and health education for recipients, 2) inform providers about the program and clinical practice guidelines for each disease, and 3) operate a telephone health information line that is available to program recipients 14 hours per day, 7 days per week.//2008//

***/2009/ ND Medicaid contracted with a vendor to manage this statewide program, which was implemented October 2007.//2009//***

The Community HealthCare Association of the Dakotas works to provide a network for advocacy and support services to member organizations whose purpose is to provide primary health care to the medically underserved residents of North and South Dakota.

/2007/ The Association also works with communities requesting assistance to assess their health care access needs to determine options for continuing or creating primary health care access in a reasonable and cost-effective manner.//2007//

ND currently has five Federally Qualified Health Centers with a total of 13 delivery sites.

Coal Country Community Health Center - Beulah, Center and Halliday

Family HealthCare Center - Fargo (2) and Moorhead

Migrant Health Services, Inc. - Grafton and Moorhead

Northland Community Health Center - McClusky, Rolette and Turtle Lake

Valley Community Health Center - Northwood and Larimore

Unfortunately, the federally qualified health center in Bismarck, ND's capital city, voluntarily surrendered their federal funding as of October 31, 2003. St. Alexius, one of the city's two major medical centers, has convened a Community Task-force to study the needs of the uninsured and the viability of establishing a federally qualified health center.

/2007/ There has been no formal action begun on establishing a federally qualified health center in Bismarck.//2007//

The Aberdeen Area American Indian Healthy Start Program continues to receive funding, but Healthy Start Inc. operates only on the Turtle Mountain reservation. ND MCH Programs have had minimal involvement with the Program.

Temporary Assistance for Needy Families (TANF) Program provides a monthly payment on behalf of children who are dependent and deprived of parental support under state law. The monthly case average for the period 7/03 to 3/05 was 2,956.

/2007/ As of April 2006, there were 2,642 TANF families in ND with a total of 6,786 recipients, 1,973 adults and 4,813 children.//2007//

**/2009/ In 2007, there were 5,112 TANF families in ND with a total of 13,504 recipients; 4,173 adults and 9,331 children.//2009//**

**An attachment is included in this section.**

## **B. Agency Capacity**

CSHCN Program -- Statewide Systems

The following section describes the state CSHCN program's work to ensure a statewide system of services for children with special health care needs and their families.

State Program Collaboration with Other State Agencies and Private Organizations -- ND has many strong collaborative partnerships working at the state level. State CSHCN staff participates on 39 interagency committees, thus assuring collaboration on a wide range of issues of importance to CSHCNs and their families. One example that illustrates some of ND's successful partnerships of which Title V is a part is the Interagency Coordinating Council (ICC). The ICC is a group appointed by the Governor that provides leadership to support improvements in the early intervention system for infants and toddlers with disabilities. This group meets jointly with the Individuals with Disabilities Education Act Advisory Committee. A Memorandum of Understanding (MOU) concerning cooperation and collaboration in providing services to young children age's birth through five is in effect.

State Support for Communities -- State support for communities is addressed through funding of community-based care coordination programs and multidisciplinary clinics held at various locations throughout the state, partnerships with county social service staff that work with the CSHS program at the local level, and activities to enhance local level data capacity addressed through the SSDI grant.

**/2009/ For tables depicting uses of Title V funds at the local level for FY 2009, refer to the following URL:**

**[www.ndhealth.gov/familyhealth/grantees/fy2009/FY09UseOfTitleVFunds.doc](http://www.ndhealth.gov/familyhealth/grantees/fy2009/FY09UseOfTitleVFunds.doc) //2009//**

Coordination with Health Components of Community-based Systems - Multidisciplinary clinics and care coordination activities are the primary mechanisms by which comprehensive health components are successfully coordinated. Many health disciplines participate in team clinics, which provide comprehensive care to CSHCN's and their families. Public health care coordination staff assures coordination between public health programs, private sector health care providers and related service providers in the school setting.

Coordination of Health Services with Other Services at the Community Level - Infrastructure that supports coordination of health and other services at the community level is found in the regional interagency coordinating councils (RICC's), which focus on children birth to three in early intervention. RICCs were formed in all eight regions to advise the ND ICC, local early intervention providers, the Regional Developmental Disabilities Program Administrator and Infant Development Coordinator of Early Intervention issues affecting infants and toddlers with

developmental delays or disabilities or at-risk for developmental delays and their families. RICCs are charged with developing and monitoring regional early intervention quality improvement plans. RICC membership includes: Parents, Early Head Start, Early Intervention Providers, Protection and Advocacy, Family Support Service Providers, Special Education, Referral Sources, Childcare Providers, Arc, Legislators, and other Early Intervention partners. Membership represents the geographic areas and ethnic make-up of the region.  
/2007/ A major area of State Program Collaboration with Other State Agencies and Private Organizations has occurred through a Medical Needs Task Force.//2007//

#### Statutes and Their Impact

The State Health Officer (SHO) of the ND Department of Health (DoH) is responsible for the administration of programs carried out with allotments made to the state by Title V. The ND Department of Human Services (DHS) administers the portion of funds allotted for CSHCN.

The DoH functions in compliance with Chapter 28-32, Administrative Agencies Practice Act, North Dakota Century Code (NDCC). The Divisions of Family Health (FH), Injury Prevention and Control (IPC) and Nutrition and Physical Activity (NPA), within the Community Health Section, have statutory authority to accept and administer funds for the following programs: MCH/Title V, WIC, Family Planning/Title X and Domestic Violence (both state general and marriage license surcharge). The MCH/Title V and Family Planning/Title X are administered within the Division of FH. The WIC Program is administered within the Division of NPA. The Domestic Violence Program is administered within the Division of IPC. The Governor named the DoH the lead agency for the STOP Violence Against Women Program contained in the federal crime bill. The Division of IPC administers the STOP Program. The NDCC mandates donated dental services (23-01-27), newborn metabolic screening (23-01-03.1 and 25-17- 01 to 25-17-05) and SIDS reporting (11-19.1). All three of these programs are located in the Division of FH.

Administrative duties of state and county agencies and confidential birth reports for newborns with visible congenital deformities are addressed in NDCC Chapter 50-10. Provision of medical food and low-protein modified food products by CSHS is addressed in NDCC 25-17-03.  
/2007/ NDCC 50-10-10 addresses services to be provided by CSHS to individuals through age 18 who have been diagnosed with Russell-Silver Syndrome (RSS).//2007//  
/2008/ A new Section to the NDCC was created to address Title V program administration for CSHCN within the DoH (Section 23-01-34). Chapter 23-41 addresses administrative duties of state and county agencies, confidential birth reports for newborns with visible congenital deformities, and services for individuals with RSS. Chapter 25-17 was amended to address provision of medical food and low-protein modified food products.//2008//

#### Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

The Family Planning Program (FFP) offers education, counseling, exams, lab testing, infertility services and contraceptives. Twenty-one clinical sites, which include two correctional centers, provide services throughout the state. In 2004, services were provided to 15,674 women and men.

/2007/ In 2005, services were provided to 15,994 women and men.//2007//

/2008/ In 2006, services were provided to 16,238 women and men.//2008//

**/2009/ In 2007, services were provided to 15,368 women and men.//2009//**

The FFP is included as a constituent program represented on the MOU with the DHS to assure quality and accessible care to improve the health status of children with special health care needs, pregnant women, mothers, infants and children, especially those who are disadvantaged.

The FFP Director is a member of the Tobacco Partnership, which includes representatives from the Tobacco Program, WIC Program, Optimal Pregnancy Outcome Program and an OB/GYN physician. The goal of this partnership is to strategize avenues to prevent and/or reduce the use

of tobacco by women of reproductive age. In addition, she serves as a member of a stakeholders group whose goal is to enhance education regarding risk behaviors related to HIV, STDs, teen pregnancy and unintended pregnancy.

***/2009/ The Tobacco Partnership has targeted two groups; non medical staff and health care providers that work with pregnant and/or childbearing age women. The group has developed a position paper on Sexuality Education in ND that is currently being reviewed by the Governor's office./2009//***

The FPP receives supplemental funding from Title V to assist in the support of state administrative functions.

The Newborn Metabolic Screening (NBS) Program identifies infants at risk and in need of more definitive testing to diagnose and treat affected newborns. Program objectives include assurance that all infants testing outside of normal limits received prompt and appropriate confirmatory testing, and the development and provision of education to health care providers, families and communities. Currently, 40 conditions/disorders are included in the NBS profile. Cystic Fibrosis (CF) will be added in early fall of 2005.

ND's testing continues to be performed by the University of Iowa's Hygienic Laboratory in Des Moines. The NBS Program Director provides follow-up services for positive and borderline cases. The NBS Program has an advisory committee that meets quarterly to provide recommendations on such issues as policy/protocol development and proposed conditions/diseases to be screened for. The Advisory Committee membership includes the SHO, the NBS Program Director, the State Title V Director, the State CSHCN's Director, a geneticist, a neonatologist, a pediatric endocrinologist, an OB/GYN nurse educator, a hospital association executive, the Iowa lab director, the Iowa metabolic consultant, pediatricians, family practice physicians, and a parent representative.

*/2008/ Since the implementation of CF on January 1, 2006, there have been four confirmed cases and 37 carriers identified./2008//*

***/2009/ A private courier service was implemented June 1, 2008 to expedite the turnaround time of the blood collection to lab results./2009//***

The Optimal Pregnancy Outcome Program (OPOP) provides multi-disciplinary teams committed to enhance the prenatal care women receive from their primary health care provider. The team utilizes opportunities to nurture the pregnant woman's self esteem, self-confidence, and reinforce her important role and responsibility in having the healthiest baby possible. The outcome goals for OPOP include increased birth weights, decreased incidence of low weight births, decreased incidence of small for gestation age, pre-term labor prevention/early recognition, decreased occurrence of preventable congenital anomalies, decreased incidence of large for gestational age, reduction of morbidity of pregnancy, enhanced maternal/infant bonding to increase mothers commitment to positive pregnancy outcome, increased breastfeeding to benefit mother and infant, increased availability and access to comprehensive prenatal care services, facilitation of early entry and access into medical prenatal care, and empowerment to make healthy lifestyle choices. Nine sites throughout the state provide OPOP services.

The Maternal/Infant Nurse Consultant is the OPOP Director. She maintains collaboration with the WIC program, the tobacco program, public health and the March of Dimes to implement measures to encourage a term and healthy pregnancy.

*/2008/ In summer 2006, OPOP was awarded a graduate student from the MCH Information Resource Center to evaluate the program. A recommendation from the evaluation was to design a new OPOP data program to consolidate all infant and maternal data. The new data system is planned to be complete by December 2007./2008//*

The Sudden Infant Death Syndrome Program (SIDS) provides support, education and follow-up to those affected by a sudden infant death. In the belief that every child should live, ND enacted legislation in 1977 that prompted the development of the ND SIDS Management Program. The

SIDS Management Program provides: a system for reporting suspected SIDS cases to the DoH; provision for payment of autopsies; support and counseling to families of SIDS victims; the use of the term "sudden infant death syndrome" where appropriate on death certificates; and distribution of information about SIDS to health-care professionals and the concerned public.

The Maternal/Infant Nurse Consultant is the SIDS Program Director. She maintains collaboration with the local SIDS Affiliate, public health and Child Care Resource and Referral to implement and coordinate a safe sleeping environment for infants/children under the age of one.

/2008/ The SIDS Program was awarded \$2,855 from the CJ Foundation. The funding will be utilized in doing presentations focusing on SIDS risk reduction in three of ND's Indian reservations.//2008//

**/2009/ Due to staff transition, the project for the CJ Foundation was not completed. There were 8 SIDS deaths in 2007.//2009//**

The Women's Health Program acts as a catalyst to facilitate increased awareness of the importance of women's health through discussion of issues and gaps in service and enhance availability of services through cross referral between programs providing services to women. The FPP Director serves as the Women's Health State Coordinator. She is a member of the Outreach Committee for the Center for Excellence in Women's Health, whose goal is to facilitate the expansion of accessible women's health services across ND.

/2008/ In June 2007, the University of ND (UND), National Center of Excellence in Women's Health Region VIII Demonstration Project, applied for the Advancing System Improvements to Support Targets for Healthy People 2010 Project. A MOU was developed that outlines the partnership between the DoH and UND for this project.//2008//

**/2009/ UND did not receive the above grant. The First Lady hosts two Women's Conferences annually in which the Title V director serves on the planning committee.//2009//**

Preventive and Primary Care Services for Children

Local agencies, including public health agencies, conduct primary preventive health services for the child and adolescent populations.

The Abstinence Education Program (AEP) promotes the health of youth through abstinence-only education. The overall goal of the program is to provide abstinence across communities of ND and promote the health of youth through abstinence-only education. The program objectives are to 1) reduce teen pregnancy, and sexually transmitted diseases, 2) educate abstinence until marriage by supporting youth with abstinence education programs, and 3) involve parents and the communities in the development of efforts to promote abstinence. Currently, contracts exist with an entity in each of the state's eight regions and one tribal entity. The 59th Legislative Assembly provided direction and spending authority (\$220,000) to the DoH to seek out additional abstinence program funding. A Community-based Abstinence Education (CBAE) Grant was recently submitted for \$488,337.

/2008/ The AEP did not receive the CBAE Grant. However, the AEP Director worked with a local agency, Make-a-Sound Choice (MSC), in their CBAE grant application, which they received in 2007. Because MSC has a statewide focus, the abstinence spending authority of \$220,000 was removed from the DoH's budget for the 2007-09 biennium. The Title V, Section 510 Abstinence Education Funding will be monitored closely as Congress deliberates to extend funding authority.//2008//

**/2009/ It has been a challenge to provide abstinence-only services due to the issuing of federal funds on a quarterly basis.//2009//**

The Child and Adolescent Health Services Program provides consultation and technical assistance to state and local agencies and school nurses to promote the health of children and adolescents. The program is staffed by a 50 percent nurse consultant, who represents child and adolescent issues on various committees and workgroups, such as the Asthma State Workgroup

and the School Health Interagency Workgroup.

***/2009/ The first ND School Nurses Conference was held April 2008. Conference topics included asthma management, obesity prevention and physical assessment.//2009//***

The Coordinated School Health Program (CSHP) provides a framework for schools to use in organizing and managing school health initiatives. The goal of this program is to build state education and health agency partnership and capacity to implement and CSH programs across agencies and within schools. Eleven school districts, representing 30 percent of the student population, have been selected as demonstration sites to implement CSHP. A School Health Interagency Workgroup made up of staff from the Department of Public Instruction, DHS and DoH meets every other month to collaborate and coordinate on issues pertaining to school health. The Title V Director provides the leadership for this program.

/2008/ Leadership for the CSHP has been transferred to the Division of Chronic Disease, thus allowing the Title V Director more oversight time to Title V programs. A Healthy Weight Coordinator position has been added to CSH team. This position provides support to multiple programs and is a result of collaboration between several grants, including Title V.//2008//

***/2009/ In March 2008, ND received another five year award for CSH. A major focus area will be working with Regional Educational Agencies.//2009//***

The Early Child Comprehensive Systems (ECCS) Program supports collaborations and partnerships that support families and communities in their development of children who are healthy and ready to learn at school entry. The goal of this program is to build early childhood service systems that address access to health insurance and medical home, mental health, early care and education/child care, parent education, and family support. The Healthy North Dakota Early Childhood Alliance (HNDECA) is currently working on the development of a state ECCS plan, which is scheduled to be completed by January 1, 2006. The Child and Adolescent Health Coordinator dedicates 50 percent of her time to this program.

/2007/ On March 8, 2006, the ECCS implementation plan was submitted and approved; hence allowing ND to move from the Planning to the Implementation Phase. After a staff resignation, a new Child and Adolescent Health Coordinator started on May 11, 2006.//2007//

/2008/ The HNDECA has grown to over 90 stakeholders and is moving forward with the implementation of the State plan.//2008//

***/2009/ Grants have been awarded to six entities to carry out projects related to the ECCS Implementation Plan.//2009//***

The Injury Prevention Program promotes prevention of injuries through projects on seat belts, child passenger safety, bike helmets, home and product safety, poison control, suicide prevention and other injury-specific topics. Program staff provide training, technical assistance, educational materials, and safety products to local entities to implement community-based intervention projects. The program director and health educator are certified child passenger safety instructors, and the director is commissioned with the US Consumer Product Safety Commission to conduct recall effectiveness checks, product injury investigations and other assignments. An injury surveillance system identifies, develops and analyzes data sources to assist in the development of injury intervention initiatives and in the creation of a data based state injury plan.

/2007/ The Division of IPC reorganized programs due to the loss of program staff through retirement and reduction in grant funds. Programs within the division now include the Child Passenger Safety Program, Injury/Violence Prevention Program, and the Domestic Violence/Rape Crisis Program.//2007//

/2008/ In fall 2006, the Division of IPC, was awarded a State/Tribal Suicide Prevention Grant to: expand data collection; increase public awareness; collaborate with the Suicide Prevention Coalition; fund community-based programs to implement evidence-based programs; and collaborate with Mental Health America of ND.//2008//

***/2009/ Four tribal and two rural community suicide prevention projects were funded. The ND Injury Prevention Coalition created four subcommittees to actively work on the needs for the prevention of injury. The 2006 child passenger safety observation survey results showed a 4.1 percent increase with car seat/seat belt usage since 2004.//2009//***

The Lead Program maintains surveillance of reported childhood blood lead results and provides assistance for follow-up on elevated cases.

The Maternal and Child Health Nutrition Program provides consultation and technical assistance, monitors nutrition data, plans and evaluates nutrition programs, coordinates nutrition related activities, and acts as a clearinghouse for nutrition information and training. The State MCH Nutrition Services Director is 100 percent funded through Title V. In addition, there are 17 nutritionists working in local public health agencies throughout the state that are in part funded through Title V. The State MCH Nutrition Services Director and many of the local public health nutritionists participate in the Healthy Weight Council and the Healthy North Dakota Breastfeeding Committee, Healthy School Nutrition Committee and the Fruit and Vegetable Committee. All of these committees are working on issues directed toward healthy weight for children and adolescents through the promotion of increased fruit and vegetable intake (5-A-Day) and increased physical activity.

/2008/ The MCH Nutritionist has facilitated the development of the "Measuring Heights and Weights in Schools" position paper. This document will be released fall 2007.//2008//

***/2009/ Collaboration with various partners in writing the ND Healthy Eating and Physical Activity: A State Plan for Action is in progress.//2009//***

The Oral Health Program provides prevention education, screening and consultation and administers school fluoride programs. Program staff collaborates with public and private groups to assure policy/program development with an emphasis on improving access to oral health care. The program supports the maintenance of school-based fluoride and sealant programs and provides support for oral health outreach services at public health clinics. Six Title V funded regional dental health consultants provide training, technical assistance and consultation to local agencies to build capacity for oral health needs assessment and health promotion and prevention efforts. These efforts focus on maintaining school-based fluoride programs; promoting use of dental sealants; and providing dental health education for mothers and children with an emphasis on the prevention of early childhood caries, orofacial injuries, and tobacco use.

In 2002, ND received a CDC Control and Prevention Cooperative Agreement State-Based Oral Disease Prevention Program grant for developing capacity and infrastructure of the state oral health program. The ND Oral Health Coalition was formed in 2004 and is working on the development of a state oral health plan, which is scheduled to be completed by August 2005. In 2003, ND received a HRSA State Oral Health Collaborative Systems grant for integrating oral health with other programs within the state and to leverage resources in mutual support of oral health activities. The goals of this grant are to incorporate a service learning opportunity for dental students at the University of Minnesota for a rotation at the Bridging the Dental Gap Clinic and to provide fluoride varnish training to non-dental providers that would assure delivery of care to the most vulnerable populations in the state. The third grade Oral Health Basic Screening Survey was completed in May 2005. Regional oral health consultants partnered with local public health nutritionists to add height and weight data to the survey.

/2008/ The Oral Health State Plan and Burden Document were published in September 2006. //2008//

***/2009/ Focus on Oral Health was re-established in March 2007. The ND Oral Health Surveillance Plan was published in September 2007. ND Children's Oral Health Conference was held November 2007 which identified five top priorities including increased funding for Medicaid reimbursement, increased programs for oral health awareness, legislating expanded functions by dental hygienists, dental students rotations in community clinics, and new dental loan repayment for working in public health settings. A school-linked dental sealant pilot program was implemented in April 2008.//2009//***

Services for CSHCN

- a. To provide rehabilitation services for blind and disabled individuals under the age of 16

receiving benefits under Title XVI (SSI)

ND is a 209(b) state, which means SSI beneficiaries under 16 years of age are not automatically eligible for Medicaid. If assets are an issue affecting Medicaid eligibility, children eligible for SSI can also be covered under the children and family coverage groups where asset testing is not considered.

To monitor the status of the SSI population in the state, each year the state CSHCN program runs a special report on children receiving SSI and their Medicaid status. See Section III.F, Health Systems Capacity Indicator #08, for more information.

An interagency agreement is in place between Disability Determination Services (DDS) and CSHS to assure SSI recipients and cessations receive information about program benefits or services. State CSHCN staff conducts a variety of outreach activities related to the SSI program, including a mailing to families notifying them about programs that could be of assistance. Annually, state CSHCN staff convenes a meeting between DDS, the local Social Security Administration (SSA) office, Medicaid, and key family organizations to assure communication about any new developments that have occurred or that are expected during the year.

//2008/ The State's Federal Computer Matching and Privacy Protection Act agreement with the State expired June 30, 2007. If new agreements were not signed prior to that date, the SSA was required by law to suspend the computer data exchanges until new agreements were in place. These agreements allow the SSA to provide certain data on individuals to the State without the individuals consent for use in making eligibility determinations for certain health and income maintenance programs. As CSHS is no longer a part of the DHS, access to SSA data is no longer possible without permission from the SSA. Until these issues are resolved, CSHS is impacted in its ability to monitor status of the SSI population or to conduct outreach, information, and referral services for the SSI population.//2008//

**//2009/ Effective July 1, 2007, CSHS lost access to SSI information through the SDX and SOLO-Q systems. Staff in the division recently submitted a Request for Disclosure of SSA Information for Use in Non-1137 Programs, which is being reviewed by appropriate policy and legal staff in the Social Security Administration.//2009//**

b. To provide and promote family-centered, community-based, coordinated care including care coordination services

Efforts to enhance family-centered care include support of a CSHS Family Advisory Council that assures family involvement in policy, program development, professional education, and delivery of care; service contracts with two family organizations in the state that provide emotional support, information, and training for families; active state CSHCN staff involvement with other related family support initiatives occurring in the state (e.g.) advisory board participation, family conference planning committees, etc.; and annual telephone assessment of family satisfaction with CSHS services.

The following section describes programs administered by the State CSHCN program.

The Care Coordination Program provides community-based case management services for CSHCN's to help families' access services and resources in their community, and when needed, across multiple service delivery settings. Public health nurses (PHN's) provide care coordination services to a broad population of children with physical, developmental, behavioral or emotional conditions in five eastern counties of the state. County social service staff in all 53 counties of the state provides care coordination services for children eligible for treatment services through CSHS. State-level staff provides technical assistance, training, and quality assurance activities to support these local programs.

//2008/ PHN's now provide care coordination services in one eastern county of the state.//2008//

The Data Systems Development Program provides data on the health status of CSHCN's in order

to provide evidence-based decisions for program development and service delivery. Major activities include State Systems Development Initiative grant administration, birth defects monitoring, needs assessment, performance and outcome monitoring, estimates of chronic disease prevalence, utilization and cost, and data-related publications.

***//2009/ Current SSDI grant activities address identified gaps by enhancing collection, analysis, synthesis, translation, technical assistance, training and dissemination of data as well as building data capacity at the state and local level.//2009//***

The Information Resource Center provides public information services to families and service providers in order to increase access to health care information and resources. The CSHS Unit operates an information resource center that provides public information services free of charge.

The Metabolic Food Program is mandated to provide medical food and low-protein modified food products to certain individuals with PKU and MSUD in order to increase access to necessary dietary treatment therapies. Males under age 22 and females under age 45 receive formula at no cost while others outside those age groups can receive formula at cost. Low protein modified food products are also provided at no cost to males under age 22 and females under age 45 who are receiving medical assistance when its determined medically necessary. State-level CSHCN staff develop policies and procedures that guide the program, maintain the on-site inventory, fill client orders upon request, and provide a variety of state-level care coordination services.

The Multidisciplinary Clinic Program provides coordinated management of various chronic pediatric health conditions that are best addressed using a comprehensive, team approach. CSHS directly administers or sponsors clinics for the following 10 conditions: Cleft Lip and Palate, Scoliosis, Cardiac, Metabolic Disorders, Cerebral Palsy, Developmental Assessment, Myelodysplasia, Diabetes, Neurorehab, and Asthma. State CSHCN nursing staff coordinates some of the clinics held each year while others are provided through contracts with health systems, hospital foundations, universities, or other not-for-profit entities. For the latter, state CSHCN staff provide technical assistance, conduct quality assurance activities, and convene an annual meeting for clinic coordinator staff from across the state to assure communication about any new developments that have occurred or that are expected during the year. A network of public and private health care providers across the state participate in the multidisciplinary clinic program, including local county social workers affiliated with CSHS who staff some of the clinics. Clinics provide a secondary benefit as an avenue for pre-service training in the state, particularly for nursing and speech/language students.

***//2009/ Spring 2008, CSHS discontinued scoliosis clinics.//2009//***

The Russell-Silver Syndrome (RSS) Program mandates payment for medical food and services related to growth hormone treatment for individuals with RSS through age 18. The 2005 Legislature created this new program and required that services be provided at no cost regardless of income. Care is limited to \$50,000 per child each biennium.

The Specialty Care Program helps families pay for specialty care diagnostic and treatment services. Families apply for services at their county social service office. County staff determine financial eligibility if it is required. Income eligibility is mandated at 185 percent of the federal poverty level for treatment services through CSHS. Assets are not considered. The CSHS Medical Director determines medical eligibility at the central office based on a list of eligible medical conditions, which is developed with the help of the CSHS Medical Advisory Council. Other state-level CSHCN staff develop policy and procedures, provide technical assistance in the application process, conduct training for county social service staff, process claims payments for eligible children using the Medicaid Management Information System, and coordinate benefits between third party payers. The unit also maintains a list of qualified health care providers who have been approved to participate in the program.

CSHS Administration provides leadership and support to state and local partners to implement health service system improvements. CSHS works with others in planning and policy

development to address identified needs of CSHCN and their families. Primary partners include families, county social service staff, health care providers and related program administrators. State-level CSHCN staff participates on a number of committees, advisory boards, and task forces and work on a variety of special projects to improve children's health. Examples of special projects include:

1) First Sounds - ND's Early Hearing Detection and Intervention (EHDI) Program is administered by the ND Center for Person's with Disabilities at Minot State University. A CSHS staff member is part of the grants management team. Through this project, significant gains have been made in the percent of newborns that have had their hearing screened before hospital discharge. Future efforts will continue to focus on early hearing detection and intervention as well as tracking, surveillance, and integration activities.

/2007/ Two grants were awarded in 2005 to further ND's EHDI Program. One grant focuses on continued hospital screening prior to discharge and the other on follow-up, diagnosis and referral. In 2006, a HRSA performance review was completed for the EHDI program.//2007//

/2008/ In 2007, all hospitals in the state used a web-based reporting system; potentially improving reporting of hearing loss in children.//2008//

**/2009/ In 2008, NDCPD received another three-year MCHB EHDI grant focusing on babies lost to follow-up. A CDC grant was submitted by NDCPD to support EHDI tracking, surveillance and integration. CSHS staff are involved with these grant management teams.//2009//**

2) The State Asthma Workgroup (SAW) -- This workgroup is an informal collaboration of stakeholders, program representatives, and organizations inside and outside of state government whose membership shares the goals of enhanced asthma surveillance, education, direct services, and partnerships. Despite limited resources, this group has achieved significant results, including: development of a ND Asthma Action Plan and Physician Desk Guide, development of web-based provider training on clinical practice guidelines, funding for children's asthma clinics, enhanced data surveillance capabilities through the Behavioral Risk Factor Surveillance System, and successful legislation relating to student's possession and self-administration of medication for the treatment of asthma and anaphylaxis.

/2007/ The SAW developed an asthma web site which provides access to web training modules for medical providers and school personnel to assist them in implementing the above legislation. An anaphylaxis action plan was developed and data enhancements were made with inclusion of asthma questions on the YRBS.//2007//

/2008/ The SAW is exploring asthma reimbursement for certified asthma educators.//2008//

**/2009/ The DoH submitted a Public Health Prevention Services Program -- Field Assignment request in 2008 to address a ND Asthma Program, but was not selected.//2009//**

3) National CSHCN Objectives have been addressed, in part, through team efforts funded by a Medical home CATCH grant. The CATCH team is comprised of a pediatrician, CSHCN staff, representatives from two family organizations, and a representative from a major health system known for its services to CSHCN's. Work efforts to date have focused on assessment and community planning activities in support of medical home implementation. CSHS staff also participates on an ECCS subcommittee that addresses access to health care/medical home. Transition is addressed through participation on a Transition Steering Council lead by the Department of Public Instruction. Future transition efforts will hopefully be supported through the Champions for Progress Center state team meeting and incentive award, if a proposal that has been submitted is funded.

/2007/ A successful partnership has been developed with the MN CSHCN program around medical home. Initial focus has been on medical home learning collaborative team trainings.//2007//

/2008/ The Medical Home team met throughout the year. Funding was received through the ECCS and Head Start Collaboration grants to support various medical home activities. A Future Search community planning approach has been identified as a model as the state moves toward implementation.//2008//

**/2009/ NDCPD applied for and received a three-year Integrated Services grant that**

***encompasses the six CSHCN priority areas. CSHS staff are part of the grant management team.//2009//***

#### Culturally Competent Care

Our society is becoming more diverse and often this trend is associated with widening health disparities among culturally diverse groups. Given this development, communication interventions that affect health behavior are increasingly important strategies for improving the health of people. In a response to this issue, Dr. Terry Dwelle, SHO, has developed a Culturally Responsive Communication course. This course is intended to develop and expand the skills of public health professionals in designing and delivering culturally responsive health communication.

The DoH and the Indian Affairs Commission, along with tribal leaders through the state, have formed the Tribal State Health Care Task Force in an ongoing effort to address the health care needs of American Indians.

The State Health Disparities Work Group exists to provide leadership in identifying and positively impacting disparities affecting ND citizens. The workgroups vision is "Health equity for all North Dakotans." Health disparities in ND are defined as inequalities in health status, utilization, or access due to structural, financial, personal, or cultural barriers. Population categories affected include, but are not limited to, those identified by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation.

/2007/ The following trainings were provided to support culturally competent systems: Community Engagement Training of Trainer course, American Indian Cultural Competency, and Developing an Infrastructure for Cultural Competence. In April 2006, ND received an award of \$75,000 funded by the DoH and Human Services Office of Minority Health. The purpose of this one-year award is to build the state's infrastructure in addressing health disparities with the hope of creating a state office of minority health.//2007//

/2008/ As of July 1, 2007, the Office for the Elimination of Health Disparities (OEHD) became an official entity housed in the DoH. This achievement is the culmination of over 10 years of increasing awareness and emphasis on the social determinants of health and the impact of disparities on ND's minority and multicultural populations. The OEHD is applying for the "State Partnership Grant to Improve Minority Health". Funding will begin September 1, 2007. A course on Cultural Communication will be offered at the 2007 ND Summer Public Health Mini Institute.//2008//

***/2009/ The State Partnership Grant to Improve Minority Health was received. A program director was hired for the Office for the Elimination of Health Disparities in May 2008.//2009//***

Efforts to enhance culturally competent care include participation on the DHS Cultural Awareness Committee. This committee strives to enhance the delivery of human services to the state's increasingly diverse population. Past activities have focused on the American Indian population and included development of a cultural guidebook, staff training and meetings with tribal program staff to enhance communication and collaboration. The DHS has a wonderful resource in its Tribal Liaison. This position was created in 1997 to enhance working relationships and communication between tribal programs and the department. Title V advisory councils also include members that represent major cultural groups in the state.

### **C. Organizational Structure**

The DoH employs about 300 people dedicated to making North Dakota a healthier place to live. The five sections of the department include: 1) Administrative Support, 2) Medical Services, 3) Community Health, 4) Health Resources, 5) Environmental Health, and 6) Emergency Preparedness and Response. Employees in these sections provide public health services that benefit the citizens of North Dakota.

/2008/The Department of Health has six sections with the addition of Special Populations.//2008//

The DoH is dedicated to ensuring that North Dakota is a healthy place to live and that each person has an equal opportunity to enjoy good health. The DoH is committed to the promotion of healthy lifestyles, the protection and enhancement of health and the environment, and the provision of quality health-care services for the people of North Dakota. The DoH advances its mission by networking, facilitating local efforts, collaborating with partners and stakeholders, and providing expertise in developing creative public health solutions.

Terry Dwelle, M.D., State Health Officer, is responsible for the administration of programs carried out with allotments made to the state by Title V. The governor appoints the Health Officer. A State Health Council serves as the DoH's advisory body. The council's 11 members are appointed by the governor for three-year terms. Four members are appointed from the health-care provider community, five from the public sector, one from the energy industry and one from the manufacturing and processing industry.

The organizational chart for the DoH can be accessed at the following URL:

<http://www.health.state.nd.us/ndhd/contact.htm>

/2007/The organizational chart for the DoH can be accessed at the following URL:

<http://www.health.state.nd.us/DoH/Overview/> //2007//

/2008/The organizational chart for the DoH can be accessed at the following URL:

<http://www.health.state.nd.us/DoH/Overview/> //2008//

**/2009/The organizational chart for the DoH can be accessed at the following URL:**

**<http://www.health.state.nd.us/DoH/Overview/> //2009//**

The Family Health Division, within the Community Health Section of the DoH, is the lead division for administration of the Title V funds. The Community Health Section's mission is to improve the health of North Dakota citizens by working actively to promote the choice of healthy behaviors and to prevent disease and injury. The section is responsible for coordination of public health education and intervention activities such as wellness promotion and health-risk reduction, promotion of optimal nutrition, reduction of tobacco use, injury prevention and improvements in dental health. Many of the services are provided through local public health units.

There are six divisions within the Community Health Section: 1) Cancer Prevention and Control, 2) Chronic Disease, 3) Family Health, 4) Injury Prevention and Control, 5) Nutrition and Physical Activity, and 6) Tobacco Prevention and Control. Three of these six divisions receive funds from the Title V grant. These include Family Health (Title V leadership), Injury Prevention and Control, and Nutrition and Physical Activity.

The organizational chart for the Community Health Section can be accessed at the following URL: [www.ndhealth.gov/familyhealth/grantees/fy2009/CHSOrganizationalChart.pdf](http://www.ndhealth.gov/familyhealth/grantees/fy2009/CHSOrganizationalChart.pdf)

North Dakota's public health system is made up of 28 single- and multi-county local public health units (LPHUs). LPHU's are autonomous and not part of the DoH. Their relationship is cooperative and contractual. Services offered by each public health unit vary, but all health units provide services in the areas of maternal and child health, health promotion and education, and disease prevention and control. Some local public health units maintain environmental health programs; others partner with the North Dakota Department of Health to provide environmental services such as public water system inspections, nuisance and hazard abatement and food service inspections. Local public health activities are financed by a combination of mill levy funding and/or city or county general funds, state aid and federal funding. A state map for each LPHU can be accessed at the following URL: <http://www.health.state.nd.us/localhd/>

The DHS administers the portion of funds allotted for children with special health care needs. The DHS mission is to provide quality, efficient, and effective human services, which improves the lives of people. The Governor appoints the Executive Director of the DHS, a large umbrella

agency that is currently headed by Carol K. Olson. DHS is organized into three major subdivisions consisting of Field Services, Program and Policy Management, and Managerial Support. DHS, through the Children's Special Health Services (CSHS) Unit, administers the portion of funds allotted for children with special health care needs. CSHS is located along with Medicaid and SCHIP in the Medical Services Division in the Program and Policy Management subdivision. The CSHS mission is to provide services for children with special health care needs and their families and promote family-centered, community-based, coordinated services and systems of health care.

/2007/The DHS was restructured effective January 1, 2006. A cabinet of seven functional areas was created that includes Medical Services, Program and Policy, Institutions, Human Service Centers, Economic Assistance, Administration, and Legal. Because of this change, Medical Services, the Division in which the ND CSHCN program is currently housed, was also restructured and two Assistant Director positions were created. One position oversees Program Policy and the other focuses on Program Operations. New organizational charts can be found in the attached Word document: 1) North Dakota Department of Human Services, and 2) North Dakota Medical Services Division.//2007//

/2007/June 2006, the Office of Management and Budget made a decision to organizationally move CSHS from the DHS to the DoH effective 7/1/2007, pending legislative approval.//2007//  
/2008/Title V program administration for children with special health care needs was moved to the DoH effective 7/1/2007. This organizational change did not require a physical move in office location. New organizational charts have been drafted but were not finalized at the time of submission. It is anticipated that the Children's Special Health Services Division will be housed within the Special Populations Section along with the Division of Minority Health. No change has been made in the local delivery system. CSHS will continue the partnership with 53 county social service offices. Designated staff in each local office work cooperatively with CSHS in administering programs for children with special health care needs and their families. A state map and contact information for each county social service office can be accessed at the following URL: <http://www.nd.gov/dhs/locations/countysocialserv/> //2008//

/2008/The draft organizational chart for the Special Populations Section can be accessed at the following URL: <http://www.ndmch.com/SpecialPopulationsOrgChart.pdf> //2008//

***/2009/The organizational chart for the Special Populations Section can be accessed at the following URL:  
[www.ndhealth.gov/familyhealth/grantees/fy2009/SPOrganizationalChart.pdf](http://www.ndhealth.gov/familyhealth/grantees/fy2009/SPOrganizationalChart.pdf) //2009//***

The administrative arm of the department receives and distributes funds for human service needs, provides direction and technical assistance, sets standards, conducts training of county staff, manages the computerized eligibility systems, and provides program supervision to county employees.

Direct services are provided through the Developmental Center and the State Hospital in addition to regional Child Support Enforcement Units and Human Service Centers (HSC's). Each of the eight HSC's serves a designated multi-county area and provides an array of services such as Developmental Disabilities, Vocational Rehabilitation, Child Welfare, Children's Mental Health, etc.

The following organizational charts can be found in the attached Word document: 1) North Dakota Department of Human Services, and 2) North Dakota Medical Services Division.

Delivery of human services also involves a partnership with 53 county social service offices. In the DHS, county social service offices work cooperatively with the state agency in administering programs. County social services are important local service providers and are often the first point of contact for families. Each county social service office has a designated staff member that provides services for CSHCN's and their families served by CSHS. A state map and contact

information for each county social service office can be accessed at the following URL:  
<http://www.state.nd.us/humanservices/locations/countysocialserv/index.html>

The DoH and DHS mesh in a variety of ways, both formal and informal, through the Title V programs. Examples include: quarterly meetings held for the divisions of Family Health, Injury Prevention and Control, Nutrition and Physical Activity and CSHS staff; representation of the State Health Officer on the CSHS Medical Advisory Council; representation from the Family Health Division on the CSHS Family Advisory Council; and other committees or workgroups that utilize representation from both departments to work on issues held in common.

Through a contractual agreement with the DoH and DHS, the State Systems Development Initiative (SSDI) works to build capacity to access and use data in MCH planning. The FTE for the SSDI coordinator is located in the DHS CSHS Unit, but serves both departments.

The following organizational chart can be found in the attached Word document: State of North Dakota Title V.

See Section III B, Agency Capacity for more information on programs funded by the Federal-State Block Grant Partnership.

***An attachment is included in this section.***

#### **D. Other MCH Capacity**

Terry Dwelle, M.D., State Health Officer (SHO), is responsible for the administration of programs carried out with allotments made to the state by Title V. The SHO is appointed by the governor to be the chief administrative officer of the department as well as a member of the governor's cabinet. The SHO implements state laws governing the department within the guidance of the governor and the regulations adopted by the State Health Council. In addition, the SHO is a statutory member of about a dozen boards and commissions. Governor John Hoeven appointed Terry Dwelle, M.D., to the Office of SHO in October 2001. Dr. Dwelle earned his medical degree from St. Louis University School of Medicine. He later received a master's degree in public health and tropical medicine from Tulane University. Dr. Dwelle has worked with the University of North Dakota School of Medicine, the Centers for Disease Control and Prevention and the Indian Health Service.

The deputy state health officer(DSHO), Arvy Smith, assists the SHO in implementing state laws governing the department and serves on several boards and commissions in lieu of the SHO. In addition, the DSHO provides leadership in administrative and support functions for the department. Ms. Smith was appointed as the DSHO in October 2001. She is a certified public accountant and a certified manager who has 24 years experience in state government. Ms. Smith has completed coursework towards and continues to pursue a master's degree in public administration with a health care certificate.

***/2009/ Ms. Smith will completed her degree in August 2008./2009//***

The Division of Family Health, within the Community Health Section (CHS) of the DoH, is the lead division for administration of the Title V funds. There are six divisions within the CHS: 1) Cancer Prevention and Control, 2) Chronic Disease, 3) Family Health, 4) Injury Prevention and Control, 5) Nutrition and Physical Activity, and 6) Tobacco Prevention and Control. Three of these six divisions receive funds from the Title V grant. These include Family Health (Title V leadership), Injury Prevention and Control, and Nutrition and Physical Activity. Senior level staff within these three divisions include:

Family Health: Kim Senn is the Director for the Division of Family Health. Kim joined the DoH in 2000 as a nurse consultant and became Director of the Division of Family Health in September 2003. Kim earned a bachelor's degree in nursing from Medcenter One College of Nursing. Kim has twenty-one years experience in health care, including acute care, management and public

health.

Injury Prevention and Control: Mary Dasovick is the Director for the Division of Injury Prevention and Control. Mary joined the DoH in 1994 as a nurse consultant and became Director of the Division of Injury Prevention and Control in September 2003. She graduated from the University of Mary with a bachelor's degree in nursing. Mary has worked as a public health, geriatric and forensic nurse.

Nutrition and Physical Activity: Colleen Pearce is the Director for the Division of Nutrition and Physical Activity. Colleen joined the DoH in 1978 and has worked as the program director of the Special Supplemental Nutrition Program for Women, Infants and Children since 1979. She became the Director of the Division of Nutrition and Physical Activity in September 2003. Colleen earned a bachelor's degree in food and nutrition from ND State University and a master's degree in public health from the University of Minnesota.

Until May 31, 2005, Dr. John Joyce served as the Section Chief for the CHS. As of June 1, 2005, the CHS initiated a Leadership Team concept where by the six division directors within the CHS serve as the section lead on a two-month rotation system. Dr. Joyce will continue to serve as a Medical Consultant for the CHS. Dr. Joyce graduated from the University of ND School of Medicine and Health Sciences. He has been affiliated with the West River Medical Center in Hettinger since 1981, where he is a family practice physician. He completed his Masters in Public Health through the University of Wisconsin in 2004.

The CHS has access to a wide range of administrative support personnel within the DoH. Administrative support includes Accounting, Human Resources, Information Technology, Vital Records, Education Technology, Public Information, and Local Public Health. A finance liaison, housed in the Accounting Division, is specifically assigned to work with the Title V grant.

Healthy North Dakota (HND) is a statewide initiative whose goal is to improve the health of every North Dakotan by inspiring people to establish personal behaviors and support policies that improve health and reduce the burden of health care costs. Title V programs work closely with HND priorities and initiatives. Melissa Olson was named director of HND in 2003. She has bachelor's degrees in food and nutrition and corporate and community fitness from ND State University. Melissa has worked in state government since 2000, managing both the school health and tobacco programs.

Stephen Pickard, M.D., is a CDC epidemiologist assigned to ND. Dr. Pickard has 13 years of experience assisting state health departments as a CDC employee. He was assigned to the DoH in 2001 where he acts as the senior consulting epidemiologist for the department. Dr. Pickard's areas of expertise are in epidemiologic capacity building, state surveillance systems, and community health. He co-facilitates the HND workgroup on community engagement, administers the Behavioral Risk Factor Surveillance System, and is the epidemiologic consultant to the Youth Risk Behavior Survey.

/2007/ In January 2007, the CHS received approval for a Senior Epidemiologist. The position provides guidance on health policy, surveillance, and communications. Melissa Bronstein will begin employment on October 4, 2006. Melissa has a BSN and is working on a MPA.//2007//  
/2008/ Melissa Casteel replaced Melissa Bronstein as the Senior Epidemiologist in May 2007. Melissa has a Bachelor of Science Degree in Microbiology and an Associate of Science Degree in Nursing.//2008//

**/2009/ Approval has been received for an additional 1.0 FTE Epidemiologist III position within the section. This position will provide support to the oral health and cancer registry programs. The hiring process will occur in July 2008.//2009//**

Below is a summary of staff that work on Title V programs:

DoH Divisions/Staff funded and not funded by Title V

Family Health (funded)

Director 0.1 BNSc (Title V)

/2008/ 1.0

Nurse Consultants 2.5 BSN's (Maternal/Infant, Child/Adolescent, Newborn Screening)

2.7

**/2009/ 2.2 //2009//**

Dental Hygienists 1.0 RDH (Program Director and two out-stationed)

1.2

Support Staff 2.5 (Admin Assistant III, Admin Assistant I, Student and Permanent Temp)

2.45

Data Processing Coordinator 0.8 BS Computer Science

0.4

Senior Epi 0.35 BS Biology//2008//

\* Total Funded by Title V 6.9

/2007/ 6.6 //2007//

/2008/ 8.1 //2008//

**/2009/ 7.6 //2009//**

Family Health (not funded)

Director 0.9 BNSc (CSHP)

/2008/ 0.0

Nurse Consultants 1.5 BSN (Abstinence, ECCS, Title X)

1.3

**/2009/ .8**

***ECCS program director moved from Nurse Consultant to Human Services Program Administrator classification.***

***Oral Program Manager and ECCS Program Director 1.0 BA***

***Dental Hygienist 1.75 RDH (CDC, HRSA - Program Director and five out-stationed)***

1.3

***Family Planning/Women's Health 1.0 MBA (Title X)***

***Support Staff 0.7 (Title X, CSHP -- Admin Assistant I and Permanent Temp)***

1.55

**1.05 //2009//**

Data Processing Coordinator 0.6 BS Computer Science//2008//

\* Total Not Funded by Title V 5.85

/2007/ 5.95 //2007//

/2008/ 5.75 //2008//

**/2009/ 5.75 //2009//**

Injury Prevention and Control (funded)

Program Admin 1.0 BS Business Admin

**/2009/ .8**

***Health Educator 1.0 BA Health***

**.8 //2009//**

Support Staff 1.0 (Admin Assistant I)

\* Total Funded by Title V 3.0

/2007/ 2.6 //2007//

/2008/ 2.6 //2008//

**/2009/ 2.6 //2009//**

Injury Prevention and Control (not funded)

Director 1.0 BSN (STOP and FVPS)  
Program Admin 1.0 BA Business Admin (CDC, HRSA)  
*/2009/ .2*

*/2008/Suicide Program 1.0 Vacant//2008//*

*Suicide position filled LSW*

*Health Educator .2 //2009//*

\* Total Not Funded by Title V 2.0

*/2007/ 1.4 //2007//*

*/2008/ 2.4 //2008//*

*/2009/ 2.4 //2009//*

Nutrition and Physical Activity (funded)

Director 0.1 MPH, LN

*/2008/ 0.01*

Nutritionist 1.0 LRD

Healthy Weight Coordinator 0.4 LRD, MPA //2008//

\* Total Funded by Title V 1.1

*/2008/ 1.41 //2008//*

*/2009/ 1.41 //2009//*

Nutrition and Physical Activity (not funded)

Director 0.9 MPH, LN (WIC)

*/2008/ 0.99*

Nutritionist 2.0 LRD (WIC)

Support Staff 1.0 Office Assistant II (WIC)

Healthy Weight Coordinator 0.6 LRD, MPA //2008//

\* Total Not Funded by Title V 3.9

*/2008/ 4.59 //2008//*

*/2009/ 4.59 //2009//*

*/2008/ FTE funded by Title V has increased due to a decrease in other federal funding and the addition of new FTE's.//2008//*

*/2009/ 11.01 FTE currently being funded by Title V.//2009//*

Carol K. Olson is the Executive Director of ND's largest agency, the Department of Human Services (DHS). Olson has worked in state government in various legislative and executive branch positions for over 20 years. She holds the distinction of being the first woman to serve as chief of staff in the ND governor's office, as well as the first woman to serve as executive director of the DHS. She has a bachelor's degree in criminal justice and has completed course work toward a master's degree in public administration.

CSSH has access to a wide range of managerial and executive support personnel within the DHS. Managerial support includes the Human Resources Division, which contains the Office of Applied Research, the Information Technology Division, and the Legal Advisory Unit. Executive support staff includes a Tribal Liaison and Public Information Specialist. A finance liaison, housed in Fiscal Administration, is specifically assigned to work with the CSSH program.

*/2007/ The DHS Research Team is now housed in the Mental Health/Substance Abuse Division.//2007//*

Since the last grant application was submitted, there have been several changes in the DHS Senior Management team that reports directly to the Executive Director of DHS. JoAnne Hoesel now heads the Mental Health/Substance Abuse Division previously led by Karen Larson. JoAnne had previously worked in the area of children's mental health. The position of Disability Services Division Director, held for many years by Gene Hysjulien, is currently vacant.

David J. Zentner has been Director of the Medical Services Division since 1993. His

responsibilities include oversight of the Medicaid Program, the State Children's Health Insurance Program and CSHS. Mr. Zenter is part of the Senior Management Team that reports directly to the Executive Director of the DHS. In 1969, he graduated from the University of ND with a degree in Business Administration with an emphasis in accounting. Mr. Zentner plans to retire August 2005.

/2007/ Margaret Anderson was hired as the Director of the Medical Services Division in 2005. From 2003-05, she served as the Assistant Director. Prior to that, she had 13 years experience in the ND Department of Public Instruction as the Assistant Director in the Child Nutrition Program. She has a Masters in Management and BS in Food and Nutrition.//2007//

/2007/ Erik Elkins is the Assistant Director of Program and Policy. He has a BS in Business Administration. Prior to this position, Erik was the Claims Processing Administrator, and more recently the Business Lead on the Medicaid Systems Project.//2007//

/2007/ Karalee Adam became the Assistant Director of Budget and Operations in November 2005. She has a Masters Degree in Management and a BS in Computer Information Systems. Prior to joining Medical Services, Karalee was Deputy Director of the DHS Division of Information Technology.//2007//

Staff members within the greater Medical Services Division are also available to CSHS on a consultative basis and have proven to be a helpful resource to state CSHCN staff. Included are medical and dental consultants, a coding specialist, a pharmacist, claims payment personnel, prior authorization nurses, a managed care administrator, and various eligibility and policy staff.

Parents of special needs children have not been hired within CSHS. However, the Unit does support a nine-member Family Advisory Council that meets on a quarterly basis. Members are reimbursed mileage, meals and lodging and are paid a \$75.00 consultation fee for each quarterly meeting they attend. The CSHS Family Advisory Council assures family involvement in policy, program development, professional education, and delivery of family-centered care.

Tamara Gallup-Millner, RN, MPA became the CSHS Unit Director July 2001. Professional experiences include four years as a hospital staff nurse and over 20 years of experience within state government, including prior positions as Assistant Clinical Supervisor and Deputy Director within the CSHS unit. Tammy is a member of several professional organizations and serves on many committees, advisory boards and task forces.

/2008/ With the organizational move to the DoH, Tamara Gallup-Millner became CSHS Division Director July 2007. The CSHS Division will be housed within the Special Populations Section in the DoH. Final decisions regarding the organizational change are pending; however, the Section will likely be headed by John Baird, M.D. Dr Baird joined the DoH as a state medical officer in 2002. He earned his medical degree from Washington University, St. Louis, Mo., in 1978. Currently, he also works as a family practice physician at the Family Healthcare Center in Fargo, N.D., and serves as an associate professor in family medicine for the UND School of Medicine and Health Sciences.//2008//

**/2009/ The Special Populations Section was established in 2007 to address health issues related to people with special health-care needs and health disparities in ND. The Special Populations Section includes the Division of Children's Special Health Services and the Office for the Elimination of Health Disparities. John Baird, M.D. became chief of the Special Populations Section in 2007. Currently, he also serves as health officer for Fargo Cass Public Health, Cass County coroner, and an associate professor in family medicine for the UND School of Medicine and Health Sciences.//2009//**

CSHS contracts for the services of a part-time Medical Director, Dr. Robert Wentz, who is a pediatrician. In addition to his medical degree, Dr. Wentz received a graduate degree in Public Health from the University of California in 1980. Previously, Dr. Wentz worked in the DoH as MCH Director, Section Chief and SHO. He became CSHS Medical Director in September 1999. CSHS also benefits from a Medical Advisory Council that meets on an annual basis.

The State Systems Development Initiative (SSDI) Coordinator is currently housed in CSHS although the position serves to enhance Title V data capacity for the entire MCH population. Terry Bohn resigned as SSDI Coordinator May 2005.

/2007/ Devaiah Muccatira was hired as the SSDI Coordinator April 2006.//2007//

The CSHS Unit maintains eight full-time staff, seven of which are funded by the MCH Block Grant. Currently, all unit staff are centrally located in Bismarck, ND.

CSHS Staff (funded)

Unit Director 1.0 MPA (RN)

Administrators 2.0 BNSC and HSPA I

Nurse 1.0 BSN

Support Staff 3.0 Admin Assist I and Office Assist III

\* Total Funded by Title V 7.0

/2008/ A recent staff change occurred in CSHS. The position responsible for eligibility and claims administration, an HSPA I, was filled July 9, 2007 by Melissa Evans. Melissa has a Bachelor of Science degree in Elementary Education.//2008//

**/2009/ Support Staff remains at 3.0 but classifications have changed to Admin Assist I, II, and Office Assist III. Total staff funded by Title V is 7.0. //2009//**

CSHS Staff (not funded)

SSDI Coordinator 1.0 Vacant since 5/27/05

\* Total Not Funded by Title V 1.0

/2007/ SSDI Coordinator, MS Agricultural Entomology//2007//

**/2009/ Staff not funded by Title V is 1.0//2009//**

## **E. State Agency Coordination**

ND has a long history of interagency coordination and collaboration. MCH program staff work with other state agency staff on a daily basis through numerous coalitions, task forces, advisory groups, committees and cooperative agreements.

### Organizational Relationships Among the State Human Services Agencies

#### Public Health

MCH program staff work closely with the state local health liaison, whom acts as the liaison between the ND DoH and local public health units and other key public and private partners. In addition, the public health liaison assists in the facilitation of the quarterly local public health administrators' and director of nursing meetings. MCH program staff attends these quarterly meetings to solicit program input and to provide program updates.

The state MCH Maternal/Infant Nurse Consultant works with local public health staff on a monthly basis to continually update the Child Health Services Manual. This manual provides guidance to local public health agencies on such topics as immunizations, pediatric assessment, anticipatory guidance, newborn home visiting, etc.

#### Mental Health

The Mental Health/Substance Abuse Division Director is part of the DHS Senior Management team. The administrator for children's mental health services participated in the fall Title V planning retreat. The Children's Mental Health System of Care in ND provides therapeutic and supportive services to children with serious emotional disturbance and their families so they can manage their illness and live in the community in the least restrictive setting. Mental health and social emotional development is also one of the components collaboratively addressed through the state's Early Childhood Comprehensive Systems Grant Program. In addition, mental health/substance abuse was identified as a Healthy North Dakota (HND) priority. A HND committee has been formed to address mental health/substance abuse issues in the state.

#### Social Services/Child Welfare

County social service offices are often the first point of contact for families who need economic assistance, child welfare services, supportive services for elderly and disabled individuals, children's special health services, or help locating other local resources and programs. DHS divisions have oversight responsibility for County Social Service programs.

The Children and Family Division Director is part of the DHS Senior Management team. Programs in that division include: adoption, early childhood services, the child protection program, children's mental health services, family preservation services, foster care services, the head start state collaboration project, and refugee services. Program administrators housed within the Children and Family Division participated in the fall Title V planning retreat.

#### Education

Title V and the Department of Public Instruction (DPI) have a strong partnership and work collaboratively on many projects.

The CSHS Director is a member of the state Interagency Coordinating Council, which meets jointly with the DPI Individuals with Disabilities Education Act advisory group on a quarterly basis to better coordinate services for young children with disabilities.

ND received the Coordinated School Health Programs (CSHP) and Reduction of Chronic Diseases Infrastructure Agreement from CDC in March 2003. Please refer to Section B., Agency Capacity.

The State Asthma Workgroup, with its broad-based membership from the public and private sectors, has been influential and productive in its efforts to increase asthma awareness and education in the state. Please refer to Section B., Agency Capacity.

The ND Center for Persons with Disabilities, at Minot State University, is working with the DoH, DHS, DPI, school nurses and school personnel on the development of a School Health Service Guideline Manual. Targeted for completion by March 2006, this manual will include preventative services, educational services, emergency care, screening recommendations, referrals, and management of acute and chronic health conditions.

The ND DoH and DPI work together to administer the Youth Risk Behavior Survey (YRBS), Youth Tobacco Survey (YTS) and Profiles. The primary staffing source and lead role for the YRBS and Profiles is DPI. The DoH's epidemiologist serves in an advisory role and provides technical assistance for the surveys.

In an effort to enhance education regarding risk behaviors related to HIV, STDs, teen pregnancy and unintended pregnancy, a key stakeholders group has been formed consisting of representatives from the adolescent health, HIV, STD, family planning, and abstinence education-only programs.

/2008/ As a result of this groups work, a position paper, Supporting Sexuality Health Education,

has been developed. The paper is supported by the NDDoH and DPI and the Governor. The paper will be released via email to all school administrators in fall 2007.//2008//  
**/2009/ Due to the controversial topic of this paper, it has gone back to the Governor's office for review.//2009//**

#### Medicaid

The state Medicaid program is co-located with SCHIP and CSHS in the Medical Services Division within DHS. The Division Director is part of the DHS Senior Management team. The state CSHCN program has close ties to Medicaid and participates regularly in scheduled meetings to discuss administrative, claims policy, claims payment, and MMIS issues. In addition, a cooperative agreement to assure care and improve health status is in place between DHS, DoH, the Primary Care Office, and the Primary Care Association.

**/2009/ With the move from DHS to DoH, CSHS has maintained ties with the Medical Services Division and continues to participate in regularly scheduled meetings.//2009//**

#### SCHIP

In October 2002, Dakota Medical Foundation received a \$700,000 grant from The Robert Wood Johnson Foundation. Since January 2003, ND Covering Kids and Families (CKF) has collaborated with state and local agencies from across the state to help families learn and apply for existing low-cost/free health coverage, including Healthy Steps (ND SCHIP), Caring for Children Program and Medicaid. Through a statewide partnership including Dakota Medical Foundation, the ND Insurance Department, ND DHS, ND DoH, Cass County Social Services and Blue Cross Blue Shield's Caring Program for Children, are initiating the effort to conduct outreach, simplify and coordinate the children's health insurance programs. These efforts are enhanced by the endorsement of the Office of the Governor and involvement of ND legislators, county social service departments, business representatives, school districts, insurance agents, community health centers, hospitals, clinics, daycare centers, churches, service clubs and citizen volunteers.

**/2009/ With the move from DHS to DoH, CSHS has maintained ties with the Medical Services Division and continues to participate in regularly scheduled meetings.//2009//**

#### Social Security Administration/Disability Determination Services

Annually, the State CSHCN program convenes a meeting between Disability Determination Services (DDS), the local Social Security Administration office, 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. An interagency agreement is in place between DDS and CSHS to assure SSI recipients and cessations receive information about program benefits or services. DDS is located in the Disability Services Division. The Division Director is part of the DHS Senior Management team.

#### Vocational Rehabilitation

Vocational Rehabilitation is co-located with Developmental Disabilities in the Disability Services Division. The Disability Services Division Director is part of the DHS Senior Management team. Title V interacts with Vocational Rehabilitation through membership on the Transition Steering Council, a group that focuses on transition services for students with disabilities.

#### Alcohol and Substance Abuse

The ND Fetal Alcohol Syndrome Taskforce has a broad membership that works to identify initiatives and possible partnerships to minimize duplication for the prevention and treatment of FAS/FAE in ND. The MCH Newborn Screening Program Director, Maternal/Infant Nurse Consultant and SSDI Coordinator serve on the taskforce. The ND Fetal Alcohol Syndrome

Taskforce is a partner of the Four-state Fetal Alcohol Syndrome Consortium. Key objectives of this Consortium include: 1) development of an information base to systematize data collection on prevalence and FAS/FAE to determine high-risk areas and populations, and 2) implement and test an universal, selective and indicated scientifically defensible prevention intervention in high risk areas and populations to see how effective it is in preventing, reducing and/or delaying substance use in order to reduce the rates of FAS/FAE.

The Mental Health/Substance Abuse Division within the ND DHS collaborates with several MCH programs. The Community Coordinator for the Mental Health/Substance Abuse Division participated in the fall 2004 Title V planning retreat. She also participates in planning the Roughrider Health Promotion annual coordinated school health conference. In addition, funding is provided to support mental health and substance abuse community prevention training sessions. The Roughrider Conference is the largest health and wellness education conference in the state, reaching over 375 educators and community members.

***//2009/ The State Systems Development Initiative Coordinator participates in the State Epidemiological Outcomes Workgroup (SEOW), which was initiated in 2006 by the North Dakota Department of Human Services, Division of Mental Health and Substance Abuse Services. The SEOW advisory committee helped collect and analyze data for the publication entitled "Alcohol, Tobacco, and Illicit Drug Consumption and Consequences in North Dakota -- The North Dakota Epidemiological Profile", which was disseminated March 2007.//2009//***

Relationship of State and Local Public Health Agencies

Federally Qualified Health Centers

Please refer to Section A., Overview of the State.

Primary Care Association

The ND Deputy Director for the Community Healthcare Association of the Dakotas is an active member of the Community Health Section Advisory Committee. This advisory committee meets on a quarterly basis and receives MCH program updates and provides input into program activities. In addition, the Deputy Director, along with the directors for Title V and CSHS, participate in the quarterly HRSA partnership conference calls.

Tertiary Care Facilities

There are four major health systems in the state that serve CSHCN's and their families. The most prominent is located in the southeast quadrant and includes a children's hospital. Many of the pediatric subspecialty physicians practice in that same community.

Several physicians participate on committees that have been formed to address Title V priorities. Examples include newborn screening, obesity, etc. The CSHS Medical Advisory Council includes representation of various specialists serving CSHCN's and their families from health systems across the state.

Technical Resources

Title V programs have benefited from the technical resources of the ND Center for Persons with Disabilities (NDCPD) through Minot State University. First Sounds, ND's early hearing, detection, and intervention program is housed at NDCPD. A cooperative agreement is in place between CSHS and the NDCPD that guides detection, intervention, tracking, surveillance, and integration activities. DoH contracts with the NDCPD for the development of school health guidelines and DHS contracts with the NDCPD to provide a multidisciplinary clinic for children with disabilities.

/2007/ The NDCPD facilitated the signing of a Regional Memorandum of Understanding in November 2005 that supported a grant proposal to expand the Utah Leadership Education in Neurodevelopmental Disabilities Regional Program to North Dakota.//2007//

/2008/Potential LEND activities for the coming year could include training seminar opportunities for state and local partners and access to technical assistance support (e.g.) medical home, grant writing, surveys, trainee projects, etc.//2008//

/2008/The NDCPD at Minot State University in collaboration with the ND DoH and the UND Center for Rural Health recently received notification that ND was one of five states that was funded for a five-year State Implementation Project for Preventing Secondary Conditions and Promoting the Health of People with Disabilities. North Dakota's "Disability Health Project" will promote the health and wellness of ND citizens with disabilities, and prevent or lessen the effects of secondary conditions associated with disabilities.//2008//

***/2009/ The NDCPD at Minot State University in collaboration with the Children's Special Health Services Division applied for and received a state implementation grant for Integrated Community Systems for Children and Youth with Special health Care Needs for the period June 1, 2008 through May 31, 2011. NDs Integrated Services Project focuses on medical home, family involvement/cultural competence, and healthy transitions to work. Major objectives address learning collaboratives, pilot programs, and systemic implementation of an integrated services system for children and youth with special health care needs.//2009//***

***/2009/ The NDCPD at Minot State University received special Congressional Initiative funding for autism. The Great Plains Autism Spectrum Disorders Treatment Program (GPAST) will provide training, research, and diagnostic and treatment services to ND children and youth suspected or diagnosed with Autism Spectrum Disorders.//2009//***

The state CSHCN program and some of the state's universities have developed a mutually beneficial relationship that involves multidisciplinary clinics for CSHCN. These services are often used as a means of pre-service training for nursing, speech, audiology, and medical students. The state CSHCN program also benefits from the expertise of faculty who participate as clinic team members.

The Title V Director serves on the MCH Advisory Committee for the Center for Leadership Education in Maternal and Child Public Health at the University of Minnesota's School of Public Health. This advisory committee meets to discuss the master's of public health training program, continuing education events and outreach activities to the upper Midwest. One of their major outreach efforts, Healthy Generations (a nationally distributed newsletter), recently contained an article regarding the HND Healthy Weight Council's position paper on assessing heights and weights in school. The Title V Director also participates in the quarterly Rocky Mountain Public Health Education Consortium conference calls.

The Center for Rural Health at the University of North Dakota (UND) identifies and researches rural health issues, analyzes health policy, strengthens local capabilities, develops community-based alternatives, and advocates for rural concerns. Partnerships with Title V programs and other related programs have resulted in valuable resources/publications such as ND Health Professions: Dentists, Traumatic Brain Injury, and Health Care Access in ND: Characteristics of the Uninsured. The Center for Health Promotion and Translation Research at UND provides evaluation for the coordinated school health program.

Following is a report entitled 2003 North Dakota Rural Health Dialogues Summary. This report provides information about health priorities among rural populations that were identified fall 2003. <http://medicine.nodak.edu/crh/publications/dialogue.pdf>

Plan for Title V Coordination

## Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

Located in the ND DHS, the EPSDT Coordinator participated in the fall 2004 Title V planning retreat. In addition, she participates in numerous Title V program workgroups/coalitions such as the Early Childhood Comprehensive Systems Workgroup, the Oral Health Coalition and the Claims Policy meetings within the DHS Medical Services Division. EPSDT holds annual trainings and contacts the Title V Director prior to the training for content input. This year, a combined local CSHS and EPSDT training is planned. She also provides input and updates to the EPSDT section of the MCH Children's Health Services Manual.

## Other Federal Grant Programs

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides healthy foods for proper growth and development, education on choosing healthier ways of eating and referrals to other needed services. WIC is for eligible pregnant, breastfeeding and postpartum women, infants, and children under five years and is available in all counties in ND. An average of 13,500 mothers and children are seen each month in over 75 WIC clinic sites across the state.

WIC has an agreement with the Commodity Supplemental Food Program within the ND Department of Public Instruction. In an effort to assure quality and accessible care, the agreement identifies individuals who are not being served by either program and formalizes and strengthens relationships between programs; thus by reducing duplication, increasing accessibility and providing mechanisms for enhanced program coordination. State and local WIC staff work closely with several of the MCH programs and HND Committees to further nutrition and/or physical activity related issues.

The state CSHCN program works most closely with the Developmental Disabilities Unit in the area of early intervention. State CSHCN staff participates on the state Interagency Coordinating Council (ICC), a group appointed by the Governor to provide leadership to support improvements in the early intervention system for infants and toddlers with disabilities. Regional ICC's have also been created in eight regions of the state. A Memorandum of Understanding is in place that addresses collaboration in providing services to young children birth through age five.

Title V also works collaboratively with Developmental Disabilities and other DoH programs to implement the Birth Review Program. This program provides new parents with information on normal growth and development and helps them identify whether possible risk factors are present that may affect their child's development. Concerned parents receive additional information upon request and are linked to various ND service agencies.

A new area of coordination between the state CSHCN program and the Developmental Disabilities Unit is the joint leadership of a Medical Needs Task Force. This informal group recently began meeting to address children with extraordinary medical needs and will likely integrate planning and policy recommendations in conjunction with interim legislative child health study findings.

The Family Planning Program offers education, counseling, exams, lab testing, infertility services and contraceptives. Please refer to Section B., Agency Capacity.

## Pregnant Women and Infants

The Optimal Pregnancy Outcome Program (OPOP) provides multi-disciplinary teams committed to enhance the prenatal care women receive from their primary health care provider. Please refer to Section B., Agency Capacity.

The ND Section of the American College of Obstetricians and Gynecologists, through its involvement in the Providers' Partnership Project, have developed a clinical model to assist primary care providers to screen for depression in the clients. The OPOP Director, Tobacco Prevention and Control Director, Mental Health Association and several practicing OB/GYN's make up the Providers' Partnership Committee on Women and Depression.

#### Family Leadership and Support Programs

There are four family-led organizations in ND that provide leadership and support to families. They include Family Voices (health information for CSHCN), the Family-to-Family Network (parent-to-parent support), Pathfinder Family Center (education), and the Federation of Families (mental health). The state CSHCN program contracts with the first two organizations to provide emotional support, health information, and training for families in the state. CSHS staff also participate on their respective advisory boards.

***/2009/ Effective April 1, 2008, the Family to Family Network internally transferred from the UND Center for Rural Health to the UND Department of Social Work./2009//***

Family support is also provided through various programs that serve CSHCN's and their families. For example, CSHS supports a nine member Family Advisory Council to assure family involvement in policy, program development, professional education, and delivery of care. Families participate on many other Title V led committees. Experienced parents have been hired as staff at many of the state's regional Human Service Centers to help families who have young children with disabilities. Lastly, the ND Center for Persons with Disabilities through Minot State University has received several grants to address a variety of family leadership and support issues.

***/2009/ A State Family Liaison Project was initiated March 2008 by the Department of Human Services through a contract with Northern Plains Special Education Unit. Work activities of project staff include increasing awareness of family issues and providing technical assistance and training to regional and tribal experienced parents involved in the state's early intervention system./2009//***

*/2008/Effective March 1, 2007, the NDCPD at Minot State University, in collaboration with the UND Center for Rural Health and Family Voices of ND, received a one-year HRSA grant to create a plan for a new rural health network in ND. Expected outcomes are establishment of a collaborative network of rural health/human services partners and development of a comprehensive written strategic plan for family support services for rural North Dakota families. The plan will bring together stakeholders that support families whose children have chronic health care needs. The plan that results from this project will guide the implementation of future Rural Health Network Development grants./2008//*

***/2009/ The NDCPD at Minot State University received a three-year HRSA grant to develop a Rural Health Network for Family Support (RHN-FS) for the period May 1, 2008 through April 30, 2011. The network will assist rural ND families and providers to improve the health and well being of children with special health care needs through enhanced family support services. Efforts focus on development of a self-sustaining network that will achieve outcomes in collaboration, training, system navigation, leadership and sustainability to strengthen its capacity to help rural families. A CSHS staff person is a member of the RHN-FS board./2009//***

*/2007/ Health Resources and Services Administration (HRSA) Partners*

HRSA partners in ND continue to connect via monthly conference calls. ND was one of ten states selected to participate in a State Strategic Partnership Review with the HRSA Office of Performance Review during CY 2006.*/2007//*

*/2008/The ND Strategic Partnership Summit was held November 16, 2006 and a report was generated. Subsequent meetings have been held to further develop the action plan and monitor identified strategies that are expected to lead to increased access and utilization of primary and*

preventive health care for North Dakotans. HRSA partners in ND continue to connect via monthly conference calls.//2008//

## F. Health Systems Capacity Indicators

### Introduction

**Health Systems Capacity Indicator 01:** *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	15.0	15.0	15.7	14.1	11.5
Numerator	59	59	26	27	21
Denominator	39400	39400	16613	19111	18338
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

#### Notes - 2007

2007-The source for the Medicaid data is from the North Dakota Department of Human Services - Medical Services Division. Prior to 2005, claims from multiple payers were utilized. In 2007 a rolling average was used to determine the numerator and denominator. The denominator is a three-year average of the number of children less than five years old enrolled in Medicaid. The numerator is a three-year average of children less than five years old with asthma (ICD-9 codes: 493.0 - 493.9) that were discharged from the hospital. Calendar year Medicaid data was used for this measure.

#### Notes - 2006

The source for the Medicaid data is from the North Dakota Department of Human Services, Medical Services Division. For federal fiscal year 2007, calendar year Medicaid data was used for this measure. Previously, claims from multiple payers were utilized. Rates may be higher due to inability to use all health care systems data.

#### Notes - 2005

The source for the Medicaid data is from the North Dakota Department of Human Services, Medical Services Division. For federal fiscal year 2005, calendar year Medicaid data was used for this measure. Previously, claims from multiple payers were utilized.

#### Narrative:

***/2009/ The rate of children less than five years of age hospitalized for asthma has decreased from calendar year 2005 to calendar year 2007. Rates that were determined using Medicaid claims data were 15.7 in CY 05, 14.1 in CY 06, and 11.5 in CY 07. Starting in 2007, a three year rolling average was used to reduce variability because of small numbers.***

***For several years, Children's Special Health Services has provided leadership for a State Asthma Workgroup. This group is the primary mechanism for collaboration around asthma at the state level. It has had successful outcomes despite limitations in funding, as the state currently does not have a CDC-funded asthma program. In past years, the***

*group provided education to encourage use of national guidelines for asthma management and initiated legislation that would allow students to carry and self-administer emergency asthma and anaphylaxis medication in school. In 2003, Children's Special Health Services began supporting a multidisciplinary Regional Children's Asthma clinic. Other members of the workgroup also support activities to diagnose and treat asthma according to national standards. The last two years, the state has tried to recruit a CDC Public Health Preventative Specialist. Unfortunately, ND has not been selected as a practice site by any of the candidates. One of the needs that has been identified by the workgroup that could be addressed by the CDC Public Health Preventative Specialist is to lead the development of an asthma burden document for the state.*

*The SSDI Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.*

*//2009//*

**Health Systems Capacity Indicator 02:** *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	74.1	78.1	79.2	70.3	77.6
Numerator	2176	2455	2642	2612	2917
Denominator	2935	3145	3335	3714	3760
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2007**

2007-The source for this data is from the North Dakota Department of Human Services -- Medical Services Division Health Tracks program.

**Notes - 2006**

The source for this data is from the North Dakota Department of Human Services, Medical Services Division, Health Tracks program.

**Notes - 2005**

The source for this data is from the North Dakota Department of Human Services, Medical Services Division, Health Tracks program.

**Narrative:**

*//2009/ In 2001, the percent of Medicaid enrollees less than one year of age that received at least one initial periodic screen was 55.1 percent. This number increased to almost 78 percent in 2007, up from 70 percent in 2006. Over the last five years, the percent of Medicaid enrollees that received a screening fluctuated somewhat but averaged about 76 percent. This indicator has the potential to improve as continuous Medicaid eligibility for pregnant women and children to age 19 went into effect 6/1/2008.*

*All new Medicaid recipients receive information regarding Health Tracks services from their eligibility caseworker. Temporary Assistance for Needy Families (TANF) participants also receive an incentive for completing an annual periodic screen. Title V funded staff at*

*the state and local level encourage all Medicaid eligible children to complete an annual Health Tracks screen and promote use of medical home providers. Local public health nurses are actively involved in the screening process. Many infants eligible for Medicaid also receive well-child visits and immunizations through the private healthcare system.*

*In addition to information and referral services, CSHS actively links families to Medicaid. Children's Special Health Services requires all new applicants for the Specialty Care Program be screened for Medicaid eligibility prior to determining eligibility for Children's Special Health Services. In addition, an annual outreach mailing is conducted to families with uninsured children to provide information regarding a variety of available health care coverage programs.*

*The SSDI Coordinator collects data for this measure from the state Health Tracks Administrator. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.*

*For additional information, refer to Section III., E. State Coordination for activities related to Early Periodic Screening Diagnosis and Treatment Program. //2009//*

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	87.0	82.0	82.6	75.6	75.8
Numerator	67	50	76	118	116
Denominator	77	61	92	156	153
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2007**

2007-The source for this data is a special report run by Blue Cross Blue Shield of North Dakota.

**Notes - 2006**

The source for this data is a special report run by Blue Cross Blue Shield of North Dakota.

**Notes - 2005**

The source for this data is a special report run by Blue Cross Blue Shield of North Dakota.

**Narrative:**

*//2009/ The percent of infants less than one year that received a periodic screen decreased from 82.6 percent in 2005 to about 76 percent in both 2006 and 2007. Over the last five years, the percent of enrollees that received a screening fluctuated somewhat but averaged about 79 percent. Overall, the number of infants enrolled in the SCHIP program has increased with a five year average of 108 enrollees less than one year of age. In 2007, there were 153 enrollees in this age group.*

*In ND, the Department of Human Services is responsible for staffing the 1-877 KIDS NOW Helpline that connects families to information, assistance and applications for three low-*

*cost/free health coverage programs. A combined application and streamlined enrollment process for Medicaid, SCHIP, and Caring for Children programs is partially responsible for the increased number of eligible children and has kept many from falling through the cracks. During the 2007 legislative session, HB 1463 was passed. This bill allowed for expansion of Medicaid eligibility for individuals from birth through age 18 at 133 percent of the FPL and SCHIP eligibility at a net income of 150 percent of the poverty line, but was contingent upon federal changes during SCHIP reauthorization. Congress only approved a SCHIP continuation. However, recently North Dakota received federal approval to expand the SCHIP program from 140 percent to 150 percent of poverty effective 10/01/2008.*

*Title V funded staff at the state and local level provide information and referral services to the Healthy Steps program for families with uninsured children and encourage establishment of a medical home and well-child follow-up according to endorsed pediatric periodicity schedules. In addition to information and referral services, CSHS actively links families to SCHIP by requiring that all new uninsured applicants for the Specialty Care Program be referred to the Healthy Steps program when determining eligibility for services. An annual outreach mailing listing possible health care coverage options is also sent to families that have CSHCN's without current health care coverage.*

*The SSDI Coordinator is responsible for collecting data for this measure in collaboration with BCBS of ND. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.*

*Refer to Section III. State Overview, Health Care Coverage, for program strategies in place to maintain and/or enhance this Indicator. //2009//*

**Health Systems Capacity Indicator 04:** *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	88.1	88.0	88.3	85.3	82.4
Numerator	7030	7196	7387	7349	7242
Denominator	7976	8179	8367	8616	8794
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2007**

2007-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

**Notes - 2006**

The source of data is from the North Dakota Department of Health, Division of Vital Statistics.

**Notes - 2005**

The source of data is from the North Dakota Department of Health, Division of Vital Statistics.

**Narrative:**

*/2009/ In 2007, 82.4 percent of women received adequate prenatal care as measured by the Kotelchuck index. This Indicator has historically remained very stable with percentages ranging from 85.3 to 89.6 percent. This is the first time that this has dropped below 85 percent. This Indicator will need to be monitored closely to assure that this decrease does not continue.*

*Program strategies in place to maintain and/or enhance this Indicator include: OPOP clinic sites that focus on the importance of prenatal care, healthy lifestyles, 1:1 counseling with a licensed social worker to assist with any needed referrals in reducing the mother's stress level, and distribution of prenatal vitamins with folic acid; Family Planning clinic sites that counsel and refer clients with a positive pregnancy test for pregnancy confirmation within 15 days; WIC clinic sites that screen and refer for prenatal care (WIC vouchers can be distributed during an OPOP visit); the Healthy Start Program on one Indian reservation; and the participation of MCH staff on March of Dimes committees.*

*To assure MCH program staff access to policy and program relevant information related to this Indicator, the following activities are in place: 1) Development of PRAM-O-GRAM fact sheets utilizing data from the 2002 ND PRAMS Point-in Time survey. Five PRAM-O-GRAM fact sheets have been completed: Birth Trends, Pregnancy Intendedness, Prenatal and Postpartum Issues, Discussions with Health Care Workers During Prenatal Care Visits, and Maternal Health. The PRAM-O-GRAM fact sheets can be viewed online at: <http://www.ndhealth.gov/familyhealth>. The PRAM-O-GRAM fact sheet series will include nine publications by July 30, 2009. These information sheets are listed on the DoH and ND State Data Center web sites; and 2) Conversion of the existing OPOP DOS based application into a Microsoft Access based system. A single database for OPOP data was recommended in a 2006 OPOP evaluation. The new application will enable the state to collect and analyze health information for pregnant women who are at high risk and are very low income. The database program is completed and training was held on June 9, 2008 for OPOP staff. The program will be implemented on July 1, 2008.*

*The SSDI Coordinator is responsible for collecting data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.//2009//*

**Health Systems Capacity Indicator 07A:** *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	79.8	75.7	91.1	86.4	80.2
Numerator	30702	30995	34643	33743	34831
Denominator	38494	40950	38016	39075	43427
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2007**

2007-The source for this data is from the North Dakota Department of Human Services -- Medical Services Division. The denominator is the estimate of Medicaid eligible children in North Dakota

from the Current Population Survey (CPS) conducted by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics.

**Notes - 2006**

The source for this data is the North Dakota Department of Human Services, Medical Services Division

**Notes - 2005**

The source for this data is the North Dakota Department of Human Services, Medical Services Division.

**Narrative:**

*/2009/ Overall, there has been a small decline since 2005 in the percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program. Over the last five years, the percent has fluctuated somewhat but averaged 82.5 percent. In 2007, 80.2 percent of potentially Medicaid eligible children received a service paid by the Medicaid Program.*

*Title V funded staff at the state and local level provide information and referral services for families with uninsured children and encourage establishment of a medical home and well-child follow-up according to endorsed pediatric periodicity schedules. Local public health nurses are actively involved in the EPSDT (Health Tracks) screening process.*

*In addition to information and referral services, CSHS actively links families to SCHIP by requiring all new uninsured applicants for the Specialty Care Program be referred to the Healthy Steps program when determining eligibility for services. An annual outreach mailing listing possible health care coverage options is sent to families that have CSHCN's without current health care coverage. CSHS staff participates in a variety of Medicaid meetings to influence Medicaid payment and coverage policies for CSHCN's and their families.*

*The ND DHS is responsible for the 1-877 KIDS NOW Helpline that connects families to information, assistance and applications for three low-cost/free health coverage programs. A combined application and streamlined enrollment process for Medicaid, SCHIP, and Caring for Children programs is partially responsible for the increased number of eligible children and has kept many from falling through the cracks.*

*The SSDI Coordinator is responsible for collecting data for this measure through the DataProbe System used by the Medicaid Program. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.*

*Refer to Section III. State Overview, E. State Agency Coordination, Medicaid for program strategies in place to maintain and/or enhance this Indicator./2009//*

**Health Systems Capacity Indicator 07B:** *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	42.4	34.7	34.8	28.0	36.6
Numerator	3140	2946	2953	2390	3060
Denominator	7413	8495	8475	8544	8362

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2007**

2007-The source for this data is from the North Dakota Department of Human Services -- Medical Services Division Health Tracks program.

**Notes - 2006**

The source for this data is the North Dakota Department of Human Services, Medical Service Division, Health Tracks program.

**Notes - 2005**

The source for this data is the North Dakota Department of Human Services, Medical Service Division, Health Tracks program.

**Narrative:**

*/2009/ The percent of EPSDT eligible children aged 6 through 9 who have received dental services has seen a reduction from 52.6 percent in 2001 to 36.6 percent in 2007. Although Medicaid has played an important role in reducing financial barriers and facilitating access to health care services, this reduction could be an indication of the lack of support by health care professionals involved in providing services to young children.*

*Program strategies which are in place to maintain and enhance this Indicator include the development of guidelines by recognized dental organizations that recommend children have periodic preventive dental examinations and follow up services starting at one year of age and thereafter at intervals based on risk assessments.*

*To assure MCH program staff access to policy and program relevant information related to this indicator, the following activity is planned: development of fact sheets with detailed recommendations regarding the frequency of professional dental services, prevention and oral treatment for children. These fact sheets will be distributed to key partners and made available on the DoH's Oral Health Program's website.*

*The SSDI Coordinator is responsible for collecting data for this measure using the DataProbe System. The SSDI initiative supports the MCH program in accessing relevant information for program evaluation and policy development.//2009//*

**Health Systems Capacity Indicator 08:** *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	9.4	9.5	9.4	9.9	9.2
Numerator	266	283	284	310	274
Denominator	2833	2985	3022	3142	2987
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot					

be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2007**

2007-The source for the numerator is from the CSHS database, and the source for the denominator is from a report (Children Receiving SSI 2007) from the Social Security Administration. The data for the year 2007 is a three-year average.

**Notes - 2006**

The sources for this data are a special electronic SSI report and the CSHS database.

**Notes - 2005**

The sources for this data are a special electronic SSI report and the CSHS database.

**Narrative:**

*/2009/ The State CSHCN program served 9.2 percent of the SSI child population under the age of 16 in FFY 07. Over the last five years, the percentage averaged 9.5 percent. A new method was used to calculate the percentage this year. The numerator for the measure is now based on self-report of SSI status from families served by CSHS. The denominator for the measure is based on state reports from the Social Security Administration. This change was needed when CSHS lost access to SSI information through the SDX and SOLO-Q systems. Since the ability to report on the current measure has been affected, a Request for Disclosure of SSA Information for Use in Non-1137 Programs has been submitted and is currently being reviewed by appropriate policy and legal staff in the Social Security Administration.*

*Children's Special Health Services convenes an annual meeting with Medicaid, the Social Security Administration, Disability Determination Services, Family Voices and state CSHCN program staff to jointly monitor the status of the SSI population and share program updates or developments that have occurred during the year. CSHS also conducts outreach, information and referral activities targeted to the SSI population. Disability Determination Services recently began providing an electronic process for referrals to assure that all children are consistently being referred to the Title V program.*

*The SSDI Coordinator in partnership with state CSHCN program staff is responsible for collecting data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.*

*Refer to Section III. State Overview, B. Agency Capacity, Services for CSHCN.//2009//*

**Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams)**

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2007	payment source from birth certificate	6.9	6.1	6.3

**Notes - 2009**

2007 -The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The numerator for the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester under Medicaid and the numerator for the percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% (Kotelchuck Index) under Medicaid are the same. This is due to the high number of unknown values for the date of first prenatal care visit. Since we no longer collect the trimester prenatal care began, calculation is needed to compute this from the date of birth and date of first prenatal care visit, compared to the gestational age at birth. This leaves unknown trimester data. As more states convert to the new US Standard birth record, this may no longer be a good indicator.

**Narrative:**

*/2009/ Overall, there has been little change in this Indicator. Over the last five years, the overall percent of low birth weight in ND has ranged from 6.3 percent to 6.7 percent, with an average of 6.5 percent. In 2007, of the 554 low birth weight births, 173 were Medicaid and 381 were non-Medicaid.*

**Refer to HSCI #04 for program strategies in place to maintain and/or enhance this Indicator.**

**Refer to HSCI #04 for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator. //2009//**

**Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births**

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2007	payment source from birth certificate	5.6	8.1	7.4

**Notes - 2009**

2007 -The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The numerator for the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester under Medicaid and the numerator for the percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% (Kotelchuck Index) under Medicaid are the same. This is due to the high number of unknown values for the date of first prenatal care visit. Since we no longer collect the trimester prenatal care began, calculation is needed to compute this from the date of birth and date of first prenatal care visit, compared to the gestational age at birth. This leaves unknown trimester data. As more states convert to the new US Standard birth record, this may no longer be a good indicator.

**Narrative:**

*/2009/ Overall, there is some variability with this Indicator because of the small number of infant deaths. Over the last five years, the overall percent of infant deaths per 1,000 live births has ranged from 5.1 percent to 7.4 percent with an average of 6.3 percent. Of the 65 infant deaths per 1,000 live births, 14 were Medicaid and 51 were non-Medicaid.*

**Refer to HSCI #04 for program strategies in place to maintain and/or enhance this**

**Indicator.**

**Refer to HSCI #04 for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator.//2009//**

**Health Systems Capacity Indicator 05C:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	payment source from birth certificate	73.8	85.7	82.3

**Notes - 2009**

2007 -The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The numerator for the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester under Medicaid and the numerator for the percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% (Kotelchuck Index) under Medicaid are the same. This is due to the high number of unknown values for the date of first prenatal care visit. Since we no longer collect the trimester prenatal care began, calculation is needed to compute this from the date of birth and date of first prenatal care visit, compared to the gestational age at birth. This leaves unknown trimester data. As more states convert to the new US Standard birth record, this may no longer be a good indicator.

**Narrative:**

***/2009/ Overall, there has been a small decline in the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. Over the last five years, the overall percent has ranged from 86.5 percent in 2003 to 82.3 percent in 2007 with an average of 84.3 percent. Of the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester, in CY 2007, women covered by Medicaid were at 73.8 percent while non-Medicaid women were at 85.7 percent. Use of the new US Standard birth record has impacted data related to this indicator as there are a high number of unknown values for the date of the first prenatal care visit.***

**Refer to HSCI #04 for program strategies in place to maintain and/or enhance this Indicator.**

**Refer to HSCI #04 for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator.//2009//**

**Health Systems Capacity Indicator 05D:** *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05	YEAR	DATA SOURCE	POPULATION
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<b>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</b>			<b>MEDICAID</b>	<b>NON-MEDICAID</b>	<b>ALL</b>
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	payment source from birth certificate	73.8	85.7	82.3

**Notes - 2009**

2007 -The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The numerator for the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester under Medicaid and the numerator for the percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% (Kotelchuck Index) under Medicaid are the same. This is due to the high number of unknown values for the date of first prenatal care visit. Since we no longer collect the trimester prenatal care began, calculation is needed to compute this from the date of birth and date of first prenatal care visit, compared to the gestational age at birth. This leaves unknown trimester data. As more states convert to the new US Standard birth record, this may no longer be a good indicator.

**Narrative:**

*/2009/ Over the last five years, there has been a small decline in the percent of women with adequate prenatal care. The overall percent has ranged from 88.2 percent to 81.7 percent with an average of 85.6 percent. In 2007, the percent of women on Medicaid with adequate prenatal care was 73.8 percent compared to 85.7 percent of non-Medicaid women.*

*Use of the new US Standard birth record has impacted data related to this indicator as there are a high number of unknown values for the date of the first prenatal care visit.*

*Refer to HSCI #04 for program strategies in place to maintain and/or enhance this Indicator and for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator.//2009//*

**Health Systems Capacity Indicator 06A:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

<b>INDICATOR #06</b> The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Infants (0 to 1)	2007	133
<b>INDICATOR #06</b> The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Infants (0 to 1)	2007	140

**Notes - 2009**

2007 -The source for this Medicaid data is the North Dakota Department of Human Services -- Medicaid program.

**Notes - 2009**

2007-The source for this SCHIP data is the North Dakota Department of Human Services -- SCHIP program.

**Narrative:**

*/2009/ Eligibility levels have remained unchanged for the identified population groups for several years; however, during the 2007 legislative session, HB 1463 was passed. This bill allowed for expansion of Medicaid eligibility for individuals from birth through age 18 at 133 percent of the FPL and SCHIP eligibility at a net income of 150 percent of the poverty line, but was contingent upon federal changes during SCHIP reauthorization. Congress only approved a SCHIP continuation so these changes did not occur and eligibility levels remained unchanged for the year. However, continuous Medicaid eligibility for pregnant women and children to age 19 went into effect 6/1/2008. ND will also expand the SCHIP program from 140 percent to 150 percent of poverty effective 10/01/2008.*

*Refer to FPM's #4 and #13 for program strategies in place to maintain and/or enhance this Indicator.*

*The SSDI Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.*

*//2009//*

**Health Systems Capacity Indicator 06B:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Medicaid Children (Age range 1 to 6) (Age range 6 to 19) (Age range to )	2007	133 100
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Medicaid Children (Age range 1 to 6) (Age range 6 to 19) (Age range to )	2007	140 140

**Notes - 2009**

2007 -The source for this Medicaid data is the North Dakota Department of Human Services -- Medicaid program.

**Notes - 2009**

2007-The source for this SCHIP data is the North Dakota Department of Human Services -- SCHIP program.

**Narrative:**

*/2009/ Eligibility levels have remained unchanged for the identified population groups for several years; however, during the 2007 legislative session, HB 1463 was passed. This bill allowed for expansion of Medicaid eligibility for individuals from birth through age 18 at*

**133 percent of the FPL and SCHIP eligibility at a net income of 150 percent of the poverty line, but was contingent upon federal changes during SCHIP reauthorization. Congress only approved a SCHIP continuation so these changes did not occur and eligibility levels remained unchanged for the year. However, continuous Medicaid eligibility for pregnant women and children to age 19 went into effect 6/1/2008. ND will also expand the SCHIP program from 140 percent to 150 percent of poverty effective 10/01/2008.**

**Refer to FPM's #4 and #13 for program strategies in place to maintain and/or enhance this Indicator.**

**The SSDI Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.**

**//2009//**

**Health Systems Capacity Indicator 06C: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women**

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Pregnant Women	2007	133
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Pregnant Women	2007	140

**Notes - 2009**

2007 -The source for this Medicaid data is the North Dakota Department of Human Services -- Medicaid program.

**Notes - 2009**

2007-The source for this SCHIP data is the North Dakota Department of Human Services -- SCHIP program.

**Narrative:**

**/2009/ Eligibility levels have remained unchanged for the identified population groups for several years; however, during the 2007 legislative session, HB 1463 was passed. This bill allowed for expansion of Medicaid eligibility for individuals from birth through age 18 at 133 percent of the FPL and SCHIP eligibility at a net income of 150 percent of the poverty line, but was contingent upon federal changes during SCHIP reauthorization. Congress only approved a SCHIP continuation so these changes did not occur and eligibility levels remained unchanged for the year. However, continuous Medicaid eligibility for pregnant women and children to age 19 went into effect 6/1/2008. ND will also expand the SCHIP program from 140 percent to 150 percent of poverty effective 10/01/2008.**

**Refer to FPM's #4 and #13 for program strategies in place to maintain and/or enhance this Indicator.**

**The SSDI Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.**

**//2009//**

**Health Systems Capacity Indicator 09A:** *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

<b>DATABASES OR SURVEYS</b>	<b>Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)</b>	<b>Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)</b>
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	2	Yes

**Notes - 2009**

2007-The source of this data is North Dakota Department of Health.

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2007-The source of this data is North Dakota Department of Health.

2007-The source of this data is North Dakota Department of Health.

2007-The source of this data is North Dakota Department of Health.

**Narrative:**

*//2009/ The States' ability to assure that the MCH program and Title V agency have access to policy and program relevant information and data was maintained at 16. Program strategies in place to maintain and/or enhance this Indicator include various grant activities identified in the State Systems Development Initiative (SSDI) that address identified gaps by enhancing collection, analysis, synthesis, translation, technical assistance, training and dissemination of data as well as building data capacity at the state and local level.*

*The following activities are in place through the State Systems Development Initiative (SSDI):*

- 1) Efforts to establish or improve data linkages and analysis between birth records and infant death, WIC, Early Hearing Detection and Intervention, Medicaid, and newborn screening files*
- 2) Efforts to establish or improve access to registries and surveys, including continuation of the ND Birth Defects Monitoring System, translation of PRAMS survey data, and analysis and dissemination of YRBS survey data*
- 3) Efforts to perform ongoing needs assessment activities for the MCH population focusing on enhancing staff skills, primary data collection, dissemination of products of analysis, support for the next five year needs assessment and planning process for the MCH Block Grant, and training of state and local partners*
- 4) Efforts to assist the state Title V program in successfully completing the annual MCH Block grant application including collection and entry of data, participation in planned activities for the select performance measures, and completion of the needs assessment narrative for the MCH block grant.*

*With support through SSDI, the Title V agency also has access to the National Survey of Children With Special Health Care Needs, Census data from ND State Data Center, CSHS program data, the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Survey, the National Children's Survey, the Pediatric Nutrition Surveillance System, the STD\*MIS System, the Crash Reporting System from the ND Department of Transportation, and the Trauma registry as sources of data for planning and evidence-based decision-making.*

*Challenges continue with linking birth certificates and WIC eligibility files, availability of hospital discharge survey data, and a consistent survey of recent mothers (PRAMS-like data). //2009//*

**Health Systems Capacity Indicator 09B:** *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

<b>DATA SOURCES</b>	<b>Does your state participate in the YRBS survey? (Select 1 - 3)</b>	<b>Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)</b>
Youth Risk Behavior Survey (YRBS)	3	Yes
Youth Tobacco Survey	3	Yes

**Notes - 2009**

The source of this information is from the, North Dakota Department of Health, Division of Tobacco prevention and control and Department of Public Instruction.

The source of this information is from the, North Dakota Department of Health, Division of Tobacco prevention and control.

**Narrative:**

*/2009/ Since 1993, the Youth Risk Behavior Survey (YRBS) has been conducted every two years in ND. MCH program staff has direct access to the state YRBS database for analysis. According to the YRBS, the percentage of ND youth who currently smoke cigarettes significantly decreased from 40.6 percent in 1999 to 21.1 percent in 2007. Between 1999 and 2007, the use of smokeless tobacco products among ND youth decreased from 15.1 percent to 11.7 percent. The percentage of individuals who smoked their first whole cigarette before the age of 13, significantly decreased from 43.7 percent in 2001 to 36.9 percent in 2007. The number of local communities with youth access ordinances, or those that restrict the sale of cigarettes to people younger than 18, has increased over the last 10 years. The percentage of youth in grades nine through twelve who have smoked cigarettes or cigars or used chewing tobacco, snuff, or dip on one or more of the past 30 days, has decreased from 34.1 percent in 2003 to 27.4 percent in 2007.*

*Program strategies in place to maintain and/or enhance this Indicator include: 1) Collaboration between the DoH, Department of Public Instruction (DPI), and other state and local entities, that allows a broad based approach in addressing youth tobacco issues. The DoH's Division of Tobacco Prevention and Control is preventing and reducing tobacco use in our state by building and supporting programs including: school, community and cessation programs; statewide public education campaigns; enforcement of state and local tobacco control laws; statewide leadership, collaboration, coordination and program evaluation; and integration with chronic disease prevention and early detection programs. Local public health units receive funding to assist with implementation of comprehensive tobacco prevention programs, which support curricula, special resources and training for teachers, and cessation support for students and staff. 2) The Coordinated School Health Program (CSHP), a collaborative between DoH and DPI, is committed to helping kids and their families embrace healthy behaviors that will last a lifetime. The overall goal of the CSHP is to improve the health and well being of K-12 students in ND, therefore improving academic performance. DPI and DoH work together in providing schools and communities with the services they need to keep students healthy. One area of focus is to decrease tobacco use among students and staff. The CSHP has developed school health strategy fact sheets to help students stay healthy and make the most of their educational opportunities. The tobacco fact sheet focuses on ways to decrease tobacco use within each of the eight CSHP component areas: Physical education, health services, health education, nutritional services, healthy school environments, family & community involvement, counseling, psychological & social service, and health promotion for staff. 3) Local Public Health Units, in an effort to reduce the number of youth who may begin to use tobacco, award a "Gold Star" status to districts that meet all components of the Gold Star Tobacco School Policy checklist.*

*To assure MCH program staff access to policy and program relevant information related to this Indicator, MCH program staff will continue to be engaged in the School Health Interagency Workgroup (SHIW). The SHIW is responsible for YRBS question selection and the development of data reports and dissemination.*

*The SSDI initiative supports the MCH program in accessing relevant information for program evaluation and policy development. SSDI grant funds are used to support analysis and dissemination of YRBS data.//2009//*

## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

Preparation for the five-year needs assessment began in early 2004. An initial workgroup comprised of representatives from the state Children with Special Health Care Needs Program in the ND Department of Human Services and five of the six divisions in the Department of Health Community Health Section (Family Health, Nutrition and Physical Activity, Injury Prevention, Tobacco Control, and Chronic Disease). Throughout the process, informal collaboration occurred with the Primary Care Association, the Primary Care Office and family organizations such as Family Voices and the CSHS Family Advisory Council.

The first task of the workgroup was to identify a list of data sources and indicators. The data sources were divided into two groups: primary sources and secondary sources. The indicators were categorized as 1) population and demographic, 2) pregnant women, mothers and infants, 3) children, 4) children with special healthcare needs, and 5) health system capacity indicators. The indicators for the three MCH population groups were further grouped as either health status, health care access or utilization, or health risk indicators.

Data collected were presented at a two-day planning retreat held in October 2004. The retreat was attended by more than forty Title V staff and state and community partners and stakeholders. The retreat facilitator led participants through a need prioritization process organized within three MCH Population groups: women, mothers and infants, children and adolescents, and children with special health care needs. Each group identified priority needs but were unable to rank them according to importance. The women, mothers and infants group identified 12 needs, the children and adolescents group 11 needs, and the children with special health care needs group 13 needs. Each group then wrote specific need statements for each of the priority needs. Following is a list of the priority needs.

#### Children and Adolescents

- \* To increase physical activity among pre-school and school age children.
- \* To reduce the rate of intentional and unintentional injury among children and adolescents.
- \* To improve early intervention for children with mental health and substance abuse disorders.
- \* For children with mental health and substance abuse disorders to receive appropriate treatment.
- \* To reduce marijuana use among children and adolescents.
- \* To reduce the rate of underage drinking.
- \* To reduce exposure to second hand smoke among children and adolescents.
- \* To reduce tobacco use among children and adolescents.
- \* To increase the percent of healthy weight among children and adolescents.
- \* To reduce the number of teens engaging in sexual activity.
- \* To improve access to health care (i.e. dental, mental health, school health).

#### Women, Mothers and Infants

- \* To increase access to dental services for low-income women.
- \* To improve early intervention of mental health and substance abuse disorders in women.
- \* To increase physical activity among women.
- \* To increase healthy weight among women.
- \* To improve early access to prenatal care among low-income populations.
- \* To increase the initiation and duration of breastfeeding.
- \* To decrease the rate of SIDS among American Indians.
- \* To increase the number of women consistently screened for domestic violence.
- \* To increase access to screening for mental health and wellness of infants.
- \* To increase access to preventive care.
- \* To reduce tobacco use among all women of child bearing age.

- \* To increase the rate of pregnancies that are intended.

#### Children with Special Health Care Needs

- \* To reduce the incidence of diabetes among children.
- \* To reduce the percent of inpatient hospitalization due to mental health and behavioral disorders among children.
- \* To improve/increase geographic access to pediatric specialty care providers.
- \* To improve access to children's mental health services.
- \* To improve the capacity to monitor newborns diagnosed with hearing loss.
- \* To reduce the impact of chronic health conditions on children.
- \* To reduce the impact of chronic health conditions on families.
- \* To reduce family financial hardship due to child's health care expenses.
- \* To increase care coordination within medical homes.
- \* To increase transition services for youth with special health care needs.
- \* To increase the availability of family support services -- including quality respite and childcare.
- \* To improve cultural competence in the service delivery system.
- \* To increase information and awareness about available services.

### **B. State Priorities**

After the retreat, three small workgroups were formed for each of the three population groups. Workgroups members consisted of Title V staff with programmatic expertise about specific needs as well as outside stakeholders. Workgroup members worked through a process designed to sort the priority needs for their population group into one of three lists based on the following criteria:

A List: This is a developmental need. It's a priority but we need to get more information or research intervention strategies.

B List: This priority need is already addressed through one of the 18 federal performance measures OR it is something we are already doing and will continue to do. (e.g. mandated programs/grants)

C List: All of the other priority needs not on the A or B List.

For those left on the C List we asked the following questions:

- \* Can we collaborate with someone else who has primary responsibility for the priority need (e.g. Healthy ND)?
- \* Do we have the resources needed to address the priority need?
- \* Do we know if there are effective interventions?
- \* Do we have baseline data and can we track improvement?

Based on the answers to these questions, we decided:  
Should this be one of the 7-10 state performance measures?

Based on this criteria, ten priority needs were selected which were chosen for the ten state "negotiated" performance measures for the next five-year grant cycle. Those ten priority needs and performance measures are:

#### Priority Need Statement 1

To increase physical activity and healthy weight among women.

#### State Performance Measure 1

The percent of healthy weight among women age 18-44.

Priority Need Statement 2

To increase the initiation and duration of breastfeeding.

State Performance Measure 2

The percent of women breastfeeding their infants at 6 months or longer.  
/2007/ This measure was deleted because it duplicates FPM #11.//2007//

Priority Need Statement 3

To increase access to dental services for low-income women.

State Performance Measure 3

The percent of women ages 18-44 enrolled in Medicaid who receive a preventive dental service.

Priority Need Statement 4

To increase access to preventive health services for women.

State Performance Measure 4

The degree to which women ages 18-44 have access to preventive health services as measured by five indicators of health care access.

Priority Need Statement 5

To reduce the rate of intentional and unintentional injuries among children and adolescents.

State Performance Measure 5

The rate of deaths to children age 1-19 caused by intentional and unintentional injuries per 100,000 children.

Priority Need Statement 6

To increase physical activity among pre-school and school-age children.

State Performance Measure 6

The percent of children age 6-17 who exercised or participated in a physical activity that made him/her sweat and breathe hard, such as basketball, soccer, running, or similar aerobic activities on five or more days during the past week.

Priority Need Statement 7

To increase the percent of healthy weight among children and adolescents.

State Performance Measure 7

The percent of ND children age 2-17 with a Body Mass Index (BMI) in the normal weight range.

Priority Need Statement 8

To reduce the impact of chronic health conditions on children.

State Performance Measure 8

The degree to which the state can assess and plan for the health and related service needs of children with extraordinary medical needs. NOTE: The complete ranking is included as an attachment to this section.

Priority Need Statement 9

To improve geographic access to pediatric specialty care providers.

State Performance Measure 9

The percent of families who reported they "had no problem at all" in getting care for their child

from a specialist doctor.

#### Priority Need Statement 10

To increase information and awareness about available services.

#### State Performance Measure 10

The percent of activities completed in the CSHS Public Information Services plan.

After the selection of the state's 10 priority needs and development of state-negotiated performance measures, individual staff persons from the MCH program were assigned primary responsibility for each national and state performance measure that closely related to their programmatic area of expertise. CSHS program staff opted to work on CSHCN related performance measures as a group. The SSDI coordinator, who works with both Title V programs, was responsible for the collection and reporting of data for each measure and for monitoring the overall process.

For each assigned performance measure, staff were directed to write an annual plan and a process to monitor the successful completion of the activities, that was designed to impact the performance measure. Staff were also required to write an annual report for their assigned performance measure in which they commented on achievement of the objectives and summarized progress on the work plan activities. Staff were provided trend data for their measure(s) from which they provided five-year target projections.

Staff from both MCH and CSHS meet quarterly and discuss progress on their measures and discuss potential additional activities to be included in the next year's annual plan. In addition, CSHS staff review the plan related to CSHCN measures quarterly at staff meetings. For national performance measure #1 related to newborn screening, both programs have responsibility for the measure; MCH is responsible for the screening and CSHS for treatment services for affected individuals.

North Dakota has adequate capacity and resources to address most federal performance measures. MCH programs are spread primarily among three divisions within the Community Health Section in the DoH. Although the program has relatively small numbers of staff persons, MCH has experienced, qualified individuals administering injury prevention, oral health, nutrition, family planning, adolescent health and MCH nursing programs. The injury prevention program coordinates much of the programmatic activity for performance measures related to reduction of mortality and injury. The abstinence program grant manager has the responsibility for the measure related to teen birth rate. The newborn screening program director reports on the newborn screening measure. The MCH nutritionist has the responsibility for the breastfeeding measure. The maternal/infant nurse consultant has the responsibility for the measures related to low birth weight and prenatal care.

MCH program staff have little direct impact on the federal performance measures for childhood immunization, children without health insurance, children receiving a service paid by the Medicaid program, and VLBW infant born a facilities for high-risk deliveries. Most activities are collaboration efforts with other programs and agencies such as the Division of Disease Control and the state Medicaid Program.

CSHS program staff have responsibility for the six federal measures for CSHCN in addition to the measure for newborn hearing screening. For national performance measure #1, CSHS has programmatic responsibility for treatment of eligible individuals with metabolic diseases. CSHS provides metabolic food to eligible individuals with PKU and MSUD. CSHS also has direct responsibility for the newborn hearing screening performance measure.

CSHS has developed program plans to impact the five other new national performance measures for CSHCN (family partnership and satisfaction, medical home, insurance, community-based

service system organization, and transition). However, the state CSHCN program directly serves only a fraction of all CSHCN in the state, therefore making direct impact on any of the measures difficult.

**State Performance Measures**

Title V staff have the capacity and resources to carry out activities that are expected to impact each of the state selected performance measures. The Nutrition and Physical Activity Division in the Community Health Section has experienced public health nutritionists with expertise in designing interventions to address physical activity and healthy weight in children and women of child bearing age. The MCH nutritionist, along with local public health nutritionists, administer a number of programs to encourage healthy diet and exercise practices which help to promote healthy weight in children and young adults. The MCH oral health director, in collaboration with local oral health professionals, help to increase access to dental care for low income populations in the state.

Staff within the Injury Prevention Division in the Community Health Section work collaboratively with other stakeholders, including the Department of Transportation, to reduce unintentional injuries among children.

Pediatric nurses with the CSHS program work collaboratively with a number of entities to reduce the impact of chronic illness in children and to increase awareness of available programs and services for CSHCN and their families. CSHS staff also work to assist eligible children with special health care needs to access specialty care physicians as needed.

**C. National Performance Measures**

**Performance Measure 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.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	6	8	15	21	16
Denominator	6	8	15	21	16
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	100	100	100	100	100

**Notes - 2007**

2007-The source for 2007 data is the Iowa Hygienic Laboratory and North Dakota Department of Health Newborn Screening Program.

**Notes - 2006**

The source for 2006 data is the National Newborn Screening and Genetic Resource Center (NNSGRC).

There were 4 cases of Cystic Fibrosis reported in 2006.

**Notes - 2005**

The source for 2005 data is the National Newborn Screening and Genetic Resource Center (NNSGRC).

There was a five-fold increase in the detection of Primary Hypothyroidism in 2005. The reason for the increase is undetermined. Changes in laboratory sensitivity or methodology have been ruled out.

**a. Last Year's Accomplishments**

Newborns with definitive diagnosis are seen within five to eight days of birth by Dr. Alan Kenien, Pediatric Endocrinologist, for long term planning and treatment management. Long-term follow-up has primarily been addressed by: 1) providing medical food to individuals with PKU and MSUD, 2) supporting quarterly Metabolic Disorders Clinics that result in coordinated disease management, and 3) providing diagnostic and treatment services for children birth to age 21 who meet medical and financial eligibility criteria. The number of individuals receiving medical food and attending Metabolic Disorders Clinics has changed minimally over the last five years. All current newborn screening conditions are approved medical conditions for Children's Special Health Services (CSHS) coverage. With financial eligibility for treatment services legislatively mandated at 185 percent of the federal poverty level, changes in numbers eligible are not expected without consistent outreach or changes in income eligibility levels. Limitations in funding and staff resources also impact Title V capacity for short and long-term follow up.

- A protocol committee has been established with the Iowa project coordinator, hence protocol revision and/or development is occurring.
- Parenting the First Year newsletters contains information regarding newborn screening.
- The Newborn Screening Program Advisory committee met three times via telephone conference call. During this time, work was started to establish a courier service to decrease the time between collection and results.
- CSHS provided financial support through a service contract for four multidisciplinary metabolic disorders clinics during the year. Fourteen individuals were served with a total of 18 visits. The multidisciplinary clinic team is made up of a nurse, pediatric endocrinologist, social worker, pediatric nutritionist, education specialist, and pediatric psychologist.
- CSHS provided metabolic food for 24 eligible individuals with PKU and MSUD. Ninety-one percent of metabolic formula requests received by CSHS were mailed out within five working days.
- CSHS provided state level care coordination services to eligible individuals with PKU and MSUD. Examples of state level care coordination services include information dissemination, assessment of clients' diet compliance, assistance with insurance billing and payment issues, and coordination between the multidisciplinary metabolic team, local providers, state and local partners, and families.
- Meetings to address national, state and client related issues were held on a periodic basis throughout the year.
- Revisions to the CSHS Metabolic Program Procedure Guide were identified.
- CSHS offered diagnostic services for conditions addressed through the newborn screening program. CSHS also paid for treatment services for individuals when eligibility requirements were met.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Newborn Screening Video (provided through a grant by the Heartland Genetics Partnership) will be disseminated to local providers.			X	

2. Iowa and North Dakota will finalize the newborn screening protocols.				X
3. The Newborn Screening Advisory Committee will meet at least two times a year to discuss current issues.				X
4. The Newborn Screening Advisory Committee will explore options for a courier service to transport blood specimens, thus increasing response time on assumptive positive/positive results.			X	
5. Title V staff will coordinate through periodic newborn screening meetings to address ongoing and newly emerging issues (e.g.) parent information needs, continuum of screening and long term follow-up services, etc.				X
6. The Metabolic Program Procedure Guide used in CSHS will be updated as needed.				X
7. Children's Special Health Services (CSHS) will support multidisciplinary clinics for children and women of childbearing age with metabolic disorders.	X			
8. CSHS will provide metabolic food to eligible individuals with PKU and MSUD.	X			
9. CSHS will provide state level care coordination to eligible individuals with PKU and MSUD.		X		
10. CSHS will provide diagnostic and treatment services to eligible children that have conditions identified through the newborn screening program.	X			

**b. Current Activities**

- The Newborn Screening Video (provided through a grant by the Heartland Genetics Partnership) is being disseminated to local providers.
- Iowa and North Dakota are finalizing the newborn screening protocols.
- The Newborn Screening Advisory Committee continues to meet to discuss current issues.
- The Newborn Screening Advisory Committee is exploring options for a courier service to transport blood specimens, thus increasing response time on assumptive positive/positive results.
- Title V staff are coordinating through periodic newborn screening meetings to address ongoing and newly emerging issues (e.g.) parent information needs, continuum of screening and long term follow-up services, etc.
- The Metabolic Program Procedure Guide used in CSHS is being updated.
- Children's Special Health Services (CSHS) are supporting multidisciplinary clinics for children and women of childbearing age with metabolic disorders.
- CSHS is providing metabolic food to eligible individuals with PKU and MSUD.
- CSHS is providing state level care coordination to eligible individuals with PKU and MSUD.
- CSHS is providing diagnostic and treatment services to eligible children that have conditions identified through the newborn screening program.

**c. Plan for the Coming Year**

- Title V staff will coordinate through periodic newborn screening meetings to address ongoing and newly emerging issues (e.g.) informational resources, technical assistance, organizational efficiencies, etc.
- Title V staff will collaboratively explore funding options that support service system enhancements, including short and long-term follow-up strategies.
- A courier service will be implemented for the purpose of improving the turnaround time for the newborn screening specimen cards from collection to the lab results.
- Educational videos/DVDs on improving "Newborn Screening Collection" will be provided to all health care facilities.
- If ND receives a CDC Data Linkage grant, CSHS staff including the SSDI Coordinator, will promote data integration activities between newborn hearing screening, newborn blood spot

screening and vital records.

- The Metabolic Program Procedure Guide used in CSHS will be updated as needed.
- CSHS will support multidisciplinary clinics for children and women of childbearing age with metabolic disorders.
- CSHS will provide metabolic food to eligible individuals with PKU and MSUD.
- CSHS will provide state level care coordination to eligible individuals with PKU and MSUD.
- CSHS will provide diagnostic and treatment services to eligible children that have conditions identified through the newborn screening program.

**Performance Measure 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)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	61.5	61.5	61.5	65	65
Annual Indicator	61.5	61.5	61.5	61.5	63.0
Numerator					10090
Denominator					16017
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	65	65	65	65	65

**Notes - 2007**

2007-Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2004,2005 for this performance measure.

Annual data is not available for this measure; however, satisfaction surveys have been conducted in the interim indicating the following:

- Mental Health and Substance Abuse survey – 81% of youth age 10-21 were satisfied with services received while 90% of parents/family of consumers were satisfied.
- Family Voices survey – 66% of families were satisfied with the quality of primary care, obtaining referrals/appointments, and coordination between primary and specialty care, 76% were satisfied with their level of input and involvement with their primary care provider, 80% were satisfied in care received and communication, 51% were satisfied with covered service costs, 68% were satisfied with developmental monitoring, 59% were satisfied with their comfort level accessing services and knowing who to call for information and services, 42% were satisfied with financial and emotional support for involvement in state and local activities, and 16% were satisfied with partnership in policymaking at all levels
- Children’s Special Health Services – 100% of individuals/families served by CSHS reported services received met their needs, a result measure showing improved health status, chronic disease management or access to information and resources.

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Annual data is not available for this measure; however, satisfaction surveys have been conducted in the interim indicating the following:

- Mental Health and Substance Abuse survey – 81% of youth age 10-21 were satisfied with services received while 90% of parents/family of consumers were satisfied.
- Family Voices survey – 66% of families were satisfied with the quality of primary care, obtaining referrals/appointments, and coordination between primary and specialty care, 76% were satisfied with their level of input and involvement with their primary care provider, 80% were satisfied in care received and communication, 51% were satisfied with covered service costs, 68% were satisfied with developmental monitoring, 59% were satisfied with their comfort level accessing services and knowing who to call for information and services, 42% were satisfied with financial and emotional support for involvement in state and local activities, and 16% were satisfied with partnership in policymaking at all levels
- Children's Special Health Services – 100% of individuals/families served by CSHS reported services received met their needs, a result measure showing improved health status, chronic disease management or access to information and resources.

#### **a. Last Year's Accomplishments**

According to the National Survey of Children with Special Health Care Needs, the percent of families that had children with special health care needs age 0 to 18 years in ND who partnered in decision making at all levels and were satisfied with the services they received increased slightly from 61.5 percent in 2001 to 63.0 percent in 2005/2006. This is slightly higher than the national percentage, which was 57.5 in 2001 and 57.4 in 2005/2006.

Annual data is not available for this measure; however, family satisfaction has been reported in a May 2006 Family Voices of North Dakota report entitled "What Do North Dakota Families Say about Health Care for Children with Special Health Care Needs", with the following results:

- 89 percent of families were somewhat satisfied, satisfied, or very satisfied with the quality of primary care, obtaining referrals and appointments for needed services and coordination among both primary and specialty care.
- 89 percent of families were somewhat satisfied, satisfied, or very satisfied with the level of input and involvement when working with their primary care provider.
- 96 percent of families were somewhat satisfied, satisfied, or very satisfied indicating care their child received was satisfying for them and that communication happened in a way that was clear and understandable.
- 82 percent of families were somewhat satisfied, satisfied, or very satisfied with the covered costs of needed services for their child including mental health, dental, well child checks, durable medical equipment, prescription, therapy services, etc.
- 86 percent of families were somewhat satisfied, satisfied, or very satisfied in the way their child's development was being monitored.

Family participation in CSHCN programs remains high, with a score of 15 out of a total of 18 points as documented on Form 13 -- Characteristics documenting Family Participation in CSHCN Programs.

Ongoing Title V activities have focused on maintaining a CSHS Family Advisory Council, funding family support organizations in the state, monitoring family satisfaction as a quality assurance activity, and supporting activities that promote family-professional collaboration.

- CSHS continued to support a Family Advisory Council that met on a quarterly basis during the year. Advice and recommendations from advisory council members was recorded for consideration in program and policy decisions and actions taken were reported at subsequent meetings of the council. CSHS provided travel reimbursement and a consultation fee to Family

Advisory Council members that participated in the meetings.

- CSHS provided financial support through service contracts with two family organizations in the state, Family Voices of ND and the Family-to-Family Support Network. These organizations provided health information, training, and emotional support for CSHCN and their families. During the year, CSHS staff members served on the boards of these two organizations.
- Narrative addressing quality assurance activities was required in all grant applications that were submitted to CSHS during the year. Potential grantees described specific quality assurance strategies related to the program or project they hoped would be funded through CSHS service contracts. Client satisfaction assessments were included in this required narrative and results were monitored throughout the contract period for all funded projects. Satisfaction was also measured through a scripted telephone survey that was conducted with families served by CSHS in the last fiscal year. Ninety-nine percent of individuals/families served reported services received met their needs, a result showing improved health status, chronic disease management or access to information and resources.
- CSHS supported activities that promoted family/professional collaboration. Examples of collaborative work projects between state CSHCN program staff and family organizations included training opportunities (joint presentations and attendance at national conferences), medical home team activities (participation in Future Search planning activities), and a rural health network "family support" planning grant (collaborative grant-writing).

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS will continue to include family advice and recommendations from a Family Advisory Council when making program and policy decisions.				X
2. CSHS will support the activities of family organizations in the state by providing financial assistance through contracts, serving on advisory boards as requested, and collaborating together on work projects.				X
3. CSHS will conduct or contract client satisfaction assessments as part of the overall quality assurance efforts within the unit (e.g.) contract services, clinics, state telephone survey, etc.				X
4. CSHS will support activities that promote family/professional collaboration.				X
5. CSHS will participate in activities of a collaborative rural health network in ND with specific focus on the ND Family Support Coalition and development of a written strategic plan for family support services for rural ND families.				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

- CSHS includes family advice and recommendations from a Family Advisory Council when making program and policy decisions.
- CSHS is supporting the activities of family organizations in the state by providing financial assistance through contracts, serving on advisory boards as requested, and collaborating together on work projects.
- CSHS is conducting client satisfaction assessments as part of the overall quality assurance efforts within the unit (e.g.) contract services, clinics, state telephone survey, etc.
- CSHS is supporting activities that promote family/professional collaboration (e.g.) Family

Connections Conference, parent/youth leadership development opportunities, Early Childhood Comprehensive Systems plan, medical home leadership, initiating/sustaining relationships with additional family organizations, etc.

- CSHS is participating in activities of a collaborative rural health network in ND with specific focus on the ND Family Support Coalition and development of a written strategic plan for family support services for rural ND families.

**c. Plan for the Coming Year**

- CSHS will promote family/professional collaboration by participating on advisory boards of family organizations in the state and encouraging family involvement in CSHCN-related meetings, committees, training opportunities, work projects, etc.
- CSHS will support a Family Advisory Council by conducting 2-4 meetings annually and documenting family advice and recommendations used in decision-making within the CSHS division.
- CSHS will sustain and enhance family support services within the state by funding family organizations that provide information, training, and family support services for children with special health care needs and their families and assisting in the collaborative implementation of a Rural Health Network for Family Support.
- CSHS will assess family level of satisfaction with CSHS programs as part of the division's overall quality assurance plan and report results to stakeholders.
- Title V will collaborate with others to develop a state Youth Advisory Council.

**Performance Measure 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)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	54.7	54.7	54.7	60	60
Annual Indicator	54.7	54.7	54.7	54.7	51.2
Numerator					8154
Denominator					15935
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	55	57	58	59	60

**Notes - 2007**

2007-Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2004 for this performance measure.

Annual data is not available for this measure; however, the state CSHCN program annually measures progress for the children served through CSHS. During SFY 2006, 91% of children

receiving CSHS care coordination services had a medical/health home defined as a usual source or place of care with a regular provider.

#### **Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Annual data is not available for this measure; however, the state CSHCN program annually measures progress for the children served through CSHS. During SFY 2005, 91% of children receiving CSHS care coordination services had a medical/health home defined as a usual source or place of care with a regular provider.

#### **a. Last Year's Accomplishments**

According to the 2005/2006 National Survey of Children with Special Health Care Needs, the percentage of CSHCN in ND who received coordinated, ongoing, comprehensive care within a Medical Home was 51.2%, which is slightly higher than the national percentage of 47.1 percent. In 2001, ND was at 54.7 percent; however, data for this indicator is not comparable across survey years.

Partners continue to support the Medical Home concept through staff time for trainings and collaborative meetings. Funding has been sought to support a stakeholder strategic planning meeting, medical home practice implementation pilots, and a North Dakota Medical Home Coordinator position.

CSHS monitors the medical home status for children and youth who are eligible for the treatment program. While presently there is no way to assess the quality of care provided in the identified medical home, families are encouraged to list the provider they consider their child's primary care physician and efforts are made to assure care is coordinated.

- CSHS provided information on medical homes to families through well-child/immunization information packets. Family Voices, an organization that CSHS contracts with to provide family health information services, provided information to families and providers through meetings and workshops, an e-mail list serve, and through a Family Voices newsletter.
- During the year, major collaboration around medical home occurred through the work of ND's Medical home team with funding through the Early Childhood Comprehensive Systems (ECCS) grant. The ND Medical Home Team includes representation from CSHS, Family Voices of ND, the ND Family to Family Network, the ND Chapter of the American Academy of Pediatrics, and MeritCare Health Systems. ECCS funded development of a Medical Home poster and rolodex card that was disseminated to over 2,200 medical providers. This information increased awareness of the medical home concept and connected providers with information on services for children and youth with special health care needs. ECCS funding also supported attendance of team members at the national AAP meeting which focused heavily on medical home.
- CSHS monitored the Medical Home status of children served through CSHS. Ninety-five percent of the children served through the CSHS Care Coordination program were determined to have a medical home.
- CSHS monitored the percentage of children served with a service plan. One hundred percent of the children receiving CSHS care coordination services had a current, written service plan.
- A meeting was held on February 22, 2007 to discuss a Future Search stakeholder meeting. Partners from Blue Cross Blue Shield, North Dakota Medicaid, Early Childhood Comprehensive Systems, county Public Health, Family to Family Support Network, Family Voices, MeritCare Health Systems and Children's Special Health Services attended the meeting. Funds from the Head Start Collaboration Office were used to support travel expenses of the Future Search Network representative that attended.
- During the year, major planning focused on partner identification and potential funding opportunities to support medical home.
- CSHS initiated a contract with the ND Chapter of the American Academy of Pediatrics to support a ND Medical Home Initiative for the period September 1, 2007 to June 30, 2009. The

focus of the proposal submitted by the AAP was on infrastructure that would support collaborative planning, training and technical assistance for pilot practices, and impact evaluation after medical home implementation.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS will distribute information on medical homes for CSHCNs to providers and families to increase public awareness and facilitate practice implementation.			X	
2. CSHS will collaborate with partners to further the medical home concept and practice in ND.				X
3. CSHS will monitor the medical home status of children receiving care coordination services through CSHS.				X
4. CSHS will monitor the percentage of children receiving CSHS care coordination services with a comprehensive, written service plan.				X
5. CSHS will conduct a stakeholder meeting on medical home utilizing the Future Search community planning approach, if feasible.				X
6. CSHS will seek out sources of funding to support implementation of medical homes in ND.				X
7. CSHS will obtain training, technical assistance, and/or mentoring support to further knowledge of medical homes in practice.				X
8. CSHS will work with partners on website development and data infrastructure to support medical home implementation.				X
9. CSHS will provide grant funding to support medical home infrastructure in ND.				X
10.				

**b. Current Activities**

- CSHS is distributing information on medical homes for CSHCNs to providers and families to increase public awareness and facilitate practice implementation.
- CSHS is collaborating with partners to further the medical home concept and practice in ND. Partners include Indian Health Service, ND Chapter of the American Academy of Pediatrics, family organizations, providers, health systems, Early Childhood Comprehensive Systems committees, Oral Health Program, Head Start, Medicaid PCP Program, Early Hearing Detection and Intervention, neighboring state Title V programs, ULend, etc.
- CSHS is monitoring the medical home status of children receiving care coordination services through CSHS.
- CSHS is monitoring the percentage of children receiving CSHS care coordination services with a comprehensive, written service plan.
- CSHS is conducting a stakeholder meeting on medical home utilizing the Future Search Community planning approach.
- CSHS is seeking out sources of funding to support implementation of medical homes in ND.
- CSHS is obtaining training, technical assistance, and/or mentoring support to further knowledge of medical homes in practice.
- CSHS is working with partners on website development and data infrastructure to support medical home implementation.
- CSHS is providing grant funding to support medical home infrastructure in ND.

**c. Plan for the Coming Year**

- CSHS will distribute information on medical homes for CSHCN's to providers and families to increase public awareness and facilitate practice implementation.
- CSHS will collaborate with partners to further the medical home concept and practice in North Dakota. Efforts will focus on implementation of the Integrated Services Grant, development of a website that supports data infrastructure, and integration activities with BCBS on an Advanced Medical Home Initiative.
- CSHS will monitor the medical home status of children receiving care coordination services through CSHS and the percentage of children receiving CSHS care coordination services with a comprehensive, written service plan.
- CSHS will seek out sources of funding to support implementation of medical homes and provide grant funding to support medical home infrastructure development in ND.
- CSHS will obtain training, technical assistance, and/or mentoring support to further knowledge of medical homes in practice.

**Performance Measure 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)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	62	62	62	65	65
Annual Indicator	62	62	62	62	68.2
Numerator					10981
Denominator					16093
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	68.4	69	69.5	70	70

**Notes - 2007**

2007-Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2004 for this performance measure.

Annual data is not available for this measure; however, the state CSHCN program annually measures progress for the children served through CSHS. During FFY 2006, 93% of children served through CSHS had a source of health care coverage.

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Annual data is not available for this measure; however, the state CSHCN program annually measures progress for the children served through CSHS. During FFY 2005, 93% of children served through CSHS had a source of health care coverage.

**a. Last Year's Accomplishments**

According to the 2008 Kids Count Data Book, the percent of children without health insurance in 2005 was ten percent. This is a one percent increase from the previous year. According to the 2005/2006 National Survey of Children with Special Health Care Needs, 5.3 percent of CSHCN in ND were without insurance at the time the survey was conducted compared to 3.5 percent of children nationally. In ND, 9.6 percent of CSHCN were without insurance at some point in the past year compared to 8.8 percent nationally. There were 68 percent percent of CSHCN whose families had adequate private and/or public insurance to pay for the services they needed compared to 62.0 nationally.

According to a May 2006 Family Voices of North Dakota report entitled "What Do North Dakota Families Say about Health Care for Children with Special Health Care Needs", 46 percent of families surveyed were satisfied or very satisfied with the covered costs of needed services for their CSHCN. However, forty-five percent also indicated they had financial stress due to their child's health care needs and only 51 percent indicated they understood or fully understood available health care financing options.

- CSHS monitored whether children served had a source of health care coverage. In FFY 2007, 88 percent of CSHCN's served by CSHS had a source of health care coverage, almost two-thirds of which was private insurance.
- CSHS had 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 CHIP eligibility as part of the application process. If ineligible, families were linked to other available resources, including the Caring Program. Targeted outreach mailings were sent to families with uninsured children served through CSHS clinics to link them to available sources of health care coverage.
- In 2007, CSHS provided diagnostic services to 104 children and treatment services to 210 children. Service applications originating at the 53 county social service offices were reviewed by the CSHS Medical Director and state administrative staff to determine medical and financial eligibility. Staff also coordinated benefits when claims were received and reviewed care coordination plans submitted by local staff.
- CSHS staff routinely attended meetings addressing the MMIS replacement project, Medicaid policy, and pediatric health care issues, all of which were likely to impact services for CSHCN's and their families.
- Staff monitored health care legislation. Especially important was successful passage of bills that impacted Medicaid and SCHIP eligibility, including a new Medicaid Buy-In Program for children with disabilities and a new Medicaid waiver for children with extraordinary health care needs.
- CSHS staff participated in writing a new Medicaid waiver for children with extraordinary medical needs which was informally submitted to CMS for review during the federal fiscal year.
- CSHS partnered with others to support outreach and training on health coverage options. Title V representatives participated in a ND HRSA Performance Review. One of the strategies identified to increase access to and utilization of primary and preventive health care for all North Dakotans was to educate policymakers regarding the need for Medicaid and SCHIP policy changes to assure continuous health care access for affected North Dakotans. In addition, Covering Kids and Families developed a healthcare coverage tool kit, which could be adapted to various target audiences.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS will monitor the number of CSHCN's served by CSHS with a source of health care coverage.				X
2. CSHS will conduct activities to refer and link families that have CSHCN to available sources of health care coverage such as Medicaid, CHIP, Caring, and CHAND programs with a special		X		

focus on the new Buy-In Program.				
3. CSHS will provide diagnostic and treatment services to eligible uninsured and underinsured CSHCN.	X			
4. CSHS staff will coordinate with Medical Services staff regarding claims payment, MMIS system development, Medicaid policies/programs, and services to CSHCN and their families.				X
5. CSHS staff will monitor the impact of state health care coverage legislation that impacts children as well as policy changes that affect Medicaid, SCHIP, Caring, or CSHS eligibility or covered services.				X
6. CSHS will monitor implementation of a new Medicaid waiver for medically fragile children to assess access to home and community based support and Medicaid State Plan services.				X
7. CSHS will partner with others to support outreach regarding health coverage options and health benefits counseling/training (e.g.) ECCS committees, family organizations, Community Resource Coordinators, Insurance Commissioner's office, HRSA partners,				X
8.				
9.				
10.				

**b. Current Activities**

- CSHS is monitoring the number of CSHCN's served by CSHS with a source of health care coverage.
- CSHS is conducting activities to refer and link families that have CSHCN to available sources of health care coverage such as Medicaid, SCHIP, Caring, and CHAND programs with a special focus on the new Buy-In Program.
- CSHS is providing diagnostic and treatment services to eligible uninsured and underinsured CSHCN.
- CSHS staff is coordinating with Medical Services staff regarding claims payment, MMIS system development, Medicaid policies/programs, and services to CSHCN and their families.
- CSHS staff is monitoring the impact of state health care coverage legislation that impacts children as well as policy changes that affect Medicaid, SCHIP, Caring, or CSHS eligibility or covered services.
- CSHS is monitoring implementation of a new Medicaid waiver for medically fragile children to assess access to home and community based support and Medicaid State Plan services.
- CSHS is partnering with others to support outreach regarding health coverage options and health benefits counseling/training (e.g.) ECCS committees, family organizations, Community Resource Coordinators, Insurance Commissioner's office, HRSA partners, etc.

**c. Plan for the Coming Year**

- CSHS will monitor the number of CSHCN's served by CSHS with a source of health care coverage.
- CSHS will conduct activities to refer and link families that have CSHCN to available sources of health care coverage such as Medicaid, SCHIP, Caring, and CHAND as well as to other assistance programs.
- CSHS will provide diagnostic and treatment services to eligible uninsured and underinsured CSHCN.
- CSHS staff will coordinate with Medical Services staff regarding claims payment, Medicaid policies/programs, and services to CSHCN and their families.
- CSHS staff will monitor the impact of state health care coverage legislation that impacts children as well as policy changes that affect Medicaid, SCHIP, Caring, or CSHS eligibility or covered

services.

- CSHS will partner with others to support outreach regarding health coverage options and health benefits counseling/training (e.g.) ECCS committees, family organizations, Community Resource Coordinators, Insurance Commissioner's office, HRSA partners, Integrated Services Grant leadership teams, etc.

**Performance Measure 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)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	83.4	83.4	83.4	85	85
Annual Indicator	83.4	83.4	83.4	83.4	92.3
Numerator					15201
Denominator					16464
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	93	93	93.5	94	94.5

**Notes - 2007**

2007-Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2004, 2005 for this performance measure.

Annual data is not available for this measure; however, Family Voices conducted a satisfaction survey in the interim that indicated 59% of families were satisfied with their comfort level accessing comprehensive, community-based services for their child and family and knew who to call to locate information and services for their family.

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Annual data is not available for this measure; however, Family Voices conducted a satisfaction survey in the interim that indicated 59% of families were satisfied with their comfort level accessing comprehensive, community-based services for their child and family and knew who to call to locate information and services for their family.

**a. Last Year's Accomplishments**

According to the 2005/2006 National Survey of Children with Special Health Care Needs, 92.3 percent of ND respondents thought that community-based service systems were usually or always organized so they could easily use them, compared to 89.1 percent nationally. This is an increase from the 2001 survey when 83 percent of ND respondents thought that community-based service systems were usually or always organized so they could easily use them.

According to a May 2006 Family Voices of ND report entitled "What Do North Dakota Families Say about Health Care for Children with Special Health Care Needs", 53 percent of families responded they were very satisfied or satisfied with their comfort level in accessing comprehensive, community based services for their child and family and that they knew who to call for service information.

- On October 26, 2006, CSHS held a training event for county social service staff with positive evaluation comments. Thirty-six local staff attended the training. An additional training was also offered to a public health care coordinator. State CSHCN staff provided technical assistance to county social service workers, the public care coordinator, contracted service providers, and other health care providers through phone, e-mail, and periodic site visits.
- CSHS staff participated on 34 interagency workgroups and committees during FFY 2007.
- CSHS supported ten different types of clinics, three of which were managed by state CSHCN staff and seven that were funded through service contracts. 272 children received services through contracted clinics and 863 children received services through clinics that were directly managed by CSHS staff.
- CSHS held a statewide clinic coordinator meeting on September 11, 2007. All clinic coordinators, along with other members of their organization, were able to participate in the telephone conference call meeting. The Director of Family Voices of ND also participated.
- CSHS promoted access to pediatric specialists and promoted available outreach services. The 2007 Multidisciplinary Clinic Directory produced by CSHS listed multidisciplinary clinics available to children with special health care needs and their families. This directory was distributed to over 2,500 community agencies and providers. The Shriners Clinic in Minneapolis, MN conducted two outreach clinics in ND. The site and dates of these clinics were listed in the Multidisciplinary Clinic Directory. State CSHCN program experience using telemedicine services for children with special health care needs and their families is limited.
- CSHS staff participated in writing a new Medicaid waiver for children with extraordinary medical needs which was informally submitted to CMS for review during the federal fiscal year.
- CSHS partnered with various organizations to better help families locate services. CSHS provided links to family support organizations through its website and distributed information regarding family support organizations through direct mailing and display opportunities. CSHS and various family support services are included in the ND Head Start Resource Directory and are available through the 211 Help Line.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS will enhance capacity of local staff to implement CSHS programs by providing technical assistance and training opportunities for county social service staff and public health nurses.				X
2. CSHS staff will participate in interagency workgroups and committees whose focus is improved services for CSHCN.				X
3. CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCN's and their families.	X			
4. CSHS will disseminate a multidisciplinary clinic directory.		X		
5. If available, CSHS will seek technical assistance from ULEND to evaluate multidisciplinary clinic operations and management in ND.				X
6. CSHS will conduct a clinic coordinator meeting to enhance delivery of multidisciplinary clinic services.				X
7. CSHS will support access to pediatric sub-specialists through use of telemedicine or other technology and/or through promotion of outreach services such as Shriners clinics and the		X		

cardiac program.				
8. CSHS will partner with family organizations to assist families of CSHCN's in locating services (e.g.) promote toll-free numbers, websites, etc.		X		
9.				
10.				

**b. Current Activities**

- CSHS is enhancing the capacity of local staff to implement CSHS programs by providing technical assistance and training opportunities for county social service staff and public health nurses.
- CSHS staff is participating in interagency workgroups and committees whose focus is improved services for CSHCN.
- CSHS are directly managing and fund a variety of multidisciplinary clinic services for CSHCN's and their families.
- CSHS is disseminating a multidisciplinary clinic directory.
- CSHS is seeking technical assistance from ULEND to evaluate multidisciplinary clinic operations and management in ND.
- CSHS is conducting a clinic coordinator meeting to enhance delivery of multidisciplinary clinic services.
- CSHS is supporting access to pediatric sub-specialists through use of telemedicine or other technology and/or through promotion of outreach services such as Shriners clinics and the cardiac program.
- CSHS is partnering with family organizations to assist families of CSHCN's in locating services (e.g.) promote toll-free numbers, websites, etc.

**c. Plan for the Coming Year**

- CSHS will enhance capacity of local staff to implement CSHS programs by providing technical assistance and training opportunities.
- CSHS staff will participate in interagency workgroups and committees whose focus will improve services for CSHCN.
- CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCN's and their families.
- CSHS will disseminate a multidisciplinary clinic directory.
- CSHS will disseminate guidelines of care with ND resource inserts.
- CSHS staff will consider recommendations from the 2008 ULEND multidisciplinary clinic review and implement changes where determined appropriate.
- CSHS will conduct a clinic coordinator meeting to enhance delivery of multidisciplinary clinic services.
- CSHS will support access to pediatric sub-specialists through use of outreach services such as Shriners clinics and the cardiac program.
- CSHS will partner with family organizations to assist families of CSHCN's in locating services (e.g.) promote toll-free numbers, websites, etc.

**Performance Measure 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.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	5.8	5.8	5.8	10	10
Annual Indicator	5.8	5.8	5.8	5.8	51.2
Numerator					3651

Denominator					7125
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	52	52	54	56	58

**Notes - 2007**

2007-Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2004, 2005 for this performance measure.

Annual data is not available for this measure; however, the state CSHCN program annually measures progress for the children served through CSHS.

- During SFY 2005, 65% of children age 14-21 receiving CSHS care coordination services had a service plan that incorporated transition defined as movement from school to work, pediatric to adult health care, or home to independent living.

In addition, the North Dakota Center for Persons with Disabilities conducted a 2005 Transition Exit Study with the following results:

- 90.8% of Special Education students most recent IEP's identified an anticipated career or postsecondary employment goal while 5.36% of Special Education students received guidance in planning an anticipated career or postsecondary employment goal compared to 19.5% of General Education students.

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Annual data is not available for this measure; however, the state CSHCN program annually measures progress for the children served through CSHS.

- During SFY 2005, 65% of children age 14-21 receiving CSHS care coordination services had a service plan that incorporated transition defined as movement from school to work, pediatric to adult health care, or home to independent living.

In addition, the North Dakota Center for Persons with Disabilities conducted a 2005 Transition Exit Study with the following results:

- 90.8% of Special Education students most recent IEP's identified an anticipated career or postsecondary employment goal while 5.36% of Special Education students received guidance in planning an anticipated career or postsecondary employment goal compared to 19.5% of General Education students.

**a. Last Year's Accomplishments**

According to the 2005/2006 National Survey of Children with Special Health Care Needs, 51.2 percent of youth with special health care needs receive the services necessary to make appropriate transitions to adult health care, work, and independence compared to 41.2 percent nationally. According to the North Dakota Department of Public Instruction ND Transition Follow-up Annual Report dated spring 2008, 87.7 percent of general education students had health insurance one year after exiting high school compared to 65.5 percent of students in special education.

CSHS continues to build partnerships in the area of transition and encourages emphasis on health transition issues such as health care coverage.

- A CSHS staff member participated on the State Transition Steering Council led by the North Dakota Department of Public Instruction. Family Voices, an organization that CSHS contracts with to provide family health information services, reported providing transition information through encounters with families and professionals and at meetings during the federal fiscal year.
- CSHS monitored the level of transition planning for CSHCN's age 14-21 served by CSHS. During 2007, 82 percent of youth and young adults age 14-21 had an assessment or service plan that addressed transition, which was a 17 percent increase from 2005.
- CSHS completed an annual SSI report in order to monitor the status of the SSI population. CSHS staff also conducted information and referral mailings to families whose children were referred from Disability Determination Services. An annual meeting was held September 14, 2007 with Medicaid, the Social Security Administration, Disability Determination Services, and State CSHCN program staff.
- A transition resource was identified for a mailing. Mailing will be completed in FFY 08.
- Information regarding transition was discussed at clinic and care coordination site visits.
- The Collaborating for Successful Youth Transition Conference was held on October 2-4, 2006. CSHS staff assisted with the planning, staffed a booth with health transition material, and participated on an agency collaboration panel discussing program eligibility requirements and services. Information also focused on ways to promote smoother transitions into adult services.
- CSHS has a pool of potential youth that could be invited to participate on the CSHS Family Advisory Council as open positions become available.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS will collaborate with state agencies and family organizations to promote health care transitions for CSHCN (e.g.) Transition Steering Council.				X
2. CSHS will monitor the level of transition service planning for children ages 14-21 for CSHCN's served by CSHS with written service plans.				X
3. CSHS will monitor the status and provide information and referral services to the SSI population and collaborate with other stakeholders involved with children's SSI.				X
4. CSHS will disseminate health care transition resources.			X	
5. CSHS will promote transition through multidisciplinary clinics, care coordination, and diagnostic and treatment programs.		X		
6. CSHS will maintain a pool of youth/young adults as potential applicants for the CSHS Family Advisory Council.				X
7. CSHS staff will explore resources such as Vocational Rehabilitation and KASA for use in information, training, and referral efforts for transition-age youth.				X
8.				
9.				
10.				

**b. Current Activities**

- CSHS is collaborating with state agencies and family organizations to promote health care transitions for CSHCN (e.g.) Transition Steering Council.
- CSHS is monitoring the level of transition service planning for children ages 14-21 for CSHCN's served by CSHS with written service plans.

- CSHS is monitoring the status and providing information and referral services to the SSI population and collaborating with other stakeholders involved with children's SSI.
- CSHS is disseminating health care transition resources.
- CSHS is promoting transition through multidisciplinary clinics, care coordination, and diagnostic and treatment programs.
- CSHS is maintaining a pool of youth/young adults as potential applicants for the CSHS Family Advisory Council.

**c. Plan for the Coming Year**

- CSHS will collaborate with state agencies and family organizations to promote health care transitions for CSHCN (e.g.) Transition Steering Council, Integrated Services Grant leadership teams, etc.
- CSHS will monitor the level of transition service planning for children ages 14-21 served by CSHS with written service plans.
- CSHS will provide information and referral services to families and collaborate with other stakeholders involved with children's SSI.
- CSHS will disseminate health care transition resources.
- CSHS will promote transition through multidisciplinary clinics, care coordination, and diagnostic and treatment programs.
- CSHS will maintain a pool of youth/young adults as potential applicants for the CSHS Family Advisory Council.
- CSHS will work with partners to enhance health care coverage for youth/young adults, including those with special health care needs.

**Performance Measure 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.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	79	79.5	80	82.5	85.5
Annual Indicator	80.4	78.4	82.0	85.0	84.2
Numerator	18979	18507	19356	20065	19876
Denominator	23606	23606	23606	23606	23606
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	85.5	86	86	86.5	86.5

**Notes - 2007**

2007-The sources for this data are the CDC National Immunization Survey and the Bureau of Census for population estimates. The annual indicator of 84.2% is from the CDC National Immunization Survey 2006. The numerator is derived from back calculation.

**Notes - 2006**

The sources for this data are the CDC National Immunization Survey and the Bureau of Census for population estimates. The annual indicator of 82% is from the CDC National immunization Survey 2005. The numerator is derived from back calculation.

**Notes - 2005**

The sources for this data are the CDC National Immunization Survey and the Bureau of Census for population estimates. The annual indicator of 82% is from the CDC National immunization Survey 2004. The numerator is derived from back calculation.

**a. Last Year's Accomplishments**

The North Dakota Department of Health (NDDoH) collaborated with other state and local health programs to promote appropriate immunization practices. The Immunization Program supplied most recommended childhood vaccines for free to enrolled public and private providers throughout the state and coordinated the investigation of vaccine preventable disease cases. The NDDoH continued to provide all Advisory Committee on Immunization Practices (ACIP) recommended vaccines universally. The Child and Adolescent Health Program worked with the Immunization Program to provide information and education regarding immunizations and vaccine preventable diseases to health care providers and the public. An immunization newsletter is disseminated quarterly and is also available online for review.

The recommended series (4:3:1:3:3:1) of childhood vaccine consists of four doses of diphtheria, tetanus and pertussis vaccine; three doses of Haemophilus influenzae type b vaccine (Hib); three doses of Hepatitis B vaccine; and one or more doses of the varicella vaccine.

A public hearing was held in August 2007 to examine proposed expansion of child care and school immunization requirements. Discussion also examined an increase in vaccination administration fees.

The Immunization Program monitored immunization rates and coordinated the ND Immunization Information System (NDIIS). According to the 2006 IIS Annual Progress Report, 98 percent of public and 91 percent of private childhood immunization sites in ND are participating in the NDIIS.

According to the Centers for Disease Control (CDC) National Immunization Survey (NIS), the percentage of children ages 19 to 35 months who have received the recommended series of childhood vaccines was 84.2 percent in 2007, a slight decrease from 85 percent in 2006; but an increase from 78.4 percent in 2004.

- The Child & Adolescent Health Coordinator worked with the Immunization program to provide education and resources to health care providers.
- Immunization updates were provided to school nurses, child care health consultants, Head Start Health consultants and local public health unit Directors of Nursing.
- Twenty- three local public health units utilize a portion of their MCH Block Grant funding to assist with implementation of their community immunization programs.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Review and/or revise as necessary the Memorandum of Agreement between Title V and the Immunization Program to assure continued collaboration.				X
2. Collaborate with the DoH Immunization Program to provide trainings and updates to public health, school nurses, Women, Infants and Children (WIC), Head Start Health Consultants, and Child Care Health Consultants				X
3. Allow local public health grantees the option of allocating a				X

portion of the Title V funding for immunization administration.				
4. WIC staff will check and record the immunization records of all children up to 24 months of age and make referrals as needed.				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

- The Memorandum of Agreement between Title V and the Immunization Program to assure continued collaboration is currently under review.
- Trainings and updates are being provided to public health, school nurses, Women, Infants and Children (WIC), Head Start Health Consultants, and Child Care Health Consultants relating to immunization recommendations and online resources.
- Local public health grantees are utilizing a portion of their Title V funding for immunization administration.
- WIC staff is checking and recording the immunization records of all children up to 24 months of age and make referrals as needed.

**c. Plan for the Coming Year**

- Continue collaboration between Title V and the Immunization Program through the Memorandum of Agreement.
- Support Title V funding for immunization administration in local public health units.
- Provide immunization trainings and updates to school nurses, child care health consultants, Head Start Health Consultants, Women, Infants and Children (WIC) and local public health in collaboration with the Immunization Program.
- Provide immunization information through various communication methods such as newsletters and access to online information.
- WIC staff will review immunization records of all children up to 24 months of age and refer as needed.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	12	11.5	10	10	10.4
Annual Indicator	10.9	10.2	10.5	10.6	11.3
Numerator	492	462	478	481	514
Denominator	45339	45339	45339	45339	45339
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>

Annual Performance Objective	11	10	9.8	9.6	9.6
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**Notes - 2007**

2007-The sources for this data are the North Dakota Department of Health -- Division of Vital Statistics and the Bureau of Census for population estimates. The numerator is a three year total. The denominator is a census estimate of 15 through 17 year olds.

**Notes - 2006**

The sources of data are the North Dakota Department of Health, Division of Vital Statistics and the Bureau of Census for population estimates. The denominator and numerator is a three year average

**Notes - 2005**

The sources of data are the North Dakota Department of Health, Division of Vital Statistics and the Bureau of Census for population estimates. The numerator and denominator is a three year average.

**a. Last Year's Accomplishments**

The 2007 rate of birth for teenagers aged 15-17 years is 11.3 per 1,000 births. This has shown minimal fluctuation since 2002. Although there is no statewide teenage pregnancy prevention program, the Department of Public Instruction and the DoH have established a Stakeholders group that is addressing issues of unintended pregnancy.

- Requests for proposals were sent to established abstinence-only grantees, hence assuring abstinence-only programming to continue statewide.
- The Regional Stakeholders/Partners' Group completed a position paper intended for use in schools and public health units addressing issues of unintended pregnancy.
- Abstinence Education funding continues to be pursued. In addition, funding announcements are shared with partners.
- A face-to-face meeting was held with sub grantees in which local programs/activities were shared and discussions were held on the availability of speakers.
- Communication and collaboration continue with Family Planning as abstinence education is provided as the safest and most effective contraceptive method for its clients. Adolescent Health utilizes abstinence educational resources for distribution to partners such as school nurses, local public health, etc. .
- Consultation is provided to school nurses on a variety of topics such as growth and development and other puberty related issues.
- The Family Planning Program's nine delegate agencies throughout the state are active in providing education on reproductive health within their communities.
- In 2007, the ND Family Planning Program provided services to 1,324 female clients and 36 male clients less than 18 years old. All medical and counseling services provided to adolescents are confidential. A total of 947 cycles of birth control methods were prescribed to female clients less than 18 years of age.
- Family Planning Program clinicians document all family involvement and counseling provided. Parental/guardian involvement is encouraged for adolescent clients. Each Family Planning Program has an active Information and Education (I&E) Committee that reviews and approves all educational materials utilized by the agency. The I & E Committee's membership is made up of adolescents, health care providers and members of the general community.
- Family Planning Program agency staff address family involvement and encourage adolescent clients to include their parent/guardian.

**Table 4a, National Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>
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	DHC	ES	PBS	IB
1. The Child and Adolescent Health Nurse Consultant/State School Nurse Consultant will provide resources and technical assistance to school nurses on health topics relating to puberty and STDs.			X	
2. The Abstinence-only Grant Program Director will partner with the Make a Sound Choice Program, Students Against Destructive Decisions (SADD), and Community Action Partnerships to assist in providing local community abstinence activities.				X
3. Collaborate in the Regional Stakeholders Group (Family Planning, Adolescent Health/School Nursing, STD program, HIV program and the Department of Public Instruction) to support efforts in reducing unintended pregnancy and births.				X
4. The Family Planning Program will continue to provide direct, confidential medical, counseling, laboratory and contraceptive services to adolescents.	X			
5. The Family Planning delegate agency staff will provide educational resources to parents about how to talk to their children about sexuality issues.		X		
6. The Family Planning delegate agency staff will provide counseling and education to all adolescent clients about the importance of family involvement in reproductive health decisions.		X		
7.				
8.				
9.				
10.				

**b. Current Activities**

- The Child and Adolescent Health Nurse Consultant/State School Nurse Consultant is providing resources and technical assistance to school nurses on health topics relating to puberty and STDs.
- The Abstinence-only Grant Program Director is partnering with the Make a Sound Choice Program and Students Against Destructive Decisions (SADD) to assist in providing local community abstinence activities.
- Collaboration is occurring in the Regional Stakeholders Group (Family Planning, Adolescent Health/School Nursing, STD program, HIV program and the Department of Public Instruction) to support efforts in reducing unintended pregnancy and births.
- The Family Planning Program is providing direct, confidential medical, counseling, laboratory and contraceptive services to adolescents.
- The Family Planning delegate agency staff is providing educational resources to parents about how to talk to their children about sexuality issues.
- The Family Planning delegate agency staff is providing counseling and education to all adolescent clients about the importance of family involvement in reproductive health decisions.

**c. Plan for the Coming Year**

- The Child and Adolescent Health Nurse Consultant/State School Nurse Consultant will provide resources and technical assistance to school nurses on health topics relating to puberty and STDs.
- The Abstinence Education Grant Program Director will partner with the Make a Sound Choice Program and Students Against Destructive Decisions (SADD) to assist in providing local community abstinence activities.
- The Regional Stakeholders Group (Family Planning, Adolescent Health/School Nursing, STD

program, HIV program and the Department of Public Instruction) will support efforts in reducing unintended pregnancy and births.

- The Family Planning Program will continue to provide direct, confidential medical, counseling, laboratory and contraceptive services to adolescents.
- The Family Planning delegate agency staff will provide educational resources to parents about how to talk to their children about sexuality issues.
- The Family Planning delegate agency staff will provide counseling and education to all adolescent clients about the importance of family involvement in reproductive health decisions.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	54	55	56	53.5	54
Annual Indicator	53.6	53.6	53.0	53.0	53.0
Numerator	178	178	3738	3738	3738
Denominator	332	332	7052	7052	7052
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	54.5	55	55.5	56	56

**Notes - 2007**

2007-The source for this data is the North Dakota Department of Health Oral Health Basic Screening Survey 2004-2005 school year. The sample screened for this performance measure is from a specific representative sample of school children.

**Notes - 2006**

The source for this data is the North Dakota Department of Health Oral Health Basic Screening Survey 2004-2005 school year. The sample screened for this performance measure is from a specific representative sample of school children. Data for the specific representative sample for third grade school children was obtained from North Dakota Department of Public Instruction. The source for the denominator is the North Dakota Department of Public Instruction and is the actual 3rd grade population. The numerator is derived from a back calculation. There is no new data available for the year 2006.

**Notes - 2005**

The source for this data is the North Dakota Department of Health Oral Health Basic Screening Survey 2004-2005 school year. The sample screened for this performance measure is from a specific representative sample of school children. Data for the specific representative sample for third grade school children was obtained from North Dakota Department of Public Instruction. The source for the denominator is the North Dakota Department of Public Instruction and is the actual 3rd grade population. The numerator is derived from a back calculation.

**a. Last Year's Accomplishments**

According to the 2004-2005 North Dakota Basic Screening Survey, 53 percent of third grade children have received protective sealants on at least one permanent molar tooth. This exceeds

the Healthy People 2010 goal of 50 percent. The percentage of sealants in school-aged children is on the rise, although no increase has occurred among children in low-income populations.

- The Oral Health consultants continue to promote sealants. There are six consultants located throughout ND that promote and educate on oral health and preventative measures to many different entities such as schools, head start, teachers and parents.
- The school fluoride mouth rinse program is targeted to schools with an increased number of students eligible for the free and reduced lunch program and limited access to adequately fluoridated water. Sixty-five schools totaling 3,684 students accessed this program during the 2006-07 school year.
- Sealant and fluoride varnish information/trainings have been provided at local public health director of nurses meetings and to Health Tracks staff.
- An Oral Health Program Manager, Cheryle Masset, began employment on January 2, 2007. Cheryle works with the oral health program on the promotion of sealants and other preventative measures. In addition, a sealant coordinator contractor was selected to assist with the development of a pilot sealant program.
- With CDC funding, a sealant coordinator was contracted to develop, coordinate, and implement a school linked dental sealant program. The contractors scope of work included documentation of oral health needs of elementary schools, determination of eligible elementary schools based on CDC criteria, resource development, and implementation and evaluation of the pilot program.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote use of sealants through the regional oral health consultants.			X	
2. Provide information regarding sealants to Health Tracks, local public health, and school nurses via meeting presentations, mailings, etc.			X	
3. Hire an oral health sealant coordinator (supported by CDC funds) to assess the need/feasibility for a school based/linked sealant program.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

- The regional oral health consultants are promoting the use of sealants.
- The Oral Health Programs staff is providing information regarding sealants to Health Tracks, local public health, and school nurses via meeting presentations, mailings, etc.
- The oral health sealant coordinator (supported by CDC funds) has conducted a school-linked pilot program and is continuing to assess the need/feasibility for a school based/linked sealant program statewide.

**c. Plan for the Coming Year**

- Collaborate with MCH partners, WIC, Head Start and School Nurses to incorporate oral health prevention messages to these agencies to be disseminated to their clientele through displays and

newsletters.

- The Oral Health Program will seek funding to assist with the development of a statewide sealant program.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	2.9	2.8	4.7	4.5	5
Annual Indicator	3.8	5.6	5.6	5.3	3.7
Numerator	14	21	21	20	14
Denominator	366558	374218	374128	374128	374128
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	3.6	3.5	3.4	3.3	3.2

**Notes - 2007**

2007-A three-year total was used to calculate the rate to avoid fluctuations. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

**Notes - 2006**

A three-year average was used to calculate the rate to avoid fluctuations. The source of data is the North Dakota Department of Health, Division of Vital Statistics.

**Notes - 2005**

A three-year average was used to calculate the rate to avoid fluctuations. The source of data is the North Dakota Department of Health, Division of Vital Statistics.

**a. Last Year's Accomplishments**

The rate of deaths (per 100,000) to children ages 1-14 showed decrease from 5.3 in 2006 to 3.7 in 2007. The rate has fluctuated over the years, from a low of 3.0 2001 to a high of 5.6 in 2005. The 2006 child passenger safety (CPS) observation surveys conducted by the DoH showed an increase in restraint use by 4.1 percent for children younger than 11 years of age.

- The CPS program received another year of funding from the North Dakota Department of Transportation for the timeframe of October 1, 2006 through September 30, 2007.
- Educational materials were distributed to physicians, public health, Safe Communities programs, Safe Kids programs, law enforcement, Child Care Resource and Referral and other agencies that work with caregivers or parents who have contact with children. CPS month was celebrated across the state in February 2007, with 84 local agencies participating. 1,044 classroom presentations were completed in the schools, reaching 33,995 children with the "buckle up" message.
- CPS law fact sheets and photo frame magnets were distributed to agencies working with caregivers of young children. Laminated CPS law cards were distributed to law enforcement agencies to update law enforcement personnel on the CPS law.

- Forty-one car seat distribution programs distributed 1,718 car seats. 232 car seats were distributed to five reservations.
- Car seat checkup supplies were updated and purchased statewide. The program assisted with 91 car seat checks, inspecting 1,460 seats. Ongoing technical assistance was provided to certified CPS technicians and instructors.
- Educational efforts were promoted during CPS Month in February 2007.
- Three NHTSA Standardized CPS Courses were held; resulting in the certification of 48 technicians. Two CPS certified technician refresher courses were held, with 86 technicians participating.
- Technical assistance was continued throughout the year. ND has 176 certified CPS technicians. The Buckle Up section of the newsletter was written quarterly.
- The Occupant Protection Rally was held in November 2006. Approximately 80 participants attended the rally.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Re-apply for North Dakota Department of Transportation funds to administer the state's child passenger safety program; monitor expenditures, complete reports as required.				X
2. Provide educational efforts to increase the proper use of car seats through use of pamphlets, posters, displays, news releases, etc.			X	
3. Continue to inform ND parents and caregivers about the state's child passenger safety law. Provide information on the appropriate restraint for their child's age, weight, height, and developmental level.			X	
4. Administer the car seat distribution program throughout the state by providing car seats, policies/procedures, and training/technical assistance to local agencies. Provide car seats and training to five Indian reservations.		X		
5. Assist local agencies in conducting car seat check-ups by providing certified instructors, technicians, car seats, and check-up supplies.				X
6. Provide educational efforts to encourage the use of child passenger safety curriculums and videos for children grades K-2 and grades 3-6.				X
7. Conduct 2-3, four-day National Highway Traffic Safety Administration (NHTSA) Standardized Child Passenger Safety Courses to certify new child passenger safety technicians.				X
8. Conduct two, hands-on refresher workshops and 2-3 video-conferencing trainings for certified child passenger safety technicians and assist technicians in meeting requirements for re-certification.				X
9. Write the "Buckle Update" section of the "Building Blocks to Safety" quarterly newsletter to provide current information on child passenger safety.				X
10. Co-coordinate a statewide DoH of Health injury prevention conference.				X

**b. Current Activities**

- Managing the ND Dept of Transportation funds that administer the state's Child Passenger Safety (CPS) program.

- Educational efforts are being conducted on the proper use of car seats on the state's CPS law through use of pamphlets, posters, displays, newsletters, news releases, etc.
- Continuing the car seat distribution program throughout the state by providing car seats, policies/procedures, and training/technical assistance to local agencies, along with providing car seats and training to five Indian reservations.
- Assisting local agencies in conducting car seat check-ups by providing certified instructors, technicians, car seats, and check-up supplies.
- Conducting National Highway Traffic Safety Administration (NHTSA) Standardized CPS Courses to certify new CPS technicians.
- Conducting refresher courses for current technicians and assist current technicians in meeting requirements for re-certification.
- Providing technical assistance and updated information to technicians to maintain technical knowledge on CPS issues.
- Writing the "Buckle Update" section of the "Building Blocks to Safety" quarterly newsletter to provide current information on CPS.
- Planning for the statewide CPS and Occupant Protection conference with the ND Dept of Transportation; which is planned for fall 2008.
- Offering CPS trainings to professionals including, hospital staff, child care providers, law enforcement and more.

**c. Plan for the Coming Year**

- Re-apply for North Dakota Department of Transportation funds to administer the state's child passenger safety program; monitor expenditures, complete reports as required.
- Continue educational efforts to increase the proper use of car seats through use of pamphlets, posters, displays, news releases, etc. Sponsor Child Passenger Safety Week in February 2008.
- Continue to inform North Dakota parents and caregivers about the state's child passenger safety law. Provide information on the appropriate restraint for their child's age, weight, height, and developmental level. Distribute this information statewide with agencies who work with caregivers with children.
- Continue the car seat distribution program throughout the state by providing car seats, policies/procedures, and training/technical assistance to local agencies. Provide car seats and training to five Indian reservations.
- Assist local agencies in conducting car seat check-ups by providing certified instructors, technicians, car seats, and check-up supplies.
- Continue educational efforts to encourage the use of child passenger safety curriculums and videos for children grades K-2 and grades 3-6. Public health, law enforcement, Safe Communities, Safe Kids coalitions and other groups will be encouraged to participate in these efforts locally.
- Conduct 2-3, four-day National Highway Traffic Safety Administration (NHTSA) Standardized Child Passenger Safety Courses to certify new child passenger safety technicians.
- Conduct two, hands-on refresher workshops and 2-3 video-conferencing trainings for certified child passenger safety technicians and assist technicians in meeting requirements for re-certification.
- Write the "Buckle Update" section of the "Building Blocks to Safety" quarterly newsletter to provide current information on child passenger safety.
- Co-coordinate a statewide DoH injury prevention conference.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				35	36

Annual Indicator			34.1	34.1	34.1
Numerator			10459	10459	10459
Denominator			30670	30670	30670
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	37	38	39	40	40

**Notes - 2007**

2007-The source for this data is the 2003 National Survey of Children's Health. The data are weighted estimates.

**Notes - 2006**

The source for 2006, data is from the 2003, National Survey of Children's Health. The data is weighted estimates.

This data is from North Dakota Department of Health, WIC program. The data reported in 2006 is for the year 2005. The data restricts to North Dakota clients only. According to 2005, WIC data 22.6% of North Dakota mothers breastfed their infants at 6 month of age.

**Notes - 2005**

The data source is the National Survey of Children's Health 2003. The data is weighted estimates.

**a. Last Year's Accomplishments**

According to the 2003 National Survey of Children's Health, 34.1 percent of ND mothers are still breast feeding their infants at six months of age. The 2004 CDC Breastfeeding National Immunization Data shows that approximately 40 percent of ND mothers are still breast feeding their infants at six months of age. The total ND WIC mothers who continue to breastfeed at 6 months is at 21 percent, according to the 2007 data; both short of the 2010 goal of 50 percent. Over the past 10 years, the percentage of mothers initiating breastfeeding in the total population seems to have hit a plateau just below 70 percent, still short of the 2010 goal of 75 percent. The numbers of WIC breastfeeding mothers overall has been on a steady increase over the years (now just over 60 percent), and may catch up with the overall breastfeeding levels at some point. Two areas of particular concern for ND are with American Indian mothers (WIC data shows only about 35-40 percent of American Indian mothers breastfeed) and duration rates. Going back to school and work are the most commonly reported reasons for moms who stop breastfeeding.

- MCH and WIC Nutritionists will work to reactivate and be members of the Healthy North Dakota Breastfeeding Committee (HNDBC) and be encouraged to participate and support this committee in the revision of the State Breastfeeding plan. MCH and WIC Nutritionists have reactivated the HNDBC, are developing a position paper and working to revise the State Breastfeeding plan.
- The HNDBC was still in the reorganization phase during the 2007 legislative session; hence the "right to breastfeed" plan of work was not established.
- As a resource for breastfeeding mothers, local community breastfeeding coalitions have put together and distributed listings of breastfeeding experts and support groups in their communities. This resource will also be posted on the HND website.
- MCH Nutritionist continues to serve as the DoH's liaison to the HNDBC.
- Worksite wellness activities have been identified for the breastfeeding plan. The HND Third Party Payer Committee was not active during this time; therefore, work to promote reimbursement for lactation consultant services and electric breast pumps was not done.
- Materials and information were provided in July 2007 to all WIC agencies for the August 2007

observance.

- The State WIC Program purchased 22 electric breast pumps that were distributed to local WIC agencies.
- Breastfeeding information is posted on the Nutrition and Physical Activity pages of the DoH's website and is also on the Healthy North Dakota Breastfeeding web page.
- The peer counseling program continued in Rolette County and Southwestern District Health Unit. Grand Forks was added as a new site in 2007.
- The final report on the Motivational Interviewing (MI) project was completed March 2007. Early findings indicate that MI had a very favorable impact on breastfeeding duration. Findings have been shared with all of the WIC staff and plans are underway to utilize Motivational Interviewing in breastfeeding support for all WIC agencies. Training on MI for all WIC staff is scheduled for January 2008 and will use breastfeeding as the role playing topic.
- Planning for the biennial statewide breastfeeding conference is underway and will take place in June 2008 in Minot.
- MCH and WIC staff were encouraged to attend the 2006 biennial breastfeeding conference and state staff assisted in the organization and planning of the conference.
- Local MCH staff were encouraged to assist in the development of local breastfeeding coalitions during HNDBC conference calls and local public health MCH nutritionist meetings.
- The Bismarck-Mandan Breastfeeding Coalition has arranged for an in-depth breastfeeding training to take place in February of 2008 and state staff have assisted in providing this opportunity.
- A WIC staff member is on the Healthy North Dakota Early Childhood Alliance, Parent Education Subcommittee.
- State MCH staff offered input on the selection of speakers and presentation topics for Women's Health conferences. The Title V director serves on the planning committee and also has input on topics and speaker selection.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH and WIC Nutritionists work with the Healthy ND Breastfeeding Committee (HNDBC) in completing activities outlined in the State Breastfeeding plan. MCH Nutritionist will continue as the Department's liaison to the HNDBC.				X
2. WIC staff encourage breastfeeding as the optimal method of feeding healthy infants to the prenatal clients and provide breastfeeding support to all breastfeeding moms.				X
3. State MCH and WIC staff assist in planning the statewide biennial breastfeeding conference and encourage local staff to participate in available breastfeeding conferences or trainings.				X
4. The WIC Program supports breastfeeding by providing local agencies with resources.		X		
5. State WIC staff maintain current breastfeeding data on the NDDoH's website.				X
6. Encourage local MCH staff to pursue the development of local breastfeeding coalitions and identify and promote community breastfeeding experts and support groups as a support resource for breastfeeding mothers.				X
7. Provide breastfeeding support in child care settings by offering training as requested at the Early Childhood Professional Institute and/or Child Care Health and Safety Summit.				X
8. State WIC and MCH Nutritionists serve as members of the Bismarck/Mandan Breastfeeding Partnership.				X

9.				
10.				

**b. Current Activities**

- WIC staff is encouraging breastfeeding as the optimal method of feeding healthy infants to the prenatal clients and providing breastfeeding support to all breastfeeding moms.
- MCH and WIC Nutritionists are working with the reactivated Healthy North Dakota Breastfeeding Committee (HNDBC) in the revision of the State Breastfeeding plan.
- MCH nutritionist and other members of the HNDBC are working to assure that breastfeeding support is a component of worksite wellness initiatives of the Healthy North Dakota (HND) Worksite Wellness Committee; are working with the HND Third Party Payer Committee to promote reimbursement for lactation consultant services and electric breast pumps; and are promoting the increase of baby friendly breastfeeding practices in ND hospitals.
- WIC is purchasing additional electric breast pumps for use by mothers who are returning to work or school, as funding permits.
- Utilizing the ND WIC Motivational Interviewing Research Project findings to increasing breastfeeding duration, as appropriate.
- WIC staff is assisting the Minot Breastfeeding Coalition in planning for the biennial statewide breastfeeding conference that will be held in fall 2008.
- Provide breastfeeding support in child care settings by offering training at the Early Childhood Professional Institute and/or Child Care Health and Safety Summit.
- State MCH staff is offering input on the selection of speakers and presentation topics for the fall 2008 Women's Health Summit.

**c. Plan for the Coming Year**

- MCH and WIC Nutritionists will work with the Healthy ND Breastfeeding Committee (HNDBC) in completing activities outlined in the State Breastfeeding plan. MCH Nutritionist will continue as the Department's liaison to the HNDBC.
- WIC staff will encourage breastfeeding as the optimal method of feeding healthy infants to the prenatal clients and provide breastfeeding support to all breastfeeding moms.
- State MCH and WIC staff will assist in planning the statewide biennial breastfeeding conference and encourage local staff to participate in available breastfeeding conferences or trainings.
- The WIC Program will support breastfeeding by providing local agencies with resources for promotion of World Breastfeeding Week, by purchasing electric breast pumps for use by mothers who are returning to work or school (as funding permits), by continuing the WIC Peer Counseling Program in ND (operating at three local WIC agencies), by continuing the "breastfeeding" segment in the monthly ND WIC participant newsletter and will utilize the ND WIC Motivational Interviewing Research Project findings related to increasing breastfeeding duration, as appropriate.
- State WIC staff will maintain current breastfeeding data on the DoH's website.
- Encourage local MCH staff to pursue the development of local breastfeeding coalitions and identify and promote community breastfeeding experts and support groups as a support resource for breastfeeding mothers.
- Provide breastfeeding support in child care settings by offering training as requested at the Early Childhood Professional Institute and/or Child Care Health and Safety Summit.
- State WIC and MCH Nutritionists will serve as members of the Bismarck/Mandan Breastfeeding Partnership.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
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Annual Performance Objective	95	95	95.2	96	97
Annual Indicator	91.3	95.1	95.1	96.0	95.0
Numerator	8104	8743	8951	9233	9386
Denominator	8877	9191	9408	9622	9875
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	98	98	98	98	98

**Notes - 2007**

2007-Data was obtained from the 2006 Newborn Hearing Screening Survey Report, which was collected in 2007.

**Notes - 2006**

Data was obtained from the Newborn Hearing Screening 2005 Survey Report, which was disseminated in 2006. Data from the newborn screening survey indicated 9,223 (96%) of infants received a hearing screening prior to hospital discharge. Nine of the reporting hospitals screened 100% of their infants. An additional five hospitals missed five or fewer babies in their screening program. All ND birthing hospitals screen for hearing loss prior to hospital discharge. ND continues to work toward 100% participation in the web-based EHDI tracking system. In 2006, only two birthing hospitals were not using the web-based tracking system

**Notes - 2005**

Data was obtained from the Newborn Hearing Screening 2004 Survey Report, which was disseminated in 2005. Data from the newborn screening survey indicated 8,951 (95%) of infants received a hearing screening prior to hospital discharge. Eight of the reporting hospitals screened 100% of their infants. An additional nine hospitals missed five or fewer babies in their screening program. All hospitals reported screening for hearing loss prior to hospital discharge. In 2006, newborn hearing screening information will be incorporated into the birth certificate.

**a. Last Year's Accomplishments**

The 2006 Newborn Hearing Screening Survey Report, which is based on CY 2006 occurrent births and hearing screening survey data collected in 2007, indicated that 95.0 percent of infants born in ND hospitals had their hearing screened. Starting in 2006, newborn hearing screening results were included on the DoH's electronic birth certificate. Unfortunately, this data source does not include hearing screening results for premature babies because the birth certificate is usually submitted before screening has been completed. This year, the ND Early Hearing Detection and Intervention (EHDI) program's main focus was on follow-up care and diagnostic/intervention services. The program worked to engage community partners in sustaining the EHDI program. An application for a federal MCHB EHDI grant was submitted in November 2007.

- A state CSHS staff member served on the grant management team of the state's EHDI program administered through the ND Center for Persons with Disabilities (NDCPD) at Minot State University. The staff member also functioned as the state implementation coordinator. Work efforts during the year focused on training hospital staff to review their data and "clean up" data entries on the web-based tracking system, enhancing community partnerships that could assist in following high risk infants and infants that did not pass the hearing screening at hospital discharge, and attending the national conference. NDCPD submitted an application for a three-year MCHB EHDI grant in November 2007. ND also received a three-year CDC EHDI grant, which supports Project Kaylyn. This project covers for the period 7/1/04 -- 6/30/07. It focuses on infants that need diagnostic evaluation and their enrollment into Early Intervention services.

- CSHS conducted a mailed paper survey to all ND birthing hospitals to assess newborn hearing screening. Of the births that occurred in CY 2006 that were reported in 2007, 96% of the infants were screened for hearing loss prior to hospital discharge. A survey report was also generated and distributed to in-state EHDI contacts.
- A CSHS staff member served as the Title V state EHDI contact. During the year, the EHDI contact responded to state and national survey requests and was an information hub for any new information relating to EHDI programs. The staff person participated in the development of the federal grant application.
- Legislation for an EHDI program was not brought before the ND legislature; however, all ND legislators received an information packet regarding the importance of early hearing detection and intervention.
- An Action Plan for the ND EHDI HRSA performance review was developed and all activities were completed by the end of 2007. The majority of the performance measures related to improved reporting of hearing screening results and improved data entry regarding follow-up hearing screening.
- CSHS monitored other early screening and detection systems for young children. In 2007, the total screening ratio of children that participated in EPSDT was 62 percent and the total participant ratio was 46 percent. For Healthy Steps, ND's SCHIP program, 75 percent of members less than one year old incurred office visits during the federal fiscal year. Between July 2006 and June 2007, 7,429 developmental screenings were conducted through the Right Track program. On December 1, 2007, the ND early intervention system was serving 2.15 percent of the total population under age one and 3.34 percent of the total population under age three.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A CSHS staff member will serve on the grant management team and function as the state implementation coordinator for the EHDI Program.				X
2. If needed for monitoring purposes, CSHS will administer and analyze an annual newborn hearing screening survey to all birthing hospitals in the state.				X
3. A CSHS staff member will serve as the Title V state EHDI contact.				X
4. As time allows, CSHS will provide technical assistance to support sustainability of EHDI programs if grants supporting the program at NDCPD end.				X
5. CSHS will monitor other early screening and detection systems for young children (e.g.) Health Tracks, Right Track, etc. and evaluate potential for data linking or integration.				X
6. CSHS will monitor newborn hearing screening data reported on electronic birth certificates.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

- A CSHS staff member is serving on the grant management team and functions as the state implementation coordinator for the EHDI Program.
- A CSHS staff member is serving as the Title V state EHDI contact.
- CSHS is monitoring other early screening and detection systems for young children (e.g.) Health Tracks, Right Track, etc. and evaluating potential for data linking or integration.
- CSHS is monitoring newborn hearing screening data reported on electronic birth certificates.

**c. Plan for the Coming Year**

- A CSHS staff member will serve on the grant management team and function as the state implementation coordinator for the Early Hearing Detection and Intervention (EHDI) Program. Efforts will focus on reducing infants that are lost to follow-up and promoting EHDI program sustainability.
- CSHS will monitor the status of newborn hearing screening at all birthing hospitals in the state.
- CSHS will collect and compile newborn hearing screening data reported on the state's electronic birth certificates.
- A CSHS staff member will serve as the Title V state EHDI contact.
- If ND receives a CDC Data Linkage grant, CSHS staff will promote data integration activities between newborn hearing screening, newborn blood spot screening and vital records.
- CSHS will monitor other early screening and detection systems for young children (e.g.) Health Tracks, Right Track, etc.

**Performance Measure 13:** *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	7.8	7.7	7.4	7.3	8.5
Annual Indicator	7.5	7.5	8.0	9.0	10.0
Numerator	12064	12064	12868	14476	16085
Denominator	160849	160849	160849	160849	160849
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	9.5	9	8.5	8	7.5

**Notes - 2007**

2007-The sources for this data are the 2007 Kids Count and the U.S. Census Bureau. The denominator is based on 2000 U.S. Census data. The numerator includes children under 18 and was derived by back calculation.

**Notes - 2006**

The sources for this data are are 2005 Kids Count and the U.S. Census Bureau. The denominator is based on 2000 U.S. Census.

**Notes - 2005**

The sources for this data are are 2005 Kids Count and the U.S. Census Bureau. The denominator is based on 2000 U.S. Census.

**a. Last Year's Accomplishments**

The percent of children in ND without health insurance varies slightly depending on the data source, but generally has a range of 7.3 to 10.0 percent. The 2008 Kids Count Data Book indicates 10 percent of ND children were without health insurance in 2005 compared 11 percent nationally. Although the state's percent of uninsured children is slightly below the national average, uninsured children in North Dakota increased from nine percent in 2007 to 10 percent in

2008.

In 2007, the ND Data Center reported 9.4 percent of children as uninsured using a three-year average estimate for 2004-2006. In 2007, the Kaiser Foundation reported 10 percent of ND children were uninsured for the years 2005-2006. The 2005 National Survey of Children's Health reported 92.7 percent of ND children were currently insured (7.3% uninsured) compared to the national average of 91.2 percent (8.8% uninsured).

Medicaid and SCHIP have been effective public programs in reducing the number of uninsured, low-income children in the state. For SFY 2007, there was a total of 75,470 Medicaid recipients. Of that group, 72.34 percent were Caucasian 24.17 percent were American Indian, 3.02 percent were Black, 0.36 percent were Asian/Pacific Islander, 0.08 percent were other, and 0.02 percent were not identified. Of the 75,740 total recipients, 41,376 or 54.63 percent were 0 through 20 years of age.

- The Covering Kids and Families (CKF) grant ended in March 2007. A sustainability plan was developed that includes: continued support from ND Blue Cross and Blue Shield/Caring Program; continued outreach efforts through the ND Department of Public Instruction, DoH and the Insurance Commissioner; sustainability of the CKF Coalition and outreach funding through the NDDHS; and media and meeting support through the Dakota Medical Foundation.
- Staff have monitored enrollment levels in SCHIP and Medicaid. According to ND Kids Count, in FFY 2006, there were 42,612 Medicaid recipients ages 0 to 20 and 4,454 children eligible for the SCHIP program. According to reports from the North Dakota Department of Human Services, in SFY 2007, there were 41,376 Medicaid recipients age 0 through 20. In the month of May 2008, there were 28,113 children eligible for Medicaid with a 12 month average of 27,539 children and 4,067 children eligible for SCHIP with a 12 month average of 3,950 children. In May 2008, there were also 650 children eligible for the Caring for Children Program, a benefit program for children who do not qualify for Medicaid or Healthy Steps through Blue Cross Blue Shield of ND.
- MCH staff provided updates and information at school nurse and local public health meetings. CSHS conducted a variety of activities to assure that local staff provided support to families to help them access health care coverage programs. For CSHCN's, CSHS eligibility policies and care coordination planning activities incorporated referral and linkage to Medicaid and SCHIP. Training and technical assistance was provided on an ongoing basis to increase awareness of assistance programs available in the state. Financial help packets containing a wealth of resource information were made available to families and service providers through the CSHS Information Resource Center.
- Title V staff participated in the Healthy North Dakota Early Childhood Alliance to work on state plan activities related to increasing the number of children who have health insurance. A major activity was dissemination of a healthcare coverage tool kit that was developed by Covering Kids and Families staff.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC, OPOP and CSHS will conduct activities to refer and link families to available sources of health care coverage such as Medicaid, CHIP, Caring, and CHAND programs with a special focus on the new Buy-In Program.		X		
2. Provide contact information on Medicaid and State Children's Health Insurance Program (SCHIP) through the Parenting the First Year newsletters.		X		
3. Title V staff will participate in the Healthy North Dakota Early Childhood Alliance to work on state plan activities related to increasing the number of children who have health insurance.				X
4. Title V staff will provide information to county social service			X	

staff, local public health departments, school nurses, Head Start, and child care about CHIP and Medicaid enrollment and application procedures.				
5. CSHS will monitor the number of CSHCN's served by CSHS with a source of health care coverage.				X
6. CSHS will provide diagnostic and treatment services to eligible uninsured and underinsured CSHCN.	X			
7. CSHS staff will coordinate with Medical Services staff regarding claims payment, MMIS system development, Medicaid policies/programs, and services to CSHCN and their families.				X
8. CSHS staff will monitor the impact of state health care coverage legislation that impacts children as well as policy changes that affect Medicaid, SCHIP, Caring, or CSHS eligibility or covered services.				X
9. CSHS will monitor implementation of a new Medicaid waiver for medically fragile children to assess access to home and community based support and Medicaid State Plan services.				X
10. CSHS will partner with others to support outreach regarding health coverage options and health benefits counseling/training (e.g.) ECCS committees, family organizations, Community Resource Coordinators, Insurance Commissioner's office, HRSA partners,				X

**b. Current Activities**

- WIC and OPOP staff are asking clients what kind of health insurance they have and referring to MA and SCHIP.
- The Parenting the First Year newsletters provide contact information on MA and SCHIP.
- Title V staff are participating in the Healthy ND Early Childhood Alliance to work on state plan activities related to increasing the number of children who have health insurance.
- Title V and CSHS staff are providing information to county social service staff, local public health departments, school nurses, Head Start, and child care about SCHIP and MA enrollment and application procedures.
- CSHS is monitoring the number of CSHCN's served by CSHS with a source of health care coverage.
- CSHS is conducting activities to refer and link families that have CSHCN to available sources of health care coverage such as MA, SCHIP, Caring, and CHAND programs with a special focus on the new Buy-In Program.
- CSHS is providing diagnostic and treatment services to eligible uninsured and underinsured CSHCN.
- CSHS staff is coordinating with Medical Services staff regarding claims payment, MMIS system development, Medicaid policies/programs, and services to CSHCN and their families.
- CSHS staff is monitoring the impact of state health care coverage legislation that impacts children as well as policy changes that affect Medicaid, SCHIP, Caring, or CSHS eligibility or covered services.
- CSHS is monitoring the implementation of a new MA waiver for medically fragile children.

**c. Plan for the Coming Year**

- WIC, OPOP and CSHS staff will conduct activities to refer and link families that have to available sources of health care coverage such as Medicaid, SCHIP, Caring, and CHAND as well as to other assistance programs.
- Provide contact information on Medicaid and State Children's Health Insurance Program (SCHIP) through the Parenting the First Year newsletters.
- Title V and CSHS staff will participate in the Healthy North Dakota Early Childhood Alliance to work on state plan activities related to increasing the number of children who have health insurance.

- Title V and CSHS staff will provide information to county social service staff, local public health departments, school nurses, Head Start, and child care about CHIP and Medicaid enrollment and application procedures.
- Title V and CSHS staff will monitor the impact of state health care coverage legislation that impacts children as well as policy changes that affect Medicaid, SCHIP, Caring, or CSHS eligibility or covered services.
- CSHS will monitor the number of CSHCN's served by CSHS with a source of health care coverage.
- CSHS will provide diagnostic and treatment services to eligible uninsured and underinsured CSHCN.
- CSHS staff will coordinate with Medical Services staff regarding claims payment, Medicaid policies/programs, and services to CSHCN and their families.
- CSHS will partner with others to support outreach regarding health coverage options and health benefits counseling/training (e.g.) ECCS committees, family organizations, Community Resource Coordinators, Insurance Commissioner's office, HRSA partners, Integrated Services Grant leadership teams, etc.
- CSHS will work with partners to enhance health care coverage for youth/young adults, including those with special health care needs.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				16	29
Annual Indicator			28.9	29.8	29.8
Numerator			1820	1588	1588
Denominator			6299	5330	5330
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	28.5	28	27.5	27	26.5

**Notes - 2007**

2007-The source for this data is from the 2005 Pediatric Nutrition Surveillance System (PedNSS), which is conducted every two years.

**Notes - 2006**

2006-The source of this data is from 2005 Pediatric Nutrition Surveillance System (PedNSS). Body Mass Index (BMI) at or above the 85th percentile.

**Notes - 2005**

The source of data is from Pediatric Nutrition Surveillance System (PedNSS).

**a. Last Year's Accomplishments**

According to the 2005 Pediatric Nutrition Surveillance System, 29.8 percent of children ages two to five years are at or above the 85th percentile. The 2007 ND WIC data shows that 31.1 percent of ND WIC children two years of age and older have a BMI of 85 percent or greater. CDC categorizes 85th-<95th percentile as children "at risk of overweight" and those at the 95th percentile and over as "overweight". The 31.1 percent is double the number that should be

expected. CDC BMI for age estimates 5 percent of children should be above the 95th percentile (ND is at 13.4 percent) and 10 percent between the 85th and 95th percentile (ND is at 17.7 percent). The trend is of high concern for the entire population, but particularly among American Indians who are 25 percent higher than the state averages for both "overweight" and "at risk of" overweight.

- The ND WIC staff continued to share the ND developed video on the division of responsibilities and the three nutrition education cards designed to support the video, Parents Provide, Kids Decide; Have Enjoyable Family Meals and Fitness is for Everyone.
- The "Turn off the TV" portion was included in each of the monthly WIC participant newsletters and offered ideas to get children active.
- WIC staff asked families about the number of TV hours children watch each day. Educational materials were reviewed with the idea of using emotional based messages and materials developed by MA WIC, including some targeting physical activity.
- Findings of the ND study were shared with those interested in making effective behavioral change when working with families. We also contracted with the researchers to develop a 1/2 day WIC staff training on how to use MI in their daily counseling (scheduled for early 2008).
- WIC staff encouraged all mothers to make a low fat milk choice for their children over two years of age. The WIC three year MI Research Project revealed that both MI and traditional counseling were effective in increasing consumption of low fat milk.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State WIC staff will encourage the local WIC staff to utilize the "Parents Provide, Kids Decide" video and education cards. This video focuses on the important of nutrition and physical activity.		X		
2. State WIC staff will continue the segments of Turn off the TV, Eating Together and Breastfeeding in the monthly North Dakota WIC participant newsletter, the PICK-WIC paper.		X		
3. The State WIC staff will adopt and educate local WIC staff on the proposed United States Department of Agriculture Value Enhanced Nutrition Assessment (USDA VENA) standards related to physical activity, as appropriate.				X
4. State WIC staff will educate local WIC staff on the application of the Motivational Interviewing findings on TV viewing, low fat milk and juice consumption components, if applicable.				X
5. State WIC staff will educate and encourage local WIC staff to educate mothers on low fat milk choices.				X
6. Local WIC staff will collect BMI information on participants and provide education/counseling, as appropriate.				X
7. State and local WIC staff will continue to develop monthly education materials focusing on nutrition and physical activity messages and recipes for WIC participants.				X
8. State WIC staff will participate with the Healthy North Dakota Early Childhood Alliance.				X
9.				
10.				

**b. Current Activities**

- State WIC staff is encouraging the local WIC staff to utilize the "Parents Provide, Kids Decide" video and education cards. This video focuses on the important of nutrition and physical activity.
- State WIC staff is continuing the segments of Turn off the TV (with activity ideas for young children), Eating Together (family meals) and Breastfeeding (promotion of breastfeeding) in the

monthly North Dakota WIC participant newsletter, the PICK-WIC Paper.

- The State WIC staff is adopting and educating local WIC staff on the proposed United States Department of Agriculture Value Enhanced Nutrition Assessment (USDA VENA) standards related to physical activity, as appropriate.
- State WIC staff is educating local WIC staff on the application of the Motivational Interviewing findings on TV viewing, low fat milk and juice consumption components, if applicable.
- State WIC staff is educating and encouraging local WIC staff to educate mothers on low fat milk choices.
- Local WIC staff is collecting BMI information on participants and providing education/counseling, as appropriate.
- State and local WIC staff is developing monthly education materials focusing on nutrition and physical activity messages and recipes for WIC participants.

**c. Plan for the Coming Year**

- State WIC staff will continue the segments of Turn off the TV (with activity ideas for young children), Eating Together (family meals) and Breastfeeding (promotion of breastfeeding) in the monthly ND WIC participant newsletter, the PICK-WIC Paper.
- State WIC staff will encourage the local WIC staff to utilize the "Parents Provide, Kids Decide" video and education cards. This video focuses on the important of nutrition and physical activity.
- State WIC staff will follow up on the Motivational Interviewing (MI) training offered to local staff with additional MI resources to help them apply MI techniques in their daily counseling.
- State WIC staff will educate and encourage local WIC staff to educate mothers on low fat milk choices and prepare them for the low fat milk "only" provision in the new WIC food package.
- Local WIC staff will collect BMI information on participants and provide education or counseling, as appropriate.
- State and local WIC staff will continue to develop monthly education materials focusing on nutrition and physical activity messages and recipes for WIC participants.
- The State WIC staff will adopt and educate local WIC staff on the proposed United States Department of Agriculture Value Enhanced Nutrition Assessment (USDA VENA) standards related to physical activity, as appropriate.
- State WIC staff will participate with the Healthy ND Early Childhood Alliance.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				15	14.2
Annual Indicator				14.4	14.8
Numerator				1220	1306
Denominator				8443	8807
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	14	13.8	13.5	13.4	13.4

**Notes - 2007**

2007-The source for this data is the North Dakota Department of Health, Division of Vital Statistics.

**Notes - 2006**

The source for this data is from the North Dakota Department of Health, Division of Vital Statistics. This data was obtained from the birth certificates.

**Notes - 2005**

Actual data nor an estimate can be provided for the numerator and denominator for this performance measure. Baseline data from the 2002 North Dakota PRAMS Survey results indicate 15.6 percent of respondents smoked the last three months of pregnancy. In 2006, women smoking in the last three months of pregnancy will be incorporated into the birth certificate.

**a. Last Year's Accomplishments**

Baseline data from the 2002 ND PRAMS Survey indicated 15.6 percent of respondents smoked the last three months of pregnancy. In 2006, women smoking in the last three months of pregnancy were incorporated into the birth certificate. In 2007, 14.8 percent of women smoked during the last three months; a slight increase from 14.4 percent in 2006.

- OPOP staff discussed and distributed educational materials and referred OPOP clients as needed to any tobacco cessation programs beginning with the first prenatal visit.
- OPOP staff conducted interviews regarding lifestyles and identified risk factors for each OPOP client. Educational materials were provided including the "Fetal Growth and Development" booklet beginning with the first prenatal visit. OPOP staff made referrals to tobacco cessation programs as needed.
- OPOP staff addressed hazards during pregnancy with OPOP clients, distributed appropriate educational materials and made referrals to local tobacco cessation programs as needed.
- OPOP staff distributed appropriate educational materials related to hazards during pregnancy and made referrals to local cessation programs as needed.
- OPOP and Family Planning staff continued to participate in the Partnership for Tobacco Prevention and Cessation for Women of Reproductive Age workgroups.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The WIC, OPOP and Family Planning Programs delegate agency staff will educate clients with positive pregnancy tests about the importance of not smoking and refer, as appropriate.		X		
2. The State WIC staff will post the CDC Prenatal Nutrition Surveillance System information containing the smoking behaviors of women, before, during and after pregnancy, on the state WIC website pages.				X
3. Local OPOP staff will provide teaching and anticipatory guidance regarding pregnancy and smoking cessation and reduction strategies to clients as appropriate.		X		
4. Local OPOP staff will distribute information on local cessation programs and smoking effects on the fetus to clients, as appropriate.		X		
5. Local Tobacco Cessation Coordinators and OPOP staff will use educational materials geared towards pregnant smoking women with information on the ND Quitline.		X		
6. The State WIC, OPOP and Family Planning staff will continue to participate in the Partnership for Tobacco Prevention and Cessation for Women of Reproductive Age workgroup.				X
7. A resource directory entitled A Connection for Families and				X

Agencies: Resources for North Dakota Families will be updated and made available on the NDDoH's web site.				
8. The State OPOP and Oral Health Program Directors will explore the development of a New Mother Fact Sheet on Oral Health During Pregnancy.				X
9. Provide review for the PRAM-O-GRAM fact sheets related to maternal lifestyles and health characteristics. (The ND State University Data Center is writing the fact sheets).				X
10.				

**b. Current Activities**

- The WIC, OPOP and Family Planning Programs delegate agency staff is educating clients with positive pregnancy tests about the importance of not smoking and referring, as appropriate.
- The State WIC staff has posted the CDC Prenatal Nutrition Surveillance System information containing the smoking behaviors of women, before, during and after pregnancy, on the state WIC website pages.
- Local OPOP staff is providing teaching and anticipatory guidance regarding pregnancy and smoking cessation and reduction strategies to clients, as appropriate.
- Local OPOP staff is distributing information on local cessation programs and smoking effects on the fetus to clients, as appropriate.
- Local Tobacco Cessation Coordinators and OPOP staff is using educational materials geared towards pregnant smoking women with information on the ND Quitline.
- The State WIC, OPOP and Family Planning staff is participating in the Partnership for Tobacco Prevention and Cessation for Women of Reproductive Age workgroup.
- A resource directory entitled A Connection for Families and Agencies: Resources for North Dakota Families is updated being made available on the NDDoH's web site.
- The State OPOP and Oral Health Program Directors are exploring the development of a New Mother Fact Sheet on Oral Health During Pregnancy.

**c. Plan for the Coming Year**

- The WIC, OPOP and Family Planning Program's local delegate agency staff will educate clients with positive pregnancy tests about the importance of not smoking and refer, as appropriate.
- The State WIC staff will post the CDC Prenatal Nutrition Surveillance System information containing the smoking behaviors of women, before, during and after pregnancy, on the state WIC website pages.
- Local OPOP staff will provide teaching and anticipatory guidance regarding pregnancy and smoking cessation and reduction strategies to clients as appropriate.
- Local OPOP staff will distribute information on local cessation programs and smoking effects on the fetus to clients, as appropriate.
- Local Tobacco Cessation Coordinators and OPOP staff will use educational materials geared towards pregnant smoking women with information on the ND Quitline.
- The State WIC, OPOP and Family Planning staff will continue to participate in the Partnership for Tobacco Prevention and Cessation for Women of Reproductive Age workgroup.
- The Partnership for Tobacco Prevention and Cessation for Women of Reproductive Age workgroup will update the Smoking and Pregnancy MCH Fact Sheet and make it available on the DoH's web site.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	11	10.5	9.8	10	9.8

Annual Indicator	6.2	9.9	16.8	19.3	19.9
Numerator	10	16	27	31	32
Denominator	160854	160854	160854	160854	160854
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	19.8	19	18	17	16

**Notes - 2007**

2007-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The value of the denominator is 2000 Census estimates. Please note corrections to 2003 & 2004 reporting: 2003 AI 8.7, N14, D 160,854. 2004 AI 12.4, N 20, D 160,854.

**Notes - 2006**

The source for this data is the North Dakota Department of Health, Division of Vital Statistics. The value for the denominator is a three year average.

**Notes - 2005**

The source for this data is the North Dakota Department of Health, Division of Vital Statistics. The value for the denominator is a three year average.

**a. Last Year's Accomplishments**

The suicide rate among youth ages 15 through 19 continues to be a concern; increasing from 16.8 in 2005 to 19.9 in 2007.

- The State Adolescent Suicide Prevention Task Force was expanded into the ND Suicide Prevention Coalition in March of 2007. The Coalition established it's Mission Statement: "To empower communities to create suicide prevention programs and strengthen resiliency to reduce injury and death." The Coalition met four times.
- The Division of Injury Prevention and Control (IPC) received a 3-year Garrett Lee Smith (GLS) State/Tribal Youth Suicide Prevention Grant in September 2006 from the Substance Abuse and Mental Health Services Administration (SAMHSA). A project director was hired in January 2007. In collaboration with Mental Health America of ND (MHAND), a Request for Proposals (RFP) was developed to distribute funds to six local program sites. A grants review committee from the ND Suicide Prevention Coalition awarded grants to two rural sites and four tribal sites from a field of 14 applicants. An evaluation grant was also awarded to the University of ND (UND) Center for Rural Health.
- The ND State Legislature appropriated \$30,000 for the 2005-2007 biennium for suicide prevention efforts on the Standing Rock Indian Reservation. A "Yellow Ribbon" gatekeeper training was conducted as well as a media campaign with posters, T-shirts, development of a Public Service Announcement, and radio advertising.
- One hundred copies of the "ND Suicide Prevention Plan" were printed. They were distributed to the members of the State Adolescent Suicide Prevention Task Force, the ND State Library, and Mental Health America of ND. The Plan was also placed on the DoH website.
- This was redirected to the Suicide Prevention Coalition under the Garrett Lee Smith grant.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue coordinating the ND Suicide Prevention Coalition.				X
2. Implement the State/Tribal Youth Suicide Prevention Grant to address suicide prevention and early intervention in youth 10 – 24 years.				X
3. Collaborate with the Mental Health America of ND and the ND Suicide Prevention Coalition to address suicide prevention and early intervention through the State/Tribal Suicide Prevention Grant.				X
4. Promote collaboration between and within ND communities to create sustainable infrastructure and programs in suicide prevention and early intervention for youth 10 – 24 years.				X
5. Increase public awareness that suicide is a leading cause of death among ND youth and that suicide is preventable.				X
6. Reduce the danger and harm of suicidal behavior.				X
7. Plan for sustainable youth suicide prevention programming in ND.				X
8.				
9.				
10.				

**b. Current Activities**

- The ND Suicide Prevention Coalition is meeting on a regular basis.
- Implementing the State/Tribal Youth Suicide Prevention Grant to address suicide prevention and early intervention in youth 10 -- 24 years.
- Collaborating with the Mental Health America of ND and the ND Suicide Prevention Coalition to address suicide prevention and early intervention through the State/Tribal Suicide Prevention Grant.
- Promoting collaboration between and within ND communities to create sustainable infrastructure and programs in suicide prevention and early intervention for youth 10 -- 24 years.
- Increasing public awareness that suicide is a leading cause of death among ND youth and that suicide is preventable.
- Planning for sustainable youth suicide prevention programming in ND.

**c. Plan for the Coming Year**

- Continue coordinating the ND Suicide Prevention Coalition.
- Implement the State/Tribal Youth Suicide Prevention Grant to address suicide prevention and early intervention in youth 15-19 years in six community-based programs.
- Collaborate with the Mental Health America of ND and the ND Suicide Prevention Coalition to address suicide prevention and early intervention through the State/Tribal Suicide Prevention Grant.
- Promote collaboration between and within ND communities to create sustainable infrastructure and programs in suicide prevention and early intervention for youth 15-19.
- Increase public awareness that suicide is a leading cause of death among ND youth and that suicide is preventable.
- Reduce the danger and harm of suicidal behavior.
- Plan for sustainable youth suicide programming in ND.
- Collaborate with programs receiving MCH funds such as WIC, Family Planning, Optimum Pregnancy Outcome Program, and with appropriate listserves such as the ND Injury Coalition, school nurses, and school counselors, to disseminate appropriate messages for suicide prevention.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	59	60	50	47	48.5
Annual Indicator	51.7	45.0	46.0	48.5	53.9
Numerator	46	50	46	48	55
Denominator	89	111	100	99	102
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	54	55	56	57	58

**Notes - 2007**

2007-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The Level 3 facilities in the state are MeritCare in Fargo, St. Alexius in Bismarck and Medcenter One in Bismarck.

**Notes - 2006**

The source of this data is the North Dakota Department of Health, Division of Vital Statistics. The level 3 facilities in the state are Meritcare in Fargo, St. Alexius in Bismarck, and Medcenter One in Bismarck

**Notes - 2005**

The source of this data is the North Dakota Department of Health, Division of Vital Statistics. The level 3 facilities in the state are Meritcare in Fargo, St. Alexius in Bismarck, and Medcenter One in Bismarck.

**a. Last Year's Accomplishments**

The rates of very low birth weight infants delivered at a level III facility showed a decrease from 59.1 percent in 2000 to 45 percent in 2004. The rates most likely decreased because during this time, ND went from four level III facilities, to three. Since 2005, the rates have increased from 46 percent in 2005 to 53.9 percent in 2007.

- Continue to monitor/assess.

**Table 4a, National Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. A resource directory, A Connection for Families and Agencies: Resources for North Dakota Families is available on the DoH's web site. ND hospitals are included in the direcectory.				X
2. Continue to periodically reassess.				X
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

**b. Current Activities**

- A resource directory entitled A Connection for Families and Agencies: Resources for North Dakota Families is updated being made available on the DoH's web site. ND hospitals are included in the directory, along with the various Neonatal Intensive Care Unit levels.

**c. Plan for the Coming Year**

- Continue to periodically monitor/assess.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	85	85.5	86	86.5	87
Annual Indicator	86.5	84.9	85.1	83.2	82.3
Numerator	6900	6937	7130	7167	7250
Denominator	7976	8173	8381	8616	8807
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	87.5	88	88.5	89	89.5

**Notes - 2007**

2007-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

**Notes - 2006**

The source of this data is the North Dakota Department of Health, Division of Vital Statistics.

**Notes - 2005**

The source of this data is the North Dakota Department of Health, Division of Vital Statistics.

**a. Last Year's Accomplishments**

Women receiving prenatal care beginning in the first trimester showed little changed between 2000 (85 percent) and 2006 (83.2 percent). 2007 data shows a slight decrease to 82.3 percent.

- WIC staff continued to screen for initiating of prenatal care and referred clients as needed.
- OPOP staff continued their attempts to increase availability and access to comprehensive prenatal care services by conducting outreach activities, providing information to the general public and providing OPOP contact information and resource guide that are posted on the DoH's website.
- OPOP staff (nurse or nutritionist) distributed prenatal vitamins with folic acid to OPOP clients as needed.
- OPOP staff discussed hazards and their effect on pregnancy beginning with the client's initial

prenatal visit and referred clients to cessation programs when necessary. OPOP staff distribute appropriate educational fact sheets as needed to OPOP clients.

- OPOP staff continued to participate in March of Dimes (MOD) meetings. A WIC staff member is part of a MOD workgroup. When the MOD has an initiative, the information materials are shared with WIC clients.
- Family Planning staff continued to counsel and refer clients with a positive pregnancy test within 15 days for prenatal care and OPOP services as appropriate.
- The Aberdeen Area American Indian Healthy Start Program continues to receive funding, but Healthy Start Inc. operates only on the Turtle Mountain reservation.
- The Birth Review mailing distributes a fact sheet promoting the importance of early and adequate prenatal care continues to all moms of newborns statewide.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to support local grantees to utilize a portion of their Title V funding to support OPOP programs. There are currently eight OPOP sites throughout the state.	X			
2. The State OPOP Director provides state and local OPOP contact information on the DoH's website.				X
3. A resource directory entitled A Connection for Families and Agencies: Resources for North Dakota Families is available on the DoH's web site.				X
4. MCH provides funding for the Spirit Lake Sioux program at Fort Totten to provide prenatal care, infant care and immunizations.				X
5. MCH provides funding for the Trenton Indian Health Center to support Healthy Start and Indian Health Center coordination.				X
6. MCH provides funding at the Three Affiliated Tribes WIC program to coordinate WIC, Healthy Start and Indian Health Services Prenatal activities.				X
7. Local WIC staff screen for initiating of prenatal care and refer, as needed.		X		
8. The Family Planning Program delegate agency staff counsels and refers clients with positive pregnancy tests for pregnancy confirmation within 15 days, prenatal care and OPOP services, as appropriate.		X		
9. Utilize the Parenting Newsletters and the Birth Review mailings to inform women of the importance of early and adequate prenatal care.		X		
10. The State CSHS, OPOP and Family Planning staff participate in the March of Dimes meetings that focus on prematurity and folic acid awareness.				X

**b. Current Activities**

- Eight MCH local grantees are utilizing a portion of their Title V funding to support the Optimal Pregnancy Outcome Program (OPOP).
- A resource directory entitled A Connection for Families and Agencies: Resources for North Dakota Families is updated being made available on the DoH's web site.
- MCH is continuing to provide funding for the Spirit Lake Sioux program at Fort Totten to provide prenatal care, infant care and immunizations.
- MCH is continuing to provide funding at Trenton Indian Health Center to support Healthy Start and Indian Health Center coordination.
- MCH is continuing to provide funding at the Three Affiliated Tribes WIC program to coordinate

WIC, Healthy Start and Indian Health Services Prenatal activities.

- Local WIC staff is screening for initiating of prenatal care and referring, as needed.
- WIC, OPOP and CSHS staff is participating in the Healthy Pregnancy Taskforce. The taskforce activities include folic acid awareness and prematurity, etc.
- The Family Planning Program delegate agency staff is counseling and referring clients with positive pregnancy tests for pregnancy confirmation within 15 days, prenatal care and OPOP services, as appropriate.
- Utilizing the Parenting Newsletters and the Birth Review mailings to inform women of the importance of early and adequate prenatal care.
- The State CSHS and OPOP staff is continuing to participate in the March of Dimes meetings that focus on prematurity and folic acid awareness.

### c. Plan for the Coming Year

- Continue to allow local grantees to utilize a portion of their Title V funding to support OPOP programs (there are currently eight OPOP sites throughout the state).
- The State OPOP Director will provide state and local OPOP contact information on the NDDoH's website.
- A resource directory entitled A Connection for Families and Agencies: Resources for North Dakota Families will be made available on the DoH's web site.
- MCH will continue to provide funding for the Spirit Lake Sioux program at Fort Totten to provide prenatal care, infant care and immunizations.
- MCH will continue to provide funding at Trenton Indian Health Center to support Healthy Start and Indian Health Center coordination.
- MCH will continue to provide funding at the Three Affiliated Tribes WIC program to coordinate WIC, Healthy Start and Indian Health Services Prenatal activities.
- Local WIC staff will screen for initiating of prenatal care and refer, as needed.
- The Family Planning Program delegate agency staff will counsel and refer clients with positive pregnancy tests for pregnancy confirmation within 15 days, prenatal care and OPOP services, as appropriate.
- Utilize the Parenting Newsletters and the Birth Review mailings to inform women of the importance of early and adequate prenatal care.
- The State CSHS, OPOP and Family Planning staff will continue to participate in the March of Dimes meetings that focus on prematurity and folic acid awareness.

## D. State Performance Measures

**State Performance Measure 1:** *The percent of healthy weight among women age 18-44.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				54	55
Annual Indicator			53.4	53.3	56.2
Numerator			58064	59924	63066
Denominator			108671	112428	112138
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	56.5	57	58	59	59

### Notes - 2007

2007-The data for body mass index (BMI) and number of women age 18 through 44 were collected from the 2007 Behavioral Risk Factor Surveillance Survey (BRFSS). The denominator

is an estimate of women ages 18 through 44 in North Dakota from the U.S.Census Bureau, Current Population Survey (CPS) annual March Supplement.

**Notes - 2006**

The data for body mass index (BMI) and number of women age 18-44 were collected from the Behavioral Risk Factor Surveillance Survey (BRFSS).The numerator is derived from back calculation.

**Notes - 2005**

The data for body mass index (BMI) and number of women age 18-44 were collected from the Behavioral Risk Factor Surveillance Survey (BRFSS).

**a. Last Year's Accomplishments**

The percentage of healthy weight women age 18-44 has increased slightly from 53.4 percent in 2005 to 56.2 percent in 2007. Collaboration between many programs has been occurring that promotes healthy eating and physical activity.

- Local MCH nutrition staff participated in facilitating group community walking programs, such as Walk ND, Greener Grand Forks, etc.
- State and local MCH nutritionists worked with the Cardiovascular Program, 5 A Day consultant and the ND Cooperative Extension Service to support the activities of the 17 local 5 + 5 Community Coalitions.
- Local MCH staff educated on low fat milk in schools. In the WIC three year Motivational Interviewing (MI) Research Project, one emphasis area revealed that both MI and traditional counseling were effective in increasing consumption of low fat milk.
- The MCH nutritionist held two face-to-face meetings with local public health nutritionists, but no conference call due to lack of need as expressed by the local MCH nutritionists.
- Local MCH staff continued to collaborate and promote the HND worksite wellness programs such as the Healthy Wannabe's.
- WIC and Family Planning staff collected BMI information on clients and provided education/counseling as appropriate.
- State MCH nutritionist gave nutrition and physical activity input for the "Healthy Women" brochure that is available to clients through the family planning program at its 22 clinic sites.
- State MCH nutritionist continued to serve on CORE Team Plus work group for CSH and provided input to the Roughrider conference.
- State and local MCH staff offered presentations at Roughrider conference.
- OPOP staff provided counseling and educational services on nutrition and physical activity.
- State MCH nutritionist offered input on the selection of speakers and presentation topics for Women's Health Summit conferences.
- State MCH staff participated on the ND Diabetes Coalition and the ND Cancer Coalition and collaborated in their efforts to promote a healthy weight. Goals relating to healthy weights are present in both state plans.
- State MCH staff continued to monitor the national and state BRFSS data regarding healthy weight among women.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State and local MCH staff promote the increase of physical activity and nutrition by promoting local and state programs.			X	
2. State MCH staff encourage local MCH staff to promote breastfeeding through educational opportunities, the creation of local coalitions, etc.				X
3. Local MCH staff collaborate and participate on the HND work groups, committees and other task forces to promote healthy				X

weight.				
4. Local WIC and Family Planning staff collect BMI information on participants and provide education/counseling as appropriate.		X		
5. State MCH staff provide nutrition and physical activity input to other state MCH programs and collaborate to develop materials regarding healthy weight among women.				X
6. State MCH staff monitor the national and state BRFSS data and serve on the DoH's BRFSS committee.				X
7. The Healthy Weight Coordinator coordinates the community program for local nutrition and physical activity coalitions.				X
8. State MCH staff assist in planning and encourage attendance at Roughrider Health Promotion Conference.				X
9. State and local MCH staff assist, participate in and engage other partners in the development and implementation of the North Dakota Healthy Eating and Physical Activity State Plan.				X
10.				

**b. Current Activities**

- Local MCH staff is participating in the development of local community walking programs and promoting the 5+5/ More Matters Campaign.
- State MCH staff is encouraging local MCH nutritionists to participate in "low fat milk" campaigns within their community and to promote breastfeeding.
- State MCH staff is offering input on the selection of speakers and presentation topics for the fall 2008 Women's Health Summit. The Title V director is part of the planning committee.
- State MCH staff is participating in and collaborating with the ND Diabetes Coalition, the ND Cancer Coalition, the Heart Disease and Stroke Advisory Committee and ND Recreation & Park Association to promote a healthy weight.
- State and local WIC and MCH staff is participating on the ND Healthy Pregnancy Task Force.
- State and local WIC staff is developing monthly education materials focusing on nutrition and physical activity messages and recipes for WIC participants.
- The Healthy Weight Coordinator is coordinating the community program for local nutrition and physical activity coalitions (5 + 5 Communities/More Matters), including seeking funding opportunities, training coalition members, and providing technical assistance.
- The Healthy Weight Coordinator is serving as the ND Fruits and Vegetable Program coordinator for CDC's National Fruit and Vegetable Program and will update local partners at least quarterly.
- Local OPOP staff is providing information on nutrition and physical activity to all clients.

**c. Plan for the Coming Year**

- State and local MCH staff will promote the increase of physical activity, fruit and vegetable intake, whole grains and low-fat milk; decrease screen time, consumption of sugar sweetened beverages, and high energy dense foods by promoting local 5+5 programs, WalkND, parks and recreation programs, etc., at local venues i.e. grocery stores, health fairs, etc.
- State MCH staff will encourage local MCH staff to promote breastfeeding through educational opportunities, the creation of local coalitions, etc.
- Local MCH staff will continue to collaborate and participate on the HND work groups, committees and other task forces to promote healthy weight.
- Local WIC and Family Planning staff will collect BMI information on participants and provide education/counseling as appropriate.
- State MCH staff will provide nutrition and physical activity input to other state MCH programs and collaborate to develop materials regarding healthy weight among women.
- State MCH staff will continue to monitor the national and state BRFSS data and serve on the DoH's BRFSS committee.
- The Healthy Weight Coordinator will coordinate the community program for local nutrition and

physical activity coalitions (5 + 5 Communities/More Matters), including seeking funding opportunities, training coalition members, and providing technical assistance.

- State MCH staff will assist in planning and encourage attendance at Roughrider Health Promotion Conference.
- State and local MCH staff will assist, participate in and engage other partners in the development and implementation of the ND Healthy Eating and Physical Activity State Plan.

**State Performance Measure 3:** *The percent of women age 18-44 enrolled in Medicaid who receive a preventive dental service.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				22	23
Annual Indicator			26.0	24.6	24.6
Numerator			4342	3996	4087
Denominator			16728	16275	16593
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	24.8	25	26	27	28

**Notes - 2007**

2007-The source for this data is the North Dakota Department of Human Services -- Medical Services Division. The Medicaid data was extracted using Data Probe and reflects women age 18 through 44.

**Notes - 2006**

The source for this Medicaid data is the North Dakota Department of Human Services, Medical Services Division.

In the year 2005 the reported data was incorrect. The 2005 data has been corrected and reported in 2006.

**Notes - 2005**

The source for this Medicaid data is the North Dakota Department of Human Services, Medical Services Division.

**a. Last Year's Accomplishments**

Access to care is a concern for low-income individuals in North Dakota. Access and work force issues remain in the State, despite a dental loan repayment program. The percent of women age 18-44 enrolled in Medicaid who received a preventive dental service has decreased slightly from 26 percent in 2005 to 24.6 percent in 2007.

- The Optimal Pregnancy Outcome Program (OPOP) and Oral Health Program created a fact sheet regarding pregnancy and oral health. This fact sheet was placed on the oral health website and distributed in pregnancy packets to expectant mothers through the OPOP program.
- The ND Oral Health Coalition continued to meet every other month with sub committees from the coalition meeting opposite months. The coalition is made up of approximately 80 members from approximately 60 public and private organizations from across the state. The coalition is sustainable, diverse and is recognized as an advocate for oral health.
- An executive summary from the Oral Health in ND: Burden of Disease was developed and posted to the oral health website. The summary includes the most important information and key points of the burden document. The document has also been distributed to key stake holders and was also disseminated at the Children's Oral Health Conference in November 2007.

- The Oral Health State Plan was disseminated to key stake holders and partners, posted to the oral health programs website and was distributed at the children's oral health conference in November 2007.
- The Oral Health Program Director continued to serve on the Bridging the Dental Gap Board of trustees. The Board meets monthly to discuss financial information and daily operations of the clinic.
- The Oral Health Program Director continued to be on the board of directors of Red River Valley Dental Access project and the Northern Valley Access Project.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate and implement, as appropriate, the findings of the Health Systems Research (HSR) Medicaid Focus Groups regarding access.				X
2. Collaborate with public health, family planning, WIC and others to reinforce preventive oral health messages including oral health and pregnancy.				X
3. The ND Oral Health Program staff will continue to be an active participant is the ND Oral Health Coalition.				X
4. The State Oral Health Program Director will work with the oral health epidemiologist to update the surveillance system and Oral Health Burden Document.				X
5. Distribute the ND State Oral Health Plan to a broad audience.				X
6. The State Oral Health Program Director will continue to serve on the Bridging the Dental Gap Clinic board of trustee's and offer support as needed to the Red River Valley Dental Access Project, Fargo & the Northern Valley Access Project, Grand Forks.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

- Collaborating with public health, family planning, WIC and others to reinforce preventive oral health messages including oral health and pregnancy.
- The ND Oral Health Program staff is continuing to be an active participant is the ND Oral Health Coalition.
- The State Oral Health Program Director is continuing to serve on the Bridging the Dental Gap Clinic board of trustee's and offering support as needed to the Red River Valley Dental Access Project in Fargo and the Northern Valley Access Project in Grand Forks.

**c. Plan for the Coming Year**

- Collaborate with Medicaid, public health, family planning, WIC and others to reinforce preventive oral health messages including oral health and pregnancy.
- The ND Oral Health Program staff will continue to be an active participant is the ND Oral Health Coalition.
- The State Oral Health Program Director will continue to serve on the Bridging the Dental Gap Clinic board of trustee's and offer support as needed to the Red River Valley Dental Access Project in Fargo and the Northern Valley Access Project in Grand Forks.

**State Performance Measure 4:** *The degree to which women age 18-44 have access to preventive health services as measured by 5 indicators of health care access.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				67	67.5
Annual Indicator			66.7	60.0	60.0
Numerator			10	9	9
Denominator			15	15	15
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	64	65	66	67	68

**Notes - 2007**

2007-The sources for this data are the 2006-2007 Behavioral Risk Factor Surveillance Survey (BRFSS) and the North Dakota Department of Health -- Division of Vital Statistics. The components for this measure are health insurance, PAP test, cholesterol test, mammogram and first trimester prenatal care. Data for health insurance and the cholesterol test are from the 2007 BRFSS while data for the mammogram and PAP test are from the 2006 BRFSS. Survey questions alternate based on odd and even years. Data for first trimester prenatal care is from the North Dakota Department of Health -- Division of Vital Statistics.

**Notes - 2006**

The sources of this data are the Behavioral Risk Factor Surveillance Survey and the North Dakota Department of Health, Division of Vital Statistics.

Values for the scale are: 3=>90%, 2=85-90%, 1=80-85%, 0=<80%

Indicators

1. % with health insurance
2. % with PAP test in last 3 yrs
3. % with cholesterol test in last 5 yrs
4. % ever had mammogram
5. % with 1st trimester prenatal care

**Notes - 2005**

The sources of this data are the Behavioral Risk Factor Surveillance Survey and the North Dakota Department of Health, Division of Vital Statistics.

Values for the scale are: 3=>90%, 2=85-90%, 1=80-85%, 0=<80%

Indicators

1. % with health insurance
2. % with PAP test in last 3 yrs
3. % with cholesterol test in last 5 yrs
4. % ever had mammogram
5. % with 1st trimester prenatal care

**a. Last Year's Accomplishments**

Access to preventive health services was measured by five indicators of health care access using data from the 2007 Behavioral Risk Factor Surveillance Survey (BRFSS) and Vital Statistics data. The five indicators measured for women 18-44 are percent with health insurance, percent with a

PAP test in the last three years, percent with a cholesterol test in the last five years, percent that ever had a mammogram, and percent with 1st trimester prenatal care. Data from 2007 did not indicate a significant difference from the previous year for this measure. In 2007, there were 85.33 percent of women with health insurance compared to 86.68 percent in 2006. 87.05 percent of women had a PAP test in 2006 and 2007, compared to 85.48 percent in 2005. The percent of women who had a cholesterol test in the last five years increased to 62.12 percent in 2007 compared to 60.41 percent in 2006. The percent of women who ever had a mammogram remained unchanged at 32.72 percent from 2006 to 2007. The percent of women with 1st trimester prenatal care decreased slightly to 82.3 percent in 2007 from 83.2 percent in 2006. The measure as a composition of all indicators remained stable at 60 percent in 2007. Programs that focus activities around preventive women's health services include WIC, OPOP and Family Planning.

- Preventive services for women (and men) is included various state plans, including Cardiovascular Health, Cancer, Diabetes, Oral Health and Tobacco.
- The WIC and Optimal Pregnancy Outcome Programs asked all families as part of the health screening "Do you have health insurance?" If the client answered yes, the staff determined what kind (private, Medical Assistance, Healthy Steps, IHS and military). If families did not have insurance, they were referred to Medical Assistance (Title XIX), SCHIP or to the Caring Children Program.
- The Family Planning Program provided preventative screening services with client consent. A body mass index (BMI) is calculated on all clients and nutritional education and/or referrals were made as identified.
- The WIC and OPOP Programs, as a part of the health screening questions, ask all pregnant women if they have started prenatal care? If yes, data was collect on how far along they were at the first prenatal checkup and how many visits they have had? WIC also asked who their doctor/clinic was and if they or their doctor had any concerns about the pregnancy. If the client had not started prenatal care, WIC staff encourages them to do so.

The Family Planning Program provided pregnancy testing and referrals to community prenatal care agencies, such as OPOP and physicians. One of the Family Planning agencies provided prenatal vitamins at time of positive pregnancy test.

- The WIC and OPOP Programs, as a part of the health screening questions, asked all pregnant women about depression and made referrals as appropriate. In addition, staff provide educational information on postpartum depression that has been provided to the program by other agencies.
- The WIC and OPOP Programs, as a part of the health screening questions, asked all clients about stresses in the family that included living with someone who is abusive and made referrals as appropriate. The Family Planning Program's initial assessment form, clients were asked if they are a victim of abuse. Referrals were made as appropriate.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assure that preventive health services for women are addressed in the various state plans (i.e., Cardiovascular Health, Cancer, Diabetes, Oral Health, Tobacco and Family Planning Program).				X
2. Identify and/or pursue partnerships with other entities related to women's preventive health (i.e., University of North Dakota Center of Excellence for Women's Health, and American Heart Association – Go Red for Women campaign).				X
3. Encourage/assist local agencies with resources to assure access to a source of health insurance coverage.			X	
4. Encourage/assist local agencies to encourage women to receive recommended preventive screening services such as			X	

blood cholesterol, bone mineral density, triglycerides, glucose and body mass index.				
5. Encourage/assist local agencies to provide access to early and adequate prenatal care.			X	
6. Encourage/assist local agencies to provide access to mental health screenings, especially postpartum depression.			X	
7. Encourage/assist health professionals to screen and refer all women for family and intimate partner violence.			X	
8.				
9.				
10.				

**b. Current Activities**

- Collaborating with other entities related to women's preventive health (i.e., University of North Dakota Center of Excellence for Women's Health, and American Heart Association -- Go Red for Women campaign).
- Encouraging/assisting local agencies with resources to assure access to a source of health insurance coverage.
- Encouraging/assisting local agencies to encourage women to receive recommended preventive screening services such as blood cholesterol, bone mineral density, triglycerides, glucose and body mass index.
- Encouraging/assisting local agencies to provide access to early and adequate prenatal care.
- Encouraging/assisting local agencies to provide access to mental health screenings, especially postpartum depression.
- Encouraging/assisting health professionals to screen and refer all women for family and intimate partner violence.

**c. Plan for the Coming Year**

- Assure that preventive health services for women are addressed in the various state plans (i.e., Cardiovascular Health, Cancer, Diabetes, Oral Health, Tobacco and Family Planning Program).
- Identify and/or pursue partnerships with other entities related to women's preventive health (i.e., University of North Dakota Center of Excellence for Women's Health, and American Heart Association -- Go Red for Women campaign).
- Encourage/assist local agencies with resources to assure access to a source of health insurance coverage.
- Encourage/assist local agencies to encourage women to receive recommended preventive screening services such as blood cholesterol, bone mineral density, triglycerides, glucose and body mass index.
- Encourage/assist local agencies to provide access to early and adequate prenatal care.
- Encourage/assist local agencies to provide access to mental health screenings, especially postpartum depression.
- Encourage/assist health professionals to screen and refer all women for family and intimate partner violence.

**State Performance Measure 5:** *The rate of deaths to children age 1-19 caused by intentional and unintentional injuries per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				25	24
Annual Indicator			26.7	29.2	23.6
Numerator			47	49	40

Denominator			175804	167645	169138
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	23	22	21	20	19

**Notes - 2007**

2007-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

**Notes - 2006**

The source of the data is the North Dakota Department of Health, Division of Vital Statistics. The denominator is an annual estimate. The source for the denominator is U.S. Census Bureau, Population Division.

**Notes - 2005**

The source of the data is the North Dakota Department of Health, Division of Vital Statistics.

**a. Last Year's Accomplishments**

The rate of deaths to children ages 1-19 caused by intentional and unintentional injuries per 100,000 children have varied slightly since 2005, in which the rate was 26.7. The rate was 29.2 in 2006 and 23.6 in 2007.

- The Division of Injury Prevention and Control (IPC) made available to local agencies playground and/or bike helmet safety display banners. Bike helmet safety materials were distributed to local agencies requesting information in the spring of 2007.
- Building Blocks to Safety newsletter was created and distributed quarterly. Media releases were released in regards to playground safety, bike safety, holiday toy safety, holiday decorating safety and child passenger safety month.
- Emergency Medical Services for Children staff were represented on the Statewide Injury Prevention Coalition and provided technical assistance. Collaboration also occurred with Risk Watch, an injury prevention program located with the ND Fire Prevention Association. A member of the staff is on the steering committee for Safe Kids ND. IPC staff served on the advisory board for the United Tribes Technical College Injury Prevention Department, where they were revising the curriculum to be a Wellness program. IPC collaborated with the ND Council on Abused Women's Services/Coalition Against Sexual Assault in ND to work towards primary prevention of sexual assault. Many of the local agencies used an approach to anti-bullying as a means to prevent sexual assault. IPC staff is on the Child Fatality Review Panel and worked with that panel to address leading causes of injury death. A group of Injury Prevention specialists presented at the Coordinated School Health Roughrider Health Promotion Conference regarding efforts in ND to reduce injuries and injury death. Data was presented along with injury prevention programs available for local schools to make available to teachers and staff.
- Ten product recall effectiveness checks were conducted during summer 2007. Product recall information was included in all issues of the Building Blocks to Safety newsletter.
- The DoH, in conjunction with the Hennepin County Poison Control Center, maintained a website for educators, parents and the general public with poison prevention information available in a downloadable format. IPC distributed the Poison Control Help Line information to local public health agencies, health care facilities, clubs, organizations and the general public throughout the year. The number of stickers sent to local agencies was 24,639 and 26,343 magnets. IPC also had videos available for poison prevention to the public.
- The ND Injury Prevention Coalition is a group of injury prevention programs operating across the state with a mission to reduce injury related deaths and injuries do to intentional and unintentional injuries. It has representation from Safe Kids coalitions, Indian Health Services, Emergency Medical Services, ND American Medical Association, hospitals, Department of Public Instruction, law enforcement, Mental Health America ND, Suicide prevention program, ND Council on Abused Women Services, etc. The Coalition met three times between 10/1/06-9/30/07. A mission statement was approved and is being used as the coalition's primary reason

for meeting. "The North Dakota Injury Prevention Coalition is a multi-disciplinary partnership to reduce unintentional and intentional injuries and deaths." The members rely upon the meetings to network and collaborate on projects.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance, training, data, and materials to local entities on injury-specific topics, along with co-chairing a statewide Injury Prevention conference.				X
2. Provide public information and education on injury specific topics. Distribute media/news releases and produce a quarterly newsletter, "Building Blocks to Safety".			X	
3. Collaborate with state and local Safe Kids Coalitions, the ND Injury Prevention Coalition, Emergency Medical Services for Children, the US Consumer Product Safety Commission and other private/public partners on injury prevention projects.				X
4. Coordinate ND's Poison Prevention public information and education campaign.				X
5. State staff monitor the national and state YRBS data and be engaged with the School Health Interagency Workgroup, which is responsible for YRBS question selection and data dissemination.				X
6. Continue car seat distribution program throughout the state.			X	
7. Assist local agencies in conducting car seat check-ups by providing certified instructors, technicians, car seats, and checkup supplies.			X	
8. Conduct 2-3, four-day National Highway Traffic Safety Administration (NHTSA) Standardized Child Passenger Safety Courses to certify new child passenger safety technicians.				X
9.				
10.				

**b. Current Activities**

- Providing TA, training, data, and materials to local entities on injury-specific topics, product safety, bicycle safety, car seats and home safety. Sponsor Child Passenger Safety Week in September 2009 and co-coordinate a statewide DoH injury prevention conference for fall 2008.
- Providing public information and education on injury specific topics in a variety of ways. Distribute media/news releases and produce a quarterly newsletter, "Building Blocks to Safety".
- Collaborating with state and local Safe Kids Coalitions, the ND Injury Prevention Coalition, Emergency Medical Services for Children, the US Consumer Product Safety Commission and other private/public partners on injury prevention projects.
- Coordinating ND's Poison Prevention public information and education campaign.
- State staff is continuing to monitor the national and state YRBS data and be engaged with the School Health Interagency Workgroup, which is responsible for YRBS question selection and data dissemination.
- Continuing car seat distribution program.
- Assisting local agencies in conducting car seat check-ups by providing certified instructors, technicians, car seats, and checkup supplies.
- Conducting National Highway Traffic Safety Administration (NHTSA) Standardized Child Passenger Safety Courses to certify new child passenger safety technicians.
- Offering child passenger safety trainings.

**c. Plan for the Coming Year**

- Provide technical assistance, training, data, and materials to local entities on injury-specific topics, i.e., playground safety, product safety, bicycle safety, car seats and home safety (Home Safety Checklist booklet). Sponsor Child Passenger Safety Week in September 2009 and co-ordinate a statewide NDDOH injury prevention conference for fall 2008.
- Provide public information and education on injury specific topics in a variety of ways, such as through the Parenting the First Year newsletters. Distribute media/news releases and produce a quarterly newsletter, "Building Blocks to Safety" with a "Buckle Update" section.
- Collaborate with state and local Safe Kids Coalitions, the ND Injury Prevention Coalition, Emergency Medical Services for Children, the US Consumer Product Safety Commission and other private/public partners on injury prevention projects and education to the public about product recalls, conduct recall effectiveness checks, and complete special projects as assigned.
- Coordinate ND's Poison Prevention public information and education campaign. Work with Hennepin County Poison Control Center in Minnesota to assure poison consultation coverage for ND.
- State staff will continue to monitor the national and state YRBS data and be engaged with the School Health Interagency Workgroup, which is responsible for YRBS question selection and data dissemination.
- Re-apply for ND Department of Transportation funds to administer the state's child passenger safety program; monitor expenditures and complete reports as required.
- Continue car seat distribution program throughout the state by providing car seats, policies/procedures, and training/technical assistance to local agencies. Provide car seats and training to five Indian reservations.
- Assist local agencies in conducting car seat check-ups by providing certified instructors, technicians, car seats, and checkup supplies.
- Conduct 2-3, four-day National Highway Traffic Safety Administration (NHTSA) Standardized Child Passenger Safety Courses to certify new child passenger safety technicians.
- Offer child passenger safety trainings to professionals including, hospital staff, law enforcement, etc. and continue to offer child passenger safety continuing education units (CEU) opportunities for currently certified technicians in ND.

**State Performance Measure 6:** *The percentage of students who were physically active for a total of at least 60 minutes per day on five or more of the past seven days.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				44	44.5
Annual Indicator			43.7	43.7	54.7
Numerator			18730	18730	22838
Denominator			42830	42830	41743
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	55	56	57	58	59

**Notes - 2007**

2007-The source for this data is selected weighted CDC data from the North Dakota 2007 Youth Risk Behavior Survey (YRBS). The YRBS includes data from middle school (grades 7-8) and from high school (grades 9-12). This measure changed from 2006 to 2007 in order to be consistent with the new YRBS Survey question. Previously the question was the percent of children age 6-17 who exercised or participated in a physical activity that made him/her sweat and breathe hard on 5 or more days during the past week.

**Notes - 2006**

The source of this data is selected weighted CDC data from the North Dakota 2005 Youth Risk Behavior Survey (YRBS). The YRBS includes data from middle school (grades 7-8 for all ages) and from high school (grades 9-12 for ages less than or equal to 17). The percentage of middle school children who participated in physical activity was 48 percent. For high school students, it was 41.4 percent. The combined middle and high school response to this measure was 43.8 percent. The 2007 YRBS data is available this fall in 2007.

**Notes - 2005**

The source of this data is selected weighted CDC data from the North Dakota 2005 Youth Risk Behavior Survey (YRBS). The YRBS includes data from middle school (grades 7-8 for all ages) and from high school (grades 9-12 for ages less than or equal to 17). The percentage of middle school children who participated in physical activity was 48 percent. For high school students, it was 41.4 percent. The combined middle and high school response to this measure was 43.8 percent.

**a. Last Year's Accomplishments**

Available data to measure the percent of children age 6-17 who exercised or participated in a physical activity that made him/her sweat and breathe hard, such as basketball, soccer, running, or similar aerobic activities on 5 or more days during the past week is difficult to obtain because of the age span. Due to this, the performance measure has been revised to "the percent of students who were physically active for a total of at least 60 minutes per day on five or more of the past seven days". This question now aligns with the Youth Risk Behavior Survey, which is conducted every other year. 2007 YRBS data shows that 54.7 percent of students in grades 7-12 were physically active for a total of at least 60 minutes per day on five or more of the past seven days.

- Local MCH nutrition staff served on local school wellness committees.
- Local MCH staff were invited to attend conference calls and provided input on the ND Healthy Eating and Physical Activity State Plan, which was the primary activity of the HND Physical Activity Committee during this period of time.
- Local MCH nutrition staff was engaged in promoting physical activity in schools, Head Start, child care and WIC.
- Local MCH staff partnered with coordinated school health in support of policies for quality physical education and activity in grades K through 12.
- MCH Nutritionist participated in the Coordinated School Health Program and the Healthy School Nutrition Alliance.
- State and local MCH staff offered information on healthy eating and physical activity at the Roughrider conference.
- State MCH nutritionist contacted the Department of Public Instruction to assure that physical activity is incorporated into available after school programs.
- State MCH staff offered input on the selection of speakers and presentation topics for Women's Health Summit conferences. The Title V director serves on the planning committee and also has input into topic and speaker selection.
- State MCH staff continued to monitor the national and state YRBS data. Data is used to assist with planning program activities.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State and local MCH staff promote the increase of physical activity, fruit and vegetable intake, whole grains and low-fat milk; decrease screen time, consumption of sugar sweetened beverages, and high energy dense foods by promoting local and state p				X
2. Local MCH staff collaborate and participate on the HND work				X

groups, committees and other task forces to promote healthy weight.				
3. State MCH staff encourage local MCH staff to partner with coordinated school health and support policies that provide for quality physical education and activity in grades pre-K through 12.				X
4. State MCH staff will continue to monitor the national and state YRBS data and be engaged with the School Health Interagency Workgroup, which is responsible for YRBS question selection and data dissemination.				X
5. State MCH staff will be a resource to local partners for physical activity promotion.				X
6. State and local MCH staff assist, participate in and engage other partners in the development and implementation of the ND Healthy Eating and Physical Activity State Plan.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

- State and local MCH staff are promoting the increase of physical activity, fruit and vegetable intake, whole grains and low-fat milk; decrease screen time, consumption of sugar sweetened beverages, and high energy dense foods by promoting local 5+5 programs, WalkND, parks and recreation programs, etc..., at local venues i.e. grocery stores, health fairs, etc.
- Local MCH staff are continuing to collaborate and participate on the HND work groups, committees and other task forces to promote healthy weight.
- State MCH staff are encouraging local MCH staff to partner with coordinated school health and support policies that provide for quality physical education and activity in grades pre-K through 12.
- State MCH staff are continuing to monitor the national and state YRBS data and be engaged with the School Health Interagency Workgroup, which is responsible for YRBS question selection and data dissemination.
- State and local MCH staff are assisting, participating in and engaging other partners in the development and implementation of the ND Healthy Eating and Physical Activity State Plan.

**c. Plan for the Coming Year**

- State and local MCH staff will promote the increase of physical activity, fruit and vegetable intake, whole grains and low-fat milk; decrease screen time, consumption of sugar sweetened beverages, and high energy dense foods by promoting local 5+5 programs, WalkND, parks and recreation programs, etc... at local venues i.e. grocery stores, health fairs, etc.
- Local MCH staff will continue to collaborate and participate on the HND work groups, committees and other task forces to promote healthy weight.
- State MCH staff will encourage local MCH staff to partner with coordinated school health and support policies that provide for quality physical education and activity in grades pre-K through 12.
- State MCH staff will continue to monitor the national and state YRBS data and be engaged with the School Health Interagency Workgroup, which is responsible for YRBS question selection and data dissemination.
- State MCH staff will be a resource to local partners for physical activity promotion.
- Promote community physical activity initiatives such as walking to school programs and Safe Routes to School initiatives partnering with: local 5+5 programs, parks and recreation, childcare associations, after school programs, etc.
- State MCH staff will assist in planning and encourage attendance at the annual Roughrider

Health Promotion Conference.

- State and local MCH staff will assist, participate in and engage other partners in the development and implementation of the ND Healthy Eating and Physical Activity State Plan.

**State Performance Measure 7:** *The percent of ND children age 10-17 with a BMI in the normal weight range.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				0	69.5
Annual Indicator			72.1	72.1	72.1
Numerator			686	686	686
Denominator			951	951	951
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	73	73.5	74	74.5	75

**Notes - 2007**

2007-The source for this data is from the 2003 National Survey of Children's Health. This measure was changed in 2005 to reflect the percent of ND children age 10-17 with a BMI in the normal weight range. Previously the percent of ND children age 2-17 with a BMI in the normal weight range was used.

**Notes - 2006**

The source of this data is from the 2003 National Survey of Children's Health. The numerator and denominator for the age group 10 to 17 is weighted.

**Notes - 2005**

The source of this data is from the 2003 National Survey of Children's Health. The numerator and denominator for the age group 10 to 17 is weighted.

**a. Last Year's Accomplishments**

Available data to measure the percent of ND children age 2-17 with a BMI in the normal weight range was difficult to obtain because of the age span. Due to this, the reporting for the performance measure was revised to include children age 10-17. According to the 2003 National Survey of Children's Health, children age 10-17 with a BMI in the normal weight range are at 72.1 percent.

- MCH nutritionist continued to coordinate monthly meetings of the Healthy Weight Council, completed the drafting of the position paper and also coordinated the distribution of healthy weight information to members.
- Findings from the 3-year ND WIC Motivational Interviewing Research Project were inconclusive with the TV viewing since such a small number participated. Staff have taken advantage of opportunities to share the research findings on the study's effectiveness in decreasing juice consumption, weaning by 14 months of age and increasing breastfeeding initiation and duration.
- Worked with the Oral Health Program to put the results of the Oral Health Survey into a report which includes information on weight and pop consumption.
- MCH nutritionist held two face-to-face meetings with local public health nutritionists. No conference call was scheduled due to lack of need as expressed by the local MCH nutritionists; however they were invited to attend conference calls and provided input on the ND Healthy Eating and Physical Activity State Plan.
- Local MCH nutrition staff served on local school wellness committees.
- Local MCH staff were invited to attend conference calls and provided input on the North Dakota Healthy Eating and Physical Activity State Plan, which was the primary activity of the HND

Physical Activity Committee during this period of time.

- State and local MCH nutritionists worked with the Cardiovascular Program, 5 A Day consultant and the ND Cooperative Extension Service to support the activities of the 17 local 5 + 5 Community Coalitions.
- Local MCH staff educated on low fat milk in schools. In the WIC three year Motivational Interviewing (MI) Research Project, one emphasis area revealed in the study that both MI and traditional counseling were effective in increasing consumption of low fat milk.
- State MCH staff offered nutrition and physical activity information through the Early Childhood Alliance plan.
- State and local MCH staff offered information on healthy eating and physical activity at the annual Coordinated School Health Roughrider conference.
- State MCH nutritionist collaborated with the State Women's Health coordinator and offered input on the selection of speakers and presentation topics for all Women's Health Summit conferences. The Title V director serves on the planning committee and also has input into topic and speaker selection.
- State MCH staff continued to monitor the national and state YRBS data. Data was used to assist in planning program activities.
- State MCH nutritionist contacted the Department of Public Instruction to assure that physical activity is incorporated into after school programs.
- Local MCH nutrition staff was engaged in promoting physical activity in schools, Head Start, child care and WIC.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State MCH nutritionist will continue to coordinate monthly meetings of the Healthy Weight Council to draft a healthy weight tool kit to assist and compliment the position paper, "Measuring Heights and Weights in Schools".				X
2. State MCH staff will review current data sets, assess data and needs relating to BMI; continue to monitor the national and state YRBS data, as well as be engaged with the School Health Interagency Workgroup, responsible for YRBS question selection an				X
3. The Healthy Weight Coordinator will coordinate the community program for local nutrition and physical activity coalitions.				X
4. Local MCH staff will continue to collaborate and participate on the HND work groups, committees and other task forces to promote healthy weight.				X
5. State MCH staff will encourage local MCH staff to partner with coordinated school health and support policies that provide for quality physical education and activity in grades pre-K through 12.				X
6. State MCH staff will be a resource to local partners for healthy eating and physical activity promotion.				X
7. Promote community physical activity initiatives such as walking to school programs and Safe Routes to School initiatives partnering with: local 5+5 programs, parks and recreation, childcare associations, after school programs, etc.				X
8. State and local MCH staff assist, participate in and engage other partners in the development and implementation of the ND Healthy Eating and Physical Activity State Plan.				X
9. State and local MCH staff promote the increase of physical				X

activity, fruit and vegetable intake, whole grains and low-fat milk; decrease screen time, consumption of sugar sweetened beverages, and high energy dense foods.				
10. State MCH staff assist in planning and encourage attendance at the annual Roughrider Health Promotion Conference.			X	

**b. Current Activities**

- State MCH nutritionist is continuing to coordinate monthly meetings of the Healthy Weight Council to draft a healthy weight tool kit to assist and compliment the position paper, "Measuring Heights and Weights in Schools".
- State MCH staff is reviewing current data sets, assess data and needs relating to BMI; continuing to monitor the national and state YRBS data, as well as be engaging with the School Health Interagency Workgroup.
- The Healthy Weight Coordinator is coordinating the community program for local nutrition and physical activity coalitions, including seeking funding opportunities, training coalition members, and providing technical assistance.
- Local MCH staff is collaborating and participating on the HND work groups, committees and other task forces to promote healthy weight.
- State MCH staff is encouraging local MCH staff to partner with coordinated school health and support policies that provide for quality physical education and activity in grades pre-K through 12.
- State and local MCH staff is assisting and participating in the engagement of other partners in the development of the ND Healthy Eating and Physical Activity State Plan.
- State and local MCH staff is promoting the increase of physical activity, fruit and vegetable intake, whole grains and low-fat milk; decrease screen time, consumption of sugar sweetened beverages, and high energy dense foods by promoting local 5+5 programs, WalkND, parks and recreation programs.

**c. Plan for the Coming Year**

- State MCH nutritionist will continue to coordinate monthly meetings of the Healthy Weight Council to draft a healthy weight tool kit to assist and compliment the position paper, "Measuring Heights and Weights in Schools".
- State MCH staff will review current data sets, assess data and needs relating to BMI; continue to monitor the national and state YRBS data, as well as be engaged with the School Health Interagency Workgroup, responsible for YRBS question selection and data dissemination.
- The Healthy Weight Coordinator will coordinate the community program for local nutrition and physical activity coalitions (5 + 5 Communities/More Matters), including seeking funding opportunities, training coalition members, and providing technical assistance.
- Local MCH staff will continue to collaborate and participate on the HND work groups, committees and other task forces to promote healthy weight.
- State MCH staff will encourage local MCH staff to partner with coordinated school health and support policies that provide for quality physical education and activity in grades pre-K through 12.
- State MCH staff will be a resource to local partners for healthy eating and physical activity promotion.
- Promote community physical activity initiatives such as walking to school programs and Safe Routes to School initiatives partnering with: local 5+5 programs, parks and recreation, childcare associations, after school programs, etc.
- State MCH staff will assist in planning and encourage attendance at the annual Roughrider Health Promotion Conference.
- State and local MCH staff will assist, participate in and engage other partners in the development and implementation of the ND Healthy Eating and Physical Activity State Plan.
- State and local MCH staff will promote the increase of physical activity, fruit and vegetable intake, whole grains and low-fat milk; decrease screen time, consumption of sugar sweetened

beverages, and high energy dense foods by promoting local 5+5 programs, WalkND, parks and recreation programs, etc. at local venues i.e. grocery stores, health fairs, etc.

**State Performance Measure 8:** *The degree to which the state can assess and plan for the health and related service needs of children with extraordinary medical needs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				7	8
Annual Indicator			7	8	8
Numerator			7	8	8
Denominator	9	9	9	9	9
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	9	9	9	9	9

**Notes - 2007**

2007-Components of this measure are ranked by co-leaders of the Medical Needs Task Force, both are which are located in the North Dakota Department of Human Services. Values for the ranking are 0-3 with a maximum of 9 possible points. Components: 1. Surveillance and assessment through the availability and use of data. 2. Relevant partners and stakeholders are involved in the assessment and planning for children with extraordinary medical needs. 3. Policy development, planning and program development designed to address the needs of children with extraordinary medical needs and their families occurs.

**Notes - 2006**

Components of this measure are ranked by co-leaders of the Medical Needs Task Force, both are which are located in the North Dakota Department of Human Services. Values for the ranking are 0-3 with a maximum of 9 possible points.

Components:

1. Surveillance and assessment through the availability and use of data.
2. Relevant partners and stakeholders are involved in assessment and planning for children with extraordinary medical needs.
3. Policy development, planning, program development designed to address the needs of children with extraordinary medical needs and their families occurs.

**Notes - 2005**

Components of this measure are ranked by co-leaders of the Medical Needs Task Force, both are which are located in the North Dakota Department of Human Services. Values for the ranking are 0-3 with a maximum of 9 possible points.

Components:

1. Surveillance and assessment through the availability and use of data.
2. Relevant partners and stakeholders are involved in assessment and planning for children with extraordinary medical needs.
3. Policy development, planning, program development designed to address the needs of children with extraordinary medical needs and their families occurs.

**a. Last Year's Accomplishments**

Over the last few years, Title V staff members collaborated on work activities to increase access to health care coverage and family support services for a subset of CSHCN's who were medically

fragile.

Improvements in financial access and health insurance coverage for the CSHCN population have been noted based on data from the 2001 and 2005/2006 national surveys of Children with Special Health Care Needs. In 2005/2006, 68 percent of ND families with CSHCN had adequate private and/or public insurance to pay for the services they needed compared to 62.0 percent in 2001. Nationally in 2001, 59.6 percent of families with CSHCN reported having adequate private and/or public insurance to pay for the services they needed compared to 62.0 percent in 2005/2006. In 2005/2006, 9.6 percent of CSHCN in ND were without insurance at some point in the last year, compared to 12.9 percent in 2001. Of those who were currently insured, 26.1 percent relayed their insurance was inadequate to pay for the services they needed, which is slightly lower than the 31.0 percent reported in 2001. In 2005/2006, 10.9 percent of CSHCN in ND had any unmet needs for specific health care services compared to 12.8 percent in 2001. In 2005/2006, 18.5 percent of CSHCN's in ND had conditions that caused financial problems for the family compared to 24.0 percent in 2001.

In 2005/2006, 3.5 percent of ND respondents on the national survey reported any unmet needs for family support services. Families that have children with extraordinary medical needs may experience stress because of their additional care giving responsibilities.

- During FFY '07, the CSHS Division Director led three meetings of the Medical Needs Task Force, a group that was formed to address collaborative assessment and planning for children's extraordinary medical needs within the state of ND. Minutes are available for the videoconference meetings that were held during the year.
- A Medicaid waiver for medically fragile children was drafted. Its purpose was to provide assistance for families requiring long term supports in addition to Medicaid State Plan services in order to maintain their medically fragile child in a family home setting while meeting their child's unique medical needs. A news release was made available during the year to raise awareness of the opportunity for public comment on the draft waiver application. Comments received were summarized and suggested changes incorporated into subsequent drafts. The waiver was informally submitted to staff at the Centers for Medicare and Medicaid Services so that points of clarification could be addressed prior to final submission of the waiver via a web-based application system.
- CSHS staff monitored health care legislation and policies impacting children. Two major areas of expansion within the state included authorization of a new Medicaid buy-in eligibility category for children and a biennial appropriation to implement a new Medicaid waiver for children with extraordinary health care needs. Other highlights included: 1) 12-month continuous Medicaid eligibility for categorically needy children, 2) funding to sustain SCHIP outreach efforts and add income deductions, 3) funding to enhance the dental fee schedule for children's services, 4) enhanced funding for facilities that provide services to children who are medically fragile and those with behavior challenges, and 5) expansion of Medicaid and SCHIP eligibility if changes were addressed in federal SCHIP reauthorization.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS staff will co-lead periodic meetings of the medical needs task force to assess and plan for the health and related service needs of children with extraordinary medical needs in the state.				X
2. CSHS will monitor implementation of a new Medicaid waiver for medically fragile children to assess access to home and community based support and Medicaid State Plan services.				X
3. CSHS staff will monitor any state health care legislation that impacts children as well as policy changes that affect Medicaid,				X

SCHIP, Caring, or CSHS eligibility or covered services, including a the new Medicaid Buy-In program for CSHCN's.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

- CSHS staff are co-leading periodic meetings of the medical needs task force to assess and plan for the health and related service needs of children with extraordinary medical needs in the state.
- CSHS is monitoring implementation of a new Medicaid waiver for medically fragile children to assess access to home and community based support and Medicaid State Plan services.
- CSHS staff are monitoring any federal or state health care legislation that impacts children as well as policy changes that affect Medicaid, SCHIP, Caring, or CSHS eligibility or covered services, including a the new Medicaid Buy-In program for CSHCN's.

**c. Plan for the Coming Year**

- CSHS staff will attend periodic meetings of the medical needs task force as well as other pertinent workgroups to assess and plan for the health and related service needs of children with extraordinary medical needs in the state.
- CSHS will monitor implementation of a new Medicaid waiver for medically fragile children to assess access to home and community based support and Medicaid State Plan services.

**State Performance Measure 9:** *The percent of families who reported they “had no problem at all” in getting care for their child from a specialist doctor.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				77	78
Annual Indicator			75.6	75.6	75.6
Numerator			264	264	264
Denominator			349	349	349
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	79	80	81	82	83

**Notes - 2007**

2007-The source for this data is the 2003 National Children's Health Survey, question S5Q09A.

**Notes - 2006**

The source for this data is the 2003 National Children's Health Survey, question S5Q09A.

**Notes - 2005**

The source for this data is the 2003 National Children's Health Survey, question S5Q09A.

**a. Last Year's Accomplishments**

According to the 2005/2006 National Survey of Children with Special Health Care Needs, 96.2 percent of ND children received all the care from a specialty doctor that he/she needed, which is

slightly higher than the nationwide figure of 94.6 percent. There were 15.6 percent of CSHCN in ND who needed a referral who had difficulty getting it compared to 21.1 percent nationally. In the 2005 Child Health Survey, 75.6 percent of families reported they had no problem getting care from a specialist doctor.

In 2007, ND had 129 pediatricians and pediatric sub-specialists, an increase from the 120 identified in 2006. Eight-six percent were located in the four primary population hubs in the state. The majority of pediatric subspecialty physicians practice on the eastern border of ND, which requires many families to travel long distances for their child to receive specialty care. Frequently, there is only one sub-specialist of a particular type in the state. If that sub-specialist retires or moves, families are left without an in-state provider, which results in out-of-state travel to receive services.

- CSHS directly managed three types of multi-disciplinary clinics (Cleft, Cardiac and Scoliosis) and contracted with a variety of entities for seven additional types of multi-disciplinary clinic services including cerebral palsy, pediatric neurorehabilitation, asthma, metabolic disorders, diabetes, myelodysplasia and developmental assessment clinics.
- CSHS produced a 2007 Multidisciplinary Clinic Directory that listed multidisciplinary clinics that were available to children with special health care needs and their families. This directory was distributed to over 2,500 community agencies and providers. The Shriners Clinic in Minneapolis, MN conducted two outreach clinics in ND. The site and dates of the Shriners outreach clinics were included in the Multidisciplinary Clinic Directory to promote the service. The State experienced limited use of telemedicine for children with special health care needs.
- State level staff referred families to available services and providers within ND and to resources outside the state if there was a need. Staff also provided information related to the child's special health care need. Some families required extensive support to coordinate care provided by multiple providers and payers. This was especially true for children with complex dental/medical concerns.
- Guidelines of care were distributed to families seen in the Multidisciplinary Clinic Program and the Specialty Care Program. The guidelines were also provided to families and community providers at conference display opportunities.
- During FFY 2007, CSHS provided diagnostic and treatment services to 314 eligible children.
- CSHS maintained a list of participating providers. Provider certification status was reviewed on an annual basis as a quality assurance measure. The small number of providers that had a lapse in certification were contacted and encouraged to maintain board certification in their specialty.
- Travel assistance was discussed at the 2007 Medical Advisory Council meeting. Information regarding available travel support options has been collected and will be included in a fact sheet.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCNs and their families.	X			
2. CSHS will monitor status of specialty care providers.				X
3. CSHS will support access to pediatric specialty providers through use of telemedicine or other technology and/or through promotion of outreach services such as Shriners clinics and the cardiac program.			X	
4. CSHS will provide state level care coordination to link CSHCN and their families to specialty health services in the state.		X		
5. CSHS will disseminate guidelines of care with ND resource inserts.		X		
6. CSHS will provide diagnostic and treatment services provided by participating specialists, to eligible uninsured and	X			

underinsured CSHCN.				
7. CSHS will maintain a list of participating providers including their current board certification status.		X		
8. CSHS will explore transportation support options to help families with health-related travel expenses (e.g.) provide travel reimbursement or assistance for eligible children, develop a transportation fact sheet, etc.		X		
9.				
10.				

**b. Current Activities**

- CSHS is directly managing and funding a variety of multidisciplinary clinic services for CSHCNs and their families.
- CSHS is monitoring the status of specialty care providers.
- CSHS is supporting access to pediatric specialty providers through use of telemedicine or other technology and/or through promotion of outreach services such as Shriners clinics and the cardiac program.
- CSHS is providing state level care coordination to link CSHCN and their families to specialty health services in the state.
- CSHS is disseminating guidelines of care with ND resource inserts.
- CSHS is providing diagnostic and treatment services provided by participating specialists, to eligible uninsured and underinsured CSHCN.
- CSHS is maintaining a list of participating providers including their current board certification status.
- CSHS is exploring transportation support options to help families with health-related travel expenses (e.g.) providing travel reimbursement or assistance for eligible children, developing a transportation fact sheet and exploring other potential funding sources, etc.

**c. Plan for the Coming Year**

- CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCNs and their families.
- CSHS will enhance access to specialty care by monitoring the status and location of pediatricians and pediatric sub-specialists within the state and disseminating the information through the CSHS multi-disciplinary clinic directory.
- CSHS will support access to pediatric specialty providers through use of outreach services such as Shriners clinics and the cardiac program.
- CSHS will provide state level care coordination to link CSHCN and their families to specialty health services in the state.
- CSHS will provide diagnostic and treatment services provided by participating specialists, to eligible uninsured and underinsured CSHCN.
- CSHS will maintain a list of participating providers including their current board certification status.
- CSHS staff will consider recommendations from the 2008 ULEND multidisciplinary clinic review and implement changes where determined appropriate.
- CSHS will inform health systems about the need for pediatric specialists and collaboratively support recruitment activities, if necessary.

**State Performance Measure 10:** *The percent of activities completed in the CSHS Public Information Services plan.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
--	-------------	-------------	-------------	-------------	-------------

Annual Performance Objective				91	92
Annual Indicator			89.7	97.2	79.5
Numerator			26	35	31
Denominator			29	36	39
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	80	82	84	86	88

**Notes - 2007**

2007-The source for this data is the 2007 CSHS Public Information Report.

**Notes - 2006**

The source for this data is the 2006 CSHS Public Information Report.

**Notes - 2005**

The source for this data is the 2005 CSHS Public Information Report.

**a. Last Year's Accomplishments**

The CSHS Public Information Services plan is a combination of activities that focus on the CSHS toll free number; targeted outreach, information and referral efforts; a resource library; educational and consultative services; other media or marketing events and activities; and systems development projects.

- A Public Information Services plan was developed at the beginning of the fiscal year that addressed each of the specified areas. Thirty-nine work activities were included in the plan.
- Quarterly meetings were held. Minutes from each of the quarterly minutes are available.
- An annual narrative report was completed. In 2007, 80 percent of the plan was completed (31/39 activities). An annual statistical report was also compiled.
- CSHS conducts a family survey every five years. The survey is the primary method that CSHS staff uses to determine the usefulness of the public information services that are provided by division staff. Family organizations funded by CSHS also provide information and referral services. Family Voices and the Family to Family Network gave presentations at a CSHS Family Advisory council meeting to report on their ongoing work efforts. During the year, Family Voices of ND also provided an annual statistical report and conducted satisfaction surveys regarding information families have received through the Health Information and Education Center.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS will develop a Public Information Services Plan that includes activities in the following areas: toll free number; targeted outreach, information and referral; resource library; education and consultation; marketing; and systems.				X
2. Quarterly meetings will be held to monitor the status of the public information services plan.				X
3. An annual report will be available to document plan accomplishments.				X
4. CSHS will coordinate with family organizations to determine effectiveness of information and referral efforts for the CSHCN population.				X
5.				
6.				

7.				
8.				
9.				
10.				

**b. Current Activities**

- CSHS is developing a Public Information Services Plan that includes activities in the following areas: toll free number; targeted outreach, information and referral; resource library; education and consultation; marketing; and systems.
- Quarterly meetings are being held to monitor the status of the public information services plan.
- An annual report is being developed to document plan accomplishments.
- CSHS is coordinating with family organizations to determine effectiveness of information and referral efforts for the CSHCN population.

**c. Plan for the Coming Year**

- CSHS will develop a Public Information Services Plan that includes activities in the following areas: toll free number; targeted outreach, information and referral; resource library; education and consultation; marketing; and systems.
- Quarterly meetings will be held to monitor the status of the public information services plan.
- An annual report will be available to document plan accomplishments.
- CSHS will coordinate with family organizations to determine effectiveness of information and referral efforts for the CSHCN population with emphasis on assessment of family preferences on methods for delivery.
- CSHS will disseminate health promotion information for people with disabilities (e.g.) include additional health promotion information to the "Well Child" packet.

**E. Health Status Indicators**

#01A: The percent of live births weighing less than 2,500 grams.

*/2009/ The percent of live births weighing less than 2,500 grams has remained stable over the last five years from 6.3 percent to 6.7 percent. 2007 data reports 6.3 percent. Drawing conclusions on this data is difficult due to the small numbers.*

**Refer to Section III. State Overview, F. HSCI #04 for program strategies in place to maintain and/or enhance this Indicator.**

**Refer to Section III. State Overview, F. HSCI #04 for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator.**

**The SSDI Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.//2009//**

#01B: The percent of live singleton births weighing less than 2,500 grams.

*/2009/ The percent of live singleton births weighing less than 2,500 grams has remained stable over the last five years from 4.6 to 5.0 percent. 2007 data reports 4.4 percent. Drawing conclusions on this data is difficult due to the small numbers.*

**Refer to Section III. State Overview, F. HSCI #04 for program strategies in place to maintain and/or enhance this Indicator.**

**Refer to Section III. State Overview, F. HSCI #04 for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator.**

**The SSDI Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.//2009//**

#02A: The percent of live births weighing less than 1,500 grams.

**/2009/ The percent of live births weighing less than 1,500 grams has remained stable over the last five years from 1.1 percent to 1.4 percent. 2007 data reports 1.2 percent. Drawing conclusions on this data is difficult due to the small numbers.**

**Refer to Section III. State Overview, F. HSCI #04 for program strategies in place to maintain and/or enhance this Indicator.**

**Refer to Section III. State Overview, F. HSCI #04 for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator.**

**The SSDI Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.//2009//**

#02B: The percent of live singleton births weighing less than 1,500 grams.

**/2009/ The percent of live singleton births weighing less than 1,500 grams has remained stable over the last five years from 0.8 percent to 0.9 percent. 2007 data reports 0.8 percent. Drawing conclusions on this data is difficult due to the small numbers.**

**Refer to Section III. State Overview, F. HSCI #04 for program strategies in place to maintain and/or enhance this Indicator.**

**Refer to Section III. State Overview, F. HSCI #04 for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator.//2008//**

**The SSDI Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.//2009//**

#03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

**/2009/The death rate per 100,000 due to unintentional injuries among children age 14 years and younger have varied over the last five years from 9.2 to 14.6. The rate for 2007 is 6.2. Drawing conclusions on this data is difficult due to the small numbers.**

**The leading cause of death to children ages 1 to 14 in ND are due to unintentional injuries. Program strategies in place to maintain and/or enhance this Indicator include: education regarding the ND child passenger safety law that requires children younger than seven years of age to ride in a child restraint and children 7 through 17 years of age to ride in a seat belt; statewide car seat distribution programs; education on child passenger safety is distributed statewide for parents, caregivers, agencies and more; car seat checkups are available for the public to visit to reduce misuse of car seats; maintenance of the ND Poison Control Center that includes the distribution of educational materials and**

***promotion of the annual Poison Prevention Week in which ND poison statistics are released with information about the hotline and what to do if there is a suspected poisoning; distribution of bike safety educational materials to public health departments, Safe Communities Programs, law enforcement, Safe Kids coalitions and other injury prevention advocates; promotion of Bike Safety month in May; promotion of child passenger safety month in September, product safety recall effectiveness checks in the state and the publication of a quarterly newsletter to educate the public about product safety issues and prevention of future injuries and deaths associated with consumer products.***

***The SSDI Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.//2009//***

#03B: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger.

***/2009/ The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger have varied over the last five years from 1.5 to 6.2. The rate for 2007 is 1.5. Drawing conclusions on this data is difficult due to the small numbers.***

***The leading cause of death to children ages 1 to 14 in ND are injuries due to motor vehicle crashes. Program strategies in place to maintain and/or enhance this Indicator include: education regarding the ND child passenger safety law that requires children younger than seven years of age to ride in a child restraint and children 7 through 17 years of age to ride in a seat belt; statewide car seat distribution programs; offering statewide car seat checkups to the public and developing/distributing public education and information on child passenger safety. The DoH facilitates over 40 statewide car seat distribution programs, while approximately 14 cities in ND offer regularly scheduled car seat checkup clinics to the public. The DoH also offers child passenger safety trainings to professionals ranging from one hour to the 32-hour national cps certification course.***

***The SSDI Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.//2009//***

#03C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

***/2009/ The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth ages 15 through 24 have varied over the last five years 13.4 to 27.9. The rate for 2007 is 25.9. Drawing conclusions on this data is difficult due to the small numbers.***

***The leading cause of death to youth ages 15 through 24 in ND are injuries due to motor vehicle crashes. Program strategies in place to maintain and/or enhance this Indicator include: assisting the ND Department of Transportation with new projects as needed for this age group and distribution of educational materials to the public and other agencies regarding occupant protection.***

***The SSDI Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.//2009//***

#04A: The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.

***/2009/ The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger in 2005 was 128.4., 141.3 in 2006 and the rate for 2007 is 165.4. This rate has slowly increased.***

***Refer to HSI #03A for program strategies in place to maintain and/or enhance this Indicator.***

***The SSDI Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.//2009//***

#04B: The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.

***/2009/ The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 13 years and younger have varied over the last five years from 194.8 to 298.8. The rate for 2007 is 194.8. Data sources for this Indicator have changed, hence; drawing conclusions cannot be made at this time. Now that a consistent data source has been identified, trends will be monitored and conclusions can be determined.***

***Refer to HSI #03B for program strategies in place to maintain and/or enhance this Indicator.***

***The SSDI Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.//2009//***

#04C: The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

***/2009/ The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 14 through 24 years have varied over the last five years from 1426.2 to 1814.2. The rate for 2007 is 1,426.2, which is a slight decrease from previous years. Data sources for this Indicator have changed, hence; drawing conclusions cannot be made at this time. Now that a consistent data source has been identified, trends will be monitored and conclusions can be determined.***

***Refer to HSI #03C for program strategies in place to maintain and/or enhance this Indicator.***

***The SSDI Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.//2009//***

#05A: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

***/2009/ The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia has varied over the last five years from a low of 11.6 percent in 2001 to high of 19.1 percent in 2007. Increase awareness and testing may account for the increase.***

***Program strategies in place to maintain and/or enhance this Indicator include: STD testing available through local public health and Family Planning programs to this age group without parental consent and state-wide abstinence-only education programs/activities.***

***The SSDI Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and***

*policy development.//2009//*

#05B: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

*/2009/ The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia have varied over the last five years from a low of 3.4 percent in 2002 to a high of 11.8 percent in 2007. Increase awareness and testing may account for the increase. The chlamydia incidence rate for ages 15 through 19 years is more than double this rate (15). This could indicate that this older age group is better prepared for sexual activity.*

*Program strategies in place to maintain and/or enhance this Indicator include: STD testing and services available through local public health units, Family Planning clinic and private clinics/physicians.*

*The SSDI Coordinator collects the data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development.//2009//*

#06A & B: Infants and children aged 0 through 24 years enumerated by sub-populations of age group, race, and ethnicity.

*/2009/ Estimates for the infant and child population aged 0 through 24 years show a continued decrease from 2004 to 2007. In 2007, the total population 0 through 24 years was 213,844. ND remains predominately white, with American Indians the largest minority population. There has been an increase in the American Indian population from 22,056 in 2006 to 23,489 in 2007. In addition, ND has a small Hispanic population, which grew from 5,246 in 2006 to 9,564 in 2007. The 2007 estimate indicates that there is an increase in more than one race reported from 4,909 in 2006 to 8,428 in 2007. Although racial minorities in ND continue to represent a relatively small proportion of the state total population, their numbers are growing.*

*The SSDI Coordinator is responsible for collecting data for this measure in collaboration with the State Data Center. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring/evaluation and policy development. //2009/*

*#07A & B: Live births to women (of all ages) enumerated by maternal age, race and ethnicity.*

*/2009/ Live births to women of all ages increased from 8,616 in 2006 to 8,801 in 2007. Figures for 2007 reflect preliminary data from the Vital Records Division. ND remains predominately white, with American Indian the largest minority population and a very small Hispanic population. Native American and Hispanic populations are increasing slightly in the state. 10.8 percent of live births were to American Indian women, 2.1 percent were to women 17 or younger, and 9.7 percent were to women age 35 and older.*

*Refer to Section III. State Overview, F. HSCI #04 for program strategies in place to maintain and/or enhance this Indicator.*

*Refer to Section III. State Overview, F. HSCI #04 for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator.*

*//2009//*

#08A & B: Deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race and ethnicity.

*/2009/ Deaths to infants and children aged 0 through 24 have increased slightly from 155 in*

**2005 to 169 in 2007. American Indian's have a higher rate of deaths in proportion to the population. 38.5 percent of deaths occurred in the first year of life. Nearly half of all deaths occurred for children aged 15 through 24 (49.7 %).**

**Refer to Section III. State Overview, F. HSCI #04, #09B and HSI's (this section) #03A, #03B, #03C and #06A & B for program strategies in place to maintain and/or enhance this Indicator.**

**Please refer to Section III. State Overview, F. HSCI #04 and #09B for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator. //2009//**

#09A & B: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race and ethnicity.

**//2009/ Generally, infants and children aged 0 through 19 years have decreased since 2000 while the percentage of single parents has increased. Over the years, fluctuations are apparent in many of the identified program categories. Between 2006 and 2007, increases have been noted in Medicaid, SCHIP, Food Stamps, and Juvenile Crime while decreases have occurred in TANF, Foster Care, and in the percent of high school drop outs. WIC participation remained the same in 2006 and 2007 as new data was not yet available. For many programs, ethnicity is not reported.**

**The SSDI Coordinator is responsible for collecting data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring, evaluation, and policy development. //2009//**

#10: Geographic living area for all resident children aged 0 through 19 years.

**//2009/ In ND, the 2007 census estimate indicated 80,079 children aged 0 to 19 lived in metropolitan areas, 100,128 lived in urban areas, 83,336 lived in rural areas and 37,642 lived in frontier areas. Overlap between categories may occur with this data. The total number of children 0 to 19 in urban, rural and frontier areas was 221,106. Comparing urban, rural and frontier living areas, 45.3 percent lived in urban areas, 37.7 percent lived in rural areas, and 17 percent lived in frontier areas.**

**Three leading trends influencing the state's future population, which are used to project future county populations within ND are: 1) rural depopulation, 2) out-migration of young adults and young families, and 3) an increasing proportion of elderly. Decades of movement of rural residents to the larger cities have depopulated much of rural ND. Currently, more than half of the 53 counties in the state have a population base below 5,000 residents. In the last decade, population growth occurred largely in the metropolitan and Native American reservation counties of the state. The long-term trend of net out-migration is expected to continue. The loss of residents in their twenties and early thirties has increased markedly over the past two decades. The loss of young adults means that there will be fewer parents of childbearing age and therefore fewer children. If current trends continue, the number of elderly in the state will grow by 58 percent over the next 20 years and represent nearly 23 percent of the state's population.**

**ND experienced an overall net outmigration of 1,277 people between 2005 and 2006. During the same time, the state experienced 2,494 more births than deaths (a natural increase). In terms of overall population statewide, there was a loss of children ages 0 to 19. Between 2000 and 2005, children ages 0 to 19 decreased by 26,975 or 14.7 percent. Nationally, the number of children grew 1.6 percent.**

**The SSDI Coordinator is responsible for collecting data for this measure. The SSDI**

***initiative supports the MCH program in accessing relevant information for program monitoring, evaluation and policy development. //2009//***

#11: Percent of State population at various levels of the federal poverty level.

***//2009/ The percent of the State population at the lower end of the federal poverty level has worsened slightly from 2005 to 2007. The percent below 50 percent of the FPL increased from 3.4 percent in 2005 to 5.2 percent in 2007. The percent below 100 percent of the FPL also increased from 10.1 percent in 2005 to 11.9 percent in 2007. However, the percent below 200 percent of the FPL decreased slightly from 30.1 percent in 2005 to 29.2 percent in 2007.***

***The SSDI Coordinator is responsible for collecting data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring, evaluation and policy development. //2009//***

#12: Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.

***//2009/ The percent of the State population aged 0 through 19 years at the lower end of the federal poverty level has worsened from 2005 to 2007. The percent below 50 percent of the FPL increased from 5.2 percent in 2005 to 9.9 percent in 2007. The percent below 100 percent of the FPL also increased from 13.6 percent in 2005 to 17.5 percent in 2007. However, the percent below 200 percent of the FPL decreased slightly from 37.6 percent in 2005 to 36.8 percent in 2007.***

***The SSDI Coordinator is responsible for collecting data for this measure. The SSDI initiative supports the MCH program in accessing relevant information for program monitoring, evaluation and policy development. //2009//***

## **F. Other Program Activities**

The Domestic Violence/Rape Crisis Program provides grants to domestic violence/rape crisis, law enforcement, courts and prosecutorial agencies to reduce and prevent violence against women.

The Family Violence Prevention and Services Program assists in establishing, maintaining, and expanding programs and projects to prevent family violence and to provide immediate shelter and related assistance for victims of family violence and their dependents. Grant funds are distributed on a formula basis to 17 of 19 domestic violence/rape crisis agencies and to the state domestic violence coalition. Uses for the funds include: providing group and individual counseling; community, school, and professional prevention education presentations; funds crisis lines; and, providing emergency shelter for victims of domestic violence.

Rape Crisis grant funds provides services to victims of sexual assault. These funds are distributed on an equal basis to 17 of the 19 domestic violence/rape crisis agencies to manage crisis lines and provide services to victims of sexual assault.

Rape Prevention and Education grant funds are used to educate communities about sexual assault and to develop programs to prevent it. These funds are distributed on a formula basis to 19 domestic violence/rape crisis agencies to support educational seminars, crisis hotlines, training programs for professionals, development of informational materials, and special programs for underserved communities. The state domestic violence/sexual assault coalition also receives funds to implement prevention projects for middle schools and campuses on a statewide basis.

Safe Haven funds are used to help create safe places for visitation with and exchange of children

in cases of domestic violence, child abuse, sexual assault, or stalking. The ND Council on Abused Women's Services (NDCAWS) (state domestic violence/sexual assault coalition) and five local visitation centers receive funds to build an infrastructure of a statewide network of providers and enhance and strengthen local services to families.

Grants to Encourage Arrest Policies and Enforcement of Protection Orders Program recognizes domestic violence as a crime that requires the criminal justice system to hold offenders accountable for their actions through investigation, arrest, and prosecution. NDCAWS has been contracted to oversee management of the project. NDCAWS will collaborate with Minot State University's Rural Crime and Justice Center and the Northern Plains Tribal Judicial Training Institute, and a multidisciplinary advisory team from local law enforcement, domestic violence/rape crisis, tribal and prosecution agencies to assist in implementing the grant goals. The grant goals are to develop a model law enforcement domestic violence policy for North Dakota, develop a train-the trainer curriculum on local policy development, and create a pool of officers to serve as technical assistance and training resources for local law enforcement agencies and community response teams.

The Stop Violence Against Women formula grants program encourages the development and strengthening of effective law enforcement and prosecution strategies to address violent crimes against women and the development and strengthening of victims' services in cases involving violent crimes against women. Funds are allocated to 19 domestic violence/rape crisis agencies.

## **G. Technical Assistance**

Technical assistance has been requested for the following:

- 1) MCH Funding Formula - Assistance is needed to revise the MCH funding formula to local grantees due to continued reduction in MCH Block Grant funds. In addition, the funding formula has not been revised for numerous years.
- 2) NPM #03 Medical Home - Assistance is needed to assure progress in this national performance measure, which will require moving from informational/promotional activities to implementation with very limited resources. North Dakota is comparable to the United States in the percent of CSHCN who receive care in a medical home based on national SLAITS CSHCN survey data; however, only 44% of respondents in North Dakota indicated receiving effective care coordination when needed.
- 3) Data Systems Development - MCH program staff could benefit from technical assistance and/or training relating to data utilization/integration into program planning, implementation and evaluation. MCH programs are located within the Community Health Section (CHS), which includes six divisions (three of the divisions include MCH programs). The CHS does have an epidemiologist; however, this position provides support to the entire section, not just MCH programs. Limited time results in limited support, hence TA and /or training would be beneficial to increase staff knowledge and skills.

***//2009/ Revision to the Title V funding formula continues to be a priority. A technical assistance application was completed and submitted in May 2008. We are currently waiting to see if we will be selected to receive technical assistance. //2009//***

***//2009/ Techninical assistance is needed to complete the five year needs assessment to assure a comprehensive, reliable and accurate process.//2009//***

## **V. Budget Narrative**

### **A. Expenditures**

Please refer to the attached Word document.  
***An attachment is included in this section.***

### **B. Budget**

Please refer to the attached Word document.  
***An attachment is included in this section.***

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.