Maternal and Child Health Services
Title V Block Grant

State Narrative for
NORTH DAKOTA

Application for 2007
Annual Report for 2005

Document Generation Date: Wednesday, September 20, 2006

Table of Contents

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.
An attachment is included in this section.

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.

In June 2006, 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 10, 2006.

II. Needs Assessment

In application year 2007, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

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 the 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 touting 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 North Dakota Department of Health (DoH) and the North Dakota Department of Human Services (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 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//

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 competed in fall 2006. The Title V director has been an active participant in this process.//2007//

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//***

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 sited 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//

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 floatation 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)
HB1456: 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)
SB2004: 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//

/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//

/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//

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//

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, and Medicaid increased from 25,575 to 26,667. //2007//

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.state.nd.us/humanservices/info/pubs/docs/medical-recipientsurvey-results-detailed2004.pdf
/2007/ As of March 2006, 26,667 children were enrolled in Medicaid.//2007//

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//

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 it's cap and a waiting list will be established. //2007//

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//

/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//

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 Taskforce 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//

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. Relevant content is also included under the CSHCN service section.

State Program Collaboration with Other State Agencies and Private Organizations -- ND has many strong collaborative partnerships working at the state level. State CSHCN staff currently participates on 39 interagency committees, thus assuring collaboration on a wide range of issues of importance to CSHCNs and their families. One example that helps illustrate 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 (IDEA) Advisory Committee. A Memorandum of Understanding concerning cooperation and collaboration in providing services to young children age's birth through five in ND 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. For tables depicting uses of Title V funds at the local level proposed for FY 2006, refer to the following URL: http://www.ndmch.com/FY06UseOfTitleVFunds.doc
/2007/ For tables depicting uses of Title V funds at the local level proposed for FY 2007, refer to the following URL: http://www.ndmch.com/FY07UseOfTitleVFunds.doc//2007//

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, related service providers in the school setting, etc.

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 Interagency Coordinating Council, 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 unique to the region. 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, a group that was convened by the DHS in 2005.//2007//

Statutes and Their Impact

The State Health Officer 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 children with special health care needs.

The DoH functions in compliance with Chapter 28-32, Administrative Agencies Practice Act, North Dakota Century Code (NDCC). The Divisions of Family Health, Injury Prevention and

Control and Nutrition and Physical Activity, 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 Family Health. The WIC Program is administered within the Division of Nutrition and Physical Activity. The Domestic Violence Program is administered within the Division of Injury Prevention and Control. The Governor named the DoH the lead agency for the STOP Violence Against Women Program contained in the federal crime bill. The Division of Injury Prevention and Control 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 Family Health.

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.//2007//

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

The Family Planning Program 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, 74 percent of who were at or below 150% of the federal poverty level.
/2007/ In 2005, services were provided to 15,994 women and men, 64 percent of who were at or below 150% of the federal poverty level.//2007//

The Family Planning Program is included as a constituent program represented on the Memorandum of Agreement 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 Family Planning Program 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.

The Family Planning Program 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 newborn screening profile. Cystic Fibrosis 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 State Health Officer, 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.

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. In 2004, a total of 546 clients were served through OPOP clinics.

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.

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 Sudden Infant Death Syndrome (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.
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 (CCRR) to implement and coordinate a safe sleeping environment for infants/children under the age of one.

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 Family Planning Program 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.

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 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 Grant was recently

submitted for $488,337.

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 (Child and Adolescent Health Coordinator), who represents child and adolescent issues on various committees and workgroups, such as the Asthma State Workgroup and the School Health Interagency Workgroup.

The Coordinated School Health Program 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 coordinate school health 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.

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 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 with no conditions, 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//

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 Injury Prevention and Control 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//

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.

The Oral Health Program provides prevention education, screening and consultation and administers school fluoride programs. Program staff collaborate 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 Centers for Disease 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.

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 conduct a variety of outreach activities related to the SSI program, including a mailing to families notifying them about programs that could be of assistance that provides contact information if further support is needed. Annually, state CSHCN staff convenes a meeting between 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.

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, which is monitored through the department's state strategic planning process.

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

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 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.

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 (SSDI) grant administration, birth defects monitoring, needs assessment, performance and outcome monitoring, estimates of chronic disease prevalence, utilization and cost, and data-related publications.

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.

The Russell-Silver Syndrome Program is mandates payment for medical food and services related to growth hormone treatment for individuals with Russell-Silver Syndrome 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 participate 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 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 Early Hearing Detection and Intervention (EHDI) Program. One grant focuses on continued hospital screening prior to hospital discharge and the other on follow-up, diagnosis and referral. In 2006, a HRSA performance review was completed for the EHDI program.//2007//

2) The State Asthma Workgroup -- 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 (BRFSS), and successful legislation relating to student's possession and self-administration of medication for the treatment of asthma and anaphylaxis.
/2007/ The State Asthma Workgroup 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//

3) National CSHCN Objectives have been addressed, in part, through team efforts funded by a Medical home CATCH grant. The ND 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 Early Childhood Comprehensive Systems 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 by ND is funded.

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

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, State Health Officer, 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. Dr. Dwelle has been presenting this course over the last year to DoH staff.

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.//2007//

/2007/ In April 2006, ND received an award of $75,000 funded by the Department of Health 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//

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.

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//

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: http://www.ndmch.com/MCHOrganizationalChart.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//

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, is responsible for the administration of programs carried out with allotments made to the state by Title V. The state health officer 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 state health officer implements state laws governing the department within the guidance of the governor and the regulations adopted by the State Health Council. In addition, the state health officer is a statutory member of about a dozen boards and commissions. Governor John Hoeven appointed Terry Dwelle, M.D., to the Office of State Health Officer 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, Arvy Smith, assists the state health officer in implementing state laws governing the department and serves on several boards and commissions in lieu of the state health officer. In addition, the deputy state health officer provides leadership in administrative and support functions for the department. Ms. Smith was appointed as the Deputy Health Officer 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.

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 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 Healthy North Dakota priorities and initiatives. Melissa Olson was named director of Healthy North Dakota 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 Healthy North Dakota 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//

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)
Nurse Consultants 2.5 BSN's (Maternal/Infant, Child/Adolescent, Newborn Screening)
Dental Hygienists 1.0 RDH (Program Director and two out-stationed)
Support Staff 2.5 (Admin Assistant III, Admin Assistant I, Student and Permanent Temp)
Data Processing Coordinator 0.8 BS Computer Science
* Total Funded by Title V 6.9
/2007/6.6//2007//

Family Health (not funded)
Director 0.9 BNSc (CSHP)
Nurse Consultants 1.5 BSN (Abstinence, ECCS, Title X)
Dental Hygienist 1.75 RDH (CDC, HRSA - Program Director and five out-stationed)
Family Planning/Women's Health 1.0 MBA (Title X)
Support Staff 0.7 (Title X, CSHP -- Admin Assistant I and Permanent Temp)
* Total Not Funded by Title V 5.85
/2007/5.95//2007//

Injury Prevention and Control (funded)
Program Admin 1.0 BS Business Admin
Health Educator 1.0 BA Health
Support Staff 1.0 (Admin Assistant I)
* Total Funded by Title V 3.0
/2007/2.6//2007//

Injury Prevention and Control (not funded)
Director 1.0 BSN (STOP and FVPS)
Program Admin 1.0 BA Business Admin (CDC, HRSA)
* Total Not Funded by Title V 2.0
/2007/1.4//2007//

Nutrition and Physical Activity (funded)
Director 0.1 MPH, LN
Nutritionist 1.0 LRD
* Total Funded by Title V 1.1

Nutrition and Physical Activity (not funded)
Director 0.9 MPH, LN (WIC)
Nutritionist 2.0 LRD (WIC)
Support Staff 1.0 Office Assistant II (WIC)
* Total Not Funded by Title V 3.9

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.

CSHS 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 CSHS 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 Children's Special Health Services (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.

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 State Health Officer. 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 & Office Assist III
* Total Funded by Title V 7.0

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//

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.

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.

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.

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.

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//***

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.

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.

/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//

F. Health Systems Capacity Indicators

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	15.0	15.0	15.0	15.0	15.7
Numerator	59	59	59	59	26
Denominator	39400	39400	39400	39400	16613
Is the Data Provisional or Final?				Final	Final

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, calender year Medicaid data was used for this measure. Previously, claims from multiple payers were utilized.

Narrative:

/2007/ For 2005, Medicaid claims data was used for this measure, as overall asthma hospitalization discharge rates were only available through year 2000. The rate of Medicaid-eligible children hospitalized for asthma was 15.7, slightly higher than the 15.0 reported in year 2000. Lower socioeconomic status of the Medicaid population may attribute for this slight increase in asthma severity. Refer to Section III. State Overview, B. Agency Capacity, Services for CSHCN for activities related to asthma.//2007//

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	55.1	71.0	74.1	78.1	79.2
Numerator	1492	1916	2176	2455	2642
Denominator	2707	2698	2935	3145	3335
Is the Data Provisional or Final?				Final	Final

Notes - 2005

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

Narrative:

/2007/ The percent of Medicaid enrollees under age one with an initial or periodic screen has increased steadily from 44.7 percent in 1995 to 79.2 percent in 2005. Refer to Section III. State Overview, E. State Agency Coordination for activities related to Early Periodic Screening Diagnosis and Treatment Program.//2007//

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	78.7	85.0	87.0	82.0	82.6
Numerator	133	96	67	50	76
Denominator	169	113	77	61	92

Is the Data Provisional or Final?				Final	Final

Notes - 2005
The source for this data is a special report run by Blue Cross Blue Shield of North Dakota.

Narrative:
/2007/ The ND SCHIP plan was initiated in 1999. Since 2002, at least 80 percent of enrollees under age one have received a periodic screen. Refer to Section III. State Overview, A. Overview, Health Care Coverage, for activities related to Covering Kids and Families.//2007//

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	87.1	87.7	88.1	88.0	88.3
Numerator	6630	6787	7030	7196	7387
Denominator	7612	7739	7976	8179	8367
Is the Data Provisional or Final?				Final	Final

Notes - 2005
The source of data is from the North Dakota Department of Health, Division of Vital Statistics.

Narrative:
/2007/ In 2005, 88.3 percent of ND women received adequate prenatal care as measured by the Kotelchuck index. This percent has changed little in the last five years. Refer to Section III. State Overview, B. Agency Capacity, for activities related to the Optimal Pregnancy Outcome Program (OPOP). Nine clinics throughout the state continue to provide OPOP services; however, funding for program activities has remained flat for a number of years.//2007//

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	63.0	78.3	79.8	75.7	91.1
Numerator	23029	27653	30702	30995	34643
Denominator	36575	35328	38494	40950	38016
Is the Data Provisional or Final?				Final	Final

Notes - 2005
The source for this data is the North Dakota Department of Human Services, Medical Services Division.

Narrative:
/2007/ The percent of Medicaid-eligible children who have received a service paid by the Medicaid Program increased from 75.7 percent in 2004 to 91.1 percent in 2005. This change is likely due to a variation in methodology rather than an actual substantial increase in children who have received a service. Refer to Section III. State Overview, E. State Agency Coordination, Medicaid for collaboration activities.//2007//

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	52.6	39.9	42.4	34.7	34.8
Numerator	3711	2755	3140	2946	2953
Denominator	7051	6909	7413	8495	8475
Is the Data Provisional or Final?				Final	Final

Notes - 2005

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

Narrative:

/2007/ Since 2002, less than half of all children ages six through nine (6-9) in the Medicaid EPSDT program have received dental services each year. For 2005, about one-third or 34.8 percent received any dental services during the year. Refer to Section III. State Overview, B. Agency Capacity, Preventive and Primary Care Services for Children for activities related to the Oral Health Program.//2007//

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	8.5	8.8	9.4	9.5	9.7
Numerator	238	245	266	283	294
Denominator	2808	2769	2833	2985	3022
Is the Data Provisional or Final?				Final	Final

Notes - 2005

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

Narrative:

/2007/ The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs (CSHCN) Program has remained at about nine percent over the last five years. A slight upward trend is apparent as the percent was 8.5 percent in 2001 and was 9.7 percent in 2005. Refer to Section III. State Overview, B. Agency Capacity, Services for CSHCN for SSI related activities.//2007//

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

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

Percent of low birth weight (< 2,500 grams)	2005	payment source from birth certificate	29.7	70.3	6.4

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

Narrative:
/2007/ Overall, there has been little change in this indicator from 2004 to 2005. Continued efforts through OPOP and collaboration with Medicaid have contributed to the maintenance of this indicator.//2007//

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2005	payment source from birth certificate	2.7	4.3	7

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

Narrative:
/2007/ Overall, there has been little change in this indicator from 2004 to 2005. Continued efforts through OPOP and collaboration with Medicaid have contributed to the maintenance of this indicator.//2007//

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2005	payment source from birth certificate	25	75	85.1

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

Narrative:
/2007/ Overall, there has been little change in this indicator from 2004 to 2005. Continued efforts through OPOP and collaboration with Medicaid have contributed to the maintenance of this indicator.//2007//

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 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2005	payment source from birth certificate	25.6	74.4	88.3

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

Narrative:
/2007/ Overall, there has been little change in this indicator from 2004 to 2005. Continued efforts through OPOP and collaboration with Medicaid have contributed to the maintenance of this indicator.//2007//

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2005	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2005	140

Notes - 2007
Source of this data is the North Dakota Department of Human Services, Medicaid Program.

Notes - 2007
Source of this data is the North Dakota Department of Human Services, SCHIP Program.

Narrative:
/2007/ Eligibility levels have remained unchanged for the identified population group over the last several years.//2007//

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

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 6) (Age range 6 to 19) (Age range to)	2005	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 6) (Age range 6 to 19) (Age range to)	2005	 140 140

Notes - 2007
Source of this data is the North Dakota Department of Human Services, Medicaid Program.

Notes - 2007
Source of this data is the North Dakota Department of Human Services, SCHIP Program.

Narrative:
/2007/ Eligibility levels have remained unchanged for the identified population group over the last several years.//2007//

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

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2005	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2005	140

Notes - 2007
Source of this data is the North Dakota Department of Human Services, Medicaid Program.

Notes - 2007
Source of this data is the North Dakota Department of Human Services, SCHIP Program.

Narrative:
/2007/ Eligibility levels have remained unchanged for the identified population group over the last several years.//2007//

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

DATABASES OR	Does your MCH program have	Does your MCH program

SURVEYS	the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES 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
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	2	Yes

Notes - 2007

There is concern with the Hospital Discharge Survey as a dependable data source.

Consistency to obtain data was impacted by turnover in the SSDI Coordinator position.

The 5 year PRAMS grant was not awarded to the state of North Dakota.

Narrative:

Annual linkages of infant birth and infant death certificates

/2007/ Birth and infant death certificates have been linked and made available electronically to Title V staff since 1994. These linked files have been analyzed for program planning purposes. Data linkages are a primary focus of the 2007-2011 SSDI grant.//2007//

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files

/2007/ Birth certificate files and Medicaid eligibility claims files have been linked on several occasions for specific analytic projects. Title V staff have direct access to the electronic Medicaid records. Data linkages are a primary focus of the 2007-2011 SSDI grant.//2007//

Annual linkage of birth certificates and WIC eligibility files

/2007/ To date, birth certificate and WIC files have not been linked. The ND WIC Program

has recently developed a new client data system. It is anticipated that linkage of birth certificate and WIC files will occur in the near future. Data linkages are a primary focus of the 2007-2011 SSDI grant.//2007//

Annual linkage of birth certificates and newborn screening files
/2007/ Birth certificate and newborn screening files have been linked since 1996. This linkage has helped identify the characteristics of infants not screened as well as assess the characteristics of women who breastfeed at hospital discharge. Data linkages are a primary focus of the 2007-2011 SSDI grant.//2007//

Registries and Surveys

Hospital discharge survey for at least 90 percent of the In-State discharges
/2007/ Title V staff have electronic access to hospital discharge data. In the past, program staff have analyzed this data for a number of programmatic purposes; however, there is concern with the hospital discharge survey as a dependable data source.//2007//

Annual birth defects surveillance system
/2007/ The state has developed a passive birth defects monitoring system. In the past, Title V staff have managed the database which is available electronically for program planning purposes. Ranking fell from a 3 to a 2 this year because consistency to obtain data was impacted by turnover in the SSDI Coordinator position. The SSDI Coordinator is responsible for the birth defects surveillance system in ND. Surveillance Registries are a primary focus of the 2007-2011 SSDI grant.//2007//

Survey of recent mothers at least every two years (like PRAMS)
/2007/ ND completed a Point-In-Time PRAMS Survey in 2002 and issued its ND PRAMS report in 2004. ND applied but did not receive a five-year PRAMS grant. Plans are to reapply as grant funds become available or explore the feasibility of conducting a state New Mother survey. PRAMS data dissemination is an activity within the 2007-2011 SSDI grant.//2007//

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

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

Notes - 2007

Narrative:
/2007/ The DoH collaborates with the North Dakota Department of Public Instruction to complete the YRBS every two years and has access to the database for analysis. ND students who currently smoke cigarettes decreased from 40 percent in 1995 to 22 percent in 2005. YRBS data analysis and dissemination are primary focuses of the 2007-2011 SSDI grant.//2007//

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			100	100	100
Annual Indicator		100.0	100.0	100.0	100.0
Numerator		6	6	8	15
Denominator		6	6	8	15
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100

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
The Newborn Screening Program Policies and Procedures Manual is an ongoing work effort. The Newborn Screening Program developed the 'Guidelines for Healthcare Providers.' The Newborn Screening Program follow-up staff traveled throughout the state and distributed these manuals as well as provided education about the changes in newborn screening.

The Newborn Screening Advisory group met in March, June, August and December in 2005.

There was also an ad hoc group that met twice to discuss adding Cystic Fibrosis to newborn screening panel.

The newborn screening program was transferred to the Division of Family Health.

Dr. Sara Copeland and Stan Barbaric from the Iowa lab visited North Dakota in April 2005 to meet with the state pediatricians, CSHS staff as well as the newborn screening follow-up staff. Dr. Copeland did a presentation at the pediatric meeting.

CSHS provided financial support through a service contract for four multidisciplinary metabolic disorders clinics during the year. 15 individuals were served with a total of 20 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 21 eligible individuals with PKU and MSUD. 95% 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 coordination via unit metabolic long term follow-up meetings, assessment of clients for diet compliance, assistance with insurance billing and payment access issues, and information and coordination of metabolic products and available services between the multidisciplinary metabolic team, local providers, state and local partners, and families.

A CSHS staff member was a member of the newborn screening advisory committee and participated in telephone conference call meetings.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The MCH Newborn Screening Program follow-up policies and procedures will be revised and updated, including the expanded MS/MS screening follow-up.				X
2. The Newborn Screening Program Advisory Group will meet by conference call at least four times during 05.				X
3. Transitioning the Newborn Screening Program from the Division of Nutrition & Physical Activity to the Division of Family Health was completed.				X
4. The Newborn Screening Program will invite the Iowa Biochemical Geneticist, Dr. Sara Copeland, to North Dakota to meet with the Newborn Screening Program, CSHS Staff and Advisory Committee members, and if possible to speak at the 2005 meeting of the N				X
5. CSHS will support multidisciplinary clinics for children and women of childbearing age with metabolic disorders.	X			
6. CSHS will provide metabolic food to eligible individuals with PKU and MSUD.	X			
7. CSHS will provide state level care coordination to eligible individuals with PKU and MSUD.		X		
8. CSHS staff will participate on the newborn screening advisory committee.				X
9. In January 2006, Cystic Fibrosis was added to the newborn screening panel. To date, there have been four confirmed cases			X	

and 15 carriers identified.				
10.				

b. Current Activities
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 long term follow-up services through state level care coordination to eligible individuals with PKU and MSUD.

The Metabolic Program Procedure Guide used in CSHS will be updated as needed.

The Newborn Screening Advisory Committee will meet by conference call at least four times during 2006.

Distribution and education of the NBS Guidelines to healthcare agencies.

Distribution of Parent Fact Sheets to healthcare agencies.

Title V staff will participate in the Heartland Genetics and Newborn Screening Collaborative.

In January 2006, Cystic Fibrosis was added to the newborn screening panel. To date, there have been four confirmed cases and 15 carriers identified.

c. Plan for the Coming Year
Develop dissemination plan to distribute the newborn screening brochure and a "newborn screening video" for parents/families in local clinics, WIC, public health units and healthcare providers.

Establish a Protocol Committee team to review the newborn screening protocols on an ongoing basis.

Incorporate newborn screening information in the newsletter sent to parents in the first year of life (Parenting Newsletter).

The Newborn Screening Program Advisory Committee will meet by conference call at least two times per year and 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 long term follow-up services through state level care coordination to eligible individuals with PKU and MSUD.

Title V staff in DHS and DoH will coordinate via monthly newborn screening meetings to address emerging issues (e.g.) information needs, outreach, continuum of services, etc.

The Metabolic Program Procedure Guide used in CSHS will be updated as needed.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			61.5	61.5	61.5
Annual Indicator		61.5	61.5	61.5	61.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	65	65	65	65	65

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.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
CSHS offered financial support and reimbursement to Family Advisory Council members to support participation in quarterly meetings of the council as well as topical meetings of interest and CSHS training related events. CSHS utilized a process to record advice and recommendations from Advisory Council members for consideration in program and policy decisions.

CSHS provided financial support through contracts to two family organizations in the state: Family Voices of ND and the Family-to-Family Support Network. These organizations provide health information, training, and emotional support for CSHCN and their families. CSHS staff

members serve on the boards of these two organizations. In addition, a CSHS staff member participates on the steering committee that plans and organizes the annual Family Connections Conference, which provides families and professionals opportunities for joint training.

Program narrative addressing quality assurance is required in all CSHS grant applications. Potential grantees describe specific quality assurance strategies related to the program or project they hope will be funded. Client satisfaction assessments are included in this description and results are monitored throughout the contract period. Satisfaction was also measured through state performance measures required in the Department of Human Services. A scripted telephone survey was conducted of 10% of families served by CSHS in the last fiscal year. 100% of individuals/families served by CSHS reported services received met their needs, a result showing improved health status, chronic disease management or access to information and resources.

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 and serving on advisory boards as requested.		X		
3. CSHS will continue to include client satisfaction assessments as part of overall quality assurance efforts in CSHS service contracts.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHS will continue to assess client satisfaction as one of the measures of quality assurance in service contracts administered by the State CSHCN program.

CSHS will continue to include family advice and recommendations from a Family Advisory Council when making program and policy decisions.

CSHS will support the activities of family organizations in the state by providing financial assistance through contracts and serving on advisory boards as requested.

CSHS will conduct a telephone survey to determine the percent of individuals/families served by CSHS reporting services received met their needs.

c. Plan for the Coming Year

CSHS will continue to include family advice and recommendations from a Family Advisory Council when making program and policy decisions.

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.

CSHS will enhance client satisfaction assessments and measures as part of the overall quality assurance efforts within the unit (e.g.) contract services, clinics, state telephone survey, etc.

CSHS will support activities that promote family/professional collaboration (e.g.) Family Connections Conference, parent/youth leadership development opportunities, Early Childhood Comprehensive Systems plan, initiating/sustaining relationships with additional family organizations, etc.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			54.7	54.7	54.7
Annual Indicator		54.7	54.7	54.7	54.7
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	60	60	60	60	60

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.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
CSHS provided information on medical homes for CSHCNs to providers and families. The state office sent information to 32 individuals via well child/immunization information packets. Family Voices, an organization that CSHS contracts with to provide family health information services, provided information to 1,835 individuals. Through Community Access to child Health (CATCH) grant activities and focus groups, 21 individuals that attended the community meetings received information on medical homes for CSHCNs. A survey regarding medical homes was sent to 636 individuals; 146 surveys were returned (39 from PCP, 91 from community partners and 16 from families).

CSHS collaborated with the ND Early Childhood Comprehensive Systems grantee to increase the number of health care provider practices that incorporate the seven medical home core components. The ND Early Hearing Detection and Intervention program had a North Dakota Chapter American Academy of Pediatrics representative on its Advisory Board. Results of the

newborn hearing screening were shared with the infant's Primary Care Provider. CSHS staff, along with a representative from a family organization and the transition coordinator from the ND Department of Public Instruction, attended the Champions for Progress Multi-state meeting. Champions for Progress focused on the six core performance measures for CSHCN. The ND team focused on furthering the medical home concept and transition services. CSHS staff also collaborated with two family organizations in the state to submit a Champions for Progress Incentive Award but were not awarded funding.

CSHS monitored the medical home status of children served through CSHS and receiving Medicaid. 91 percent of the children served through the CSHS Care Coordination program were determined to have a medical home. In the last Medicaid customer survey (2004), 82.4 percent of the respondents in the Women, Families and Children aid category indicated they had one person they thought of as their personal doctor, who they saw most of the time.

97 percent of the children receiving CSHS care coordination services had a current written service plan. The care coordination plan was revised to reduce duplication. The social study and service plan were also combined to document a thorough assessment, plan/interventions, and required quarterly contacts.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHS will provide information on medical homes for CSHCNs to providers and families.			X	
2. CSHS will collaborate with partners to further the medical home concept and practice in North Dakota.				X
3. CSHS will monitor the medical home status of children receiving care coordination services through CSHS and Medicaid-eligible children.				X
4. Increase the percentage of children receiving CSHS care coordination services with a comprehensive, written service plan.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHS will provide information on medical homes for CSHCNs to providers and families.

CSHS will collaborate with partners who are interested in exploring next steps toward furthering the medical home concept and practice in North Dakota. Partners could include IHS, AAP, providers, family organizations, ECCS, MA, EHDI, etc.

CSHS will monitor the medical home status of children receiving care coordination services through CSHS.

CSHS will monitor the percentage of children receiving CSHS care coordination services with a comprehensive, written service plan.

CSHS will work through the Champions for Progress Team to further the Medical Home concept in ND.

c. Plan for the Coming Year
CSHS will distribute information on medical homes for CSHCNs 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. Partners could include Indian Health Service, ND Chapter of the American Academy of Pediatrics, family organizations, providers, Health Systems, Early Childhood Comprehensive Systems, Oral Health Program, Head Start, Medicaid PCP Program, Early Hearing Detection and Intervention, neighboring state Title V programs, etc.

CSHS will monitor the medical home status of children receiving care coordination services through CSHS.

CSHS will monitor the percentage of children receiving CSHS care coordination services with a comprehensive, written service plan.

CSHS will convene a Medical Home steering council that will meet one or two times during the FFY.

CSHS will develop a state medical home implementation plan that addresses staff resources, training, technical assistance, funding, etc.

CSHS will support medical home implementation in at least one pilot practice in the state by providing technical and/or financial assistance.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			62	62	62
Annual Indicator		62	62	62	62
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	65	65	65	65	65

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.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
93% of CSHCN's served by CSHS had a source of health care coverage during the year. A legislative committee began a study focusing on unmet needs and service gaps for the CSHCN population. Assessment and planning for children with extraordinary medical needs was also initiated.

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. 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 2005, CSHS provided diagnostic services to 98 children and treatment services to 204 children. The CSHS Medical Director determined medical eligibility. Applications taken at the County Social Service Office were reviewed for financial eligibility, coordination of benefits, and care coordination plans.

CSHS staff attended meetings related to Medicaid claims, the MMIS replacement project, administrative policy, and pediatric health care issues to influence Medicaid payment and policies for CSHCN's and their families.

Covering Kids and Families meeting minutes were reviewed to monitor activities. Staff within the DoH and the Medical Services Division of the DHS attended meetings. A joint application for Medical Assistance (Medicaid) and Healthy Steps (SCHIP) is available. Enhancements were made to the VISION system that supported enrollment of children into the appropriate health coverage programs. The 1-800-KIDS-NOW phone number transitioned from the Robert Wood Johnson grantee to the Medical Services Division.

Survey results were disseminated in three primary ways: 1) the Title V planning retreat PowerPoint presentation, 2) the CSHS website, and 3) through presentations to various groups or committees.

Staff monitored legislation during the 2005 session. Three bills that had a major impact on CSHCN's and their families included SB 2395 (Russell Silver Syndrome and Medicaid waiver), HCR 3054 (CSHCN study), and SB 2163 (Asthma and anaphlaxis possession and self administration of medication).

SSDI staff provided a minumal level of data support to help identify chronic conditions that could potentially be included in Medicaid's disease management program, once implemented.

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 and assess underinsurance issues for special demographic characteristics of CSHCN.				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 and Caring programs.		X		
3. CSHS will provide diagnostic and treatment services to eligible uninsured and underinsured CSHCN.	X			

4. CSHS staff will participate in meetings within Medical Services related to claims payment, Medicaid policy, or services to CSHCN and their families.				X
5. CSHS staff will monitor the developments of the state Covering Kids grant.				X
6. CSHS will disseminate results from the CSHCN SLAITS and CSHS Family Surveys that pertain to health insurance coverage.				X
7. CSHS staff will monitor any health care legislation that impacts children as well as policy changes that affect Medicaid eligibility or covered services.				X
8. CSHS will explore collaboration with Medicaid to explore models of chronic disease management.				X
9.				
10.				

b. Current Activities

CSHS will monitor the number of CSHCNs served by CSHS with a source of health care coverage and assess underinsurance issues for special demographic characteristics of CSHCN.

CSHS will conduct activities to refer and link families that have CSHCN to available sources of health care coverage such as Medicaid, CHIP and Caring programs.

CSHS will provide diagnostic and treatment services to eligible uninsured and underinsured CSHCN.

CSHS staff will participate in meetings within Medical Services related to claims payment, Medicaid policy, or services to CSHCN and their families.

CSHS staff will monitor the developments of state Covering Kids and Families grant.

CSHS will participate in work activities to support the rewrite of the Medicaid Management Information System (MMIS).

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, CHIP and Caring programs.

CSHS will provide diagnostic and treatment services to eligible uninsured and underinsured CSHCN.

CSHS staff will participate in meetings within Medical Services related to claims payment, MMIS system development, Medicaid policy, the Deficit Reduction Act, or services to CSHCN and their families.

CSHS staff will monitor any state health care legislation that impacts children as well as policy changes that affect Medicaid, SCHIP, Caring, or CSHS eligibility or covered services.

CSHS will participate in writing and submitting a Medicaid waiver for children with extraordinary medical needs to increase access to home and community-based support services.

CSHS will partner with others to support outreach regarding health coverage options and health

benefits counseling/training (e.g.) ECCS, family organizations, Community Resource Coordinators, Insurance Commissioner's office, 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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			83.4	83.4	83.4
Annual Indicator		83.4	83.4	83.4	83.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	85	85	85	85	85

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.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
CSHS conducted an annual training for county social service workers and public health care coordinators in October 2004. 34 people attended and evaluations were positive. State CSHCN staff provided technical assistance to county social service workers, public health care coordinators, contracted service providers, and other health care providers via phone, e-mail, and periodic site visits.

Annually, CSHS develops a Public Information Plan. For FY 2005, 26 out of 29 plan activities were completed (90%). Major activities included the toll-free number; targeted outreach, information and referral efforts; a resource library; educational/consultative services; and other media or social marketing events and activities. A Public Information report is available.

CSHS staff participated on 39 interagency workgroups and committees during FFY 2005, which is up from 33 in FFY 2004.

CSHS supported ten different types of clinics, three of which were managed by the state CSHCN staff and seven that were funded through contracted services. 302 children received contracted clinic services and 691 children received services through the clinics directly managed by the CSHS staff.

CSHS held a statewide clinic coordinator telephone conference in September 2005. Four of the five clinic coordinators, along with other members of their organization, were able to participate in

the telephone conference. A representative from Family Voices also participated. CSHS staff continues to provide ongoing technical assistance throughout the year to clinic contract providers.

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 an annual training opportunity for county social service staff and public health nurses.				X
2. CSHS will provide public information services to improve access to care including operation of a family resource center.			X	
3. CSHS staff will participate in interagency workgroups and committees whose focus is improved access to services for CSHCN.				X
4. CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCNs and their families.	X			
5. CSHS will collaborate with other stakeholders to enhance the multidisciplinary clinic infrastructure in the state by conducting a clinic coordinator meeting.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHS will enhance capacity of local staff to implement CSHS programs by providing technical assistance and an annual training opportunity for county social service staff and public health nurses.

CSHS staff will participate in interagency workgroups and committees whose focus is improved access to services for CSHCN.

CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCNs and their families.

CSHS will collaborate with other stakeholders to enhance the multidisciplinary clinic infrastructure in the state by conducting a clinic coordinator meeting.

CSHS will work through the Champions for Progress Team to implement community-based systems of care for children and youth with special health needs and their families.

c. Plan for the Coming Year

CSHS will enhance capacity of local staff to implement CSHS programs by providing technical assistance and an annual training opportunity for county social service staff and public health nurses.

CSHS staff will participate in interagency workgroups and committees whose focus is improved access to services for CSHCN.

CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCN's and

their families.

CSHS will collaborate with other stakeholders to enhance the multidisciplinary clinic infrastructure in the state by conducting a clinic coordinator meeting.

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.

CSHS will participate in writing and submitting a Medicaid waiver for children with extraordinary medical needs to increase access to home and community-based support services.

CSHS will partner with family organizations to assist families of CSHCN's in locating services (e.g.) promote toll-free numbers, 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	2001	2002	2003	2004	2005
Annual Performance Objective			5.8	5.8	5.8
Annual Indicator		5.8	5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	10	10	10	10	10

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.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
A CSHS staff member participated on the State Transition Steering Council led by the Department of Public Instruction. Champions for Progress focused on the six core performance

measures for CSHCN. Two CSHS staff members attended the Champions for Progress meeting in September. The ND team focused on furthering the medical home concept and transition services. Family Voices, an organization that CSHS contracts with to provide family health information services, provided transition information through 117 encounters and 13 meetings in 2005. Family Voices of ND also developed a transition notebook.

CSHS monitored the level of transition service planning for children ages 14-21 for CSHCNs served by CSHS with written service plans. During FY 2005, 65 percent of children age 14-21 had an assessment or service plan that addressed transition issues. A transition section was added to the revised service plan to help give focus on transition for clients served ages 14 up to 21.

Current bylaws allow youth or young adults with special health care needs to serve on the CSHS Family Advisory Council. No youth or young adults are currently serving on the advisory council.

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 70 children receiving SSI and their families. An annual meeting was held in August 2005 with Medicaid, the Social Security Administration, Disability Determination Services, Family Voices, and state CSHCN program staff.

CSHS conducted a health transition outreach mailing targeting 374 families served by CSHS with youth ages 14-21. A new transition letter has been drafted, which will be sent approximately three months prior to a CSHS client's 21st birthday that provides information regarding possible sources of health care coverage. Information on transition has been reported to the CSHS Family Advisory Council, Medical Advisory Council, Clinic Coordinators, and County Social Service Workers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHS will collaborate with state and local entities and family organizations to promote health care transitions for CSHCN.				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 explore the inclusion of youth or young adults with special health care needs on the Family Advisory Council when recruiting members.				X
4. 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
5. CSHS will explore development and dissemination of "health" transition resources.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHS will collaborate with state agencies and family organizations to promote health care transitions for CSHCN (e.g.) Champions for Progress, Transition Steering Council, etc.

CSHS will monitor the level of transition service planning for children ages 14-21 for CSHCNs served by CSHS with written service plans.

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.

CSHS will promote transition through multidisciplinary clinics.

CSHS will disseminate health care transition resources.

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.

CSHS will monitor the level of transition service planning for children ages 14-21 for CSHCN's served by CSHS with written service plans.

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.

CSHS will disseminate health care transition resources.

CSHS will promote transition through multidisciplinary clinics and care coordination programs.

CSHS staff will collaborate with the Department of Public Instruction to conduct a state transition conference.

CSHS will assemble a pool of youth as potential applicants for the CSHS Family Advisory Council.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	84	82	79	79.5	80
Annual Indicator	78.7	77.7	80.4	78.4	82.0
Numerator	18578	18342	18979	18507	18325
Denominator	23606	23606	23606	23606	22348
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	82.5	83	83.5	84	84.5

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

Memorandum of Agreement signed June 1, 2003. Will remain in effect until further review is required.

Immunization updates were provided at the Regional Public Health Nurse's meetings, Public Health Director of Nurses meeting, school nurse meeting, and the Head Start Health Coordinator's meeting.

Local public health units used funding dollars to support immunization administration.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to collaborate with the Immunization Program through the Memorandum of Agreement.				X
2. Collaborate with the Immunization Program to provide trainings/updates to public health, school nurses, childcare and head start on immunization recommendations.				X
3. Provide funding to local public health units to fund immunization administration.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Continue to collaborate with the Immunization Program through the Memorandum of Agreement.

Collaborate with the Immunization Program to provide trainings/updates to public health, school nurses, child care and head start on immunization recommendations.

Provide funding to local public health units to fund immunization administration.

c. Plan for the Coming Year
Continue to collaborate with the Immunization Program through the Memorandum of Agreement.

Collaborate with the Immunization Program to provide trainings/updates to public health, school nurses, child care and head start on immunization recommendations.

Provide funding to local public health units to fund immunization administration.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005

Annual Performance Objective	16.1	16.1	12	11.5	10
Annual Indicator	12.3	11.5	10.9	10.2	10.5
Numerator	562	523	492	462	478
Denominator	45512	45512	45339	45339	45339
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	10	9.5	9.5	9	9

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 denominator is a three year average.

a. Last Year's Accomplishments
All of the eight regions of the state as well as one of the Indian Reservations, received funding for abstinence education activities in their local communities.

Grantees have utilized consistent speakers in their local communities from the past few years.

Collaboration continues on a regular basis with Family Planning, Adolescent Health, HIV and STD programs.

Communication with the local grantees has continued in relation to programming.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with Family Planning, Adolescent Health, STD and HIV programs and the Department of Public Instruction as part of regional stakeholders group.				X
2. Providing technical assistance to the local grantees to provide quality Abstinence Education with their present and future programming.				X
3. In November 2005, the mechanism for awarding abstinence funding was changed to a competitive, Request for Proposal (RFP) process.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Collaborate with Family Planning, Adolescent Health, STD and HIV programs and the Department of Public Instruction as part of regional stakeholders group.

Providing technical assistance to the local grantees to provide quality Abstinence Education with their present and future programming.

In November 2005, the mechanism for awarding abstinence funding was changed to a competitive, Request for Proposal (RFP) process. Currently, there are three grantees -- two provide statewide programs (Make a Sound Choice and Students Against Destructive Decisions)

and one provides a community-based program (Williston Community Action). ND did not receive the Community-based Abstinence Education Grant that was applied for in 2005. In March 2006, the Abstinence Education Program supported Make a Sound Choice (a non-profit, abstinence until marriage program) in their application for a Community-based Abstinence Education grant. Make a Sound Choice will be notified in September 2006 regarding their application approval or denial.

c. Plan for the Coming Year

The State Abstinence Project Director will participate in a 'Regional Stakeholders/Partners 'group to discuss issues of unintended pregnancy.

The North Dakota Department of Health will continue to seek funds for Abstinence Education.

Communicate and collaborate with the Abstinence subgrantees to assist them in utilizing quality speakers.

Collaborate with partners such as Family Planning and Adolescent Health to support efforts in reducing teen births.

The Child and Adolescent Health Nurse Consultant will provide resources and technical assistance to school nurse on such topics as puberty, STD's.

Family Planning Program delegate agency staff will provide educational sessions to schools upon request on such topics as contraception, abstinence, family life education and STD'S.

The Family Planning Program will provide direct confidential medical, counseling, laboratory and contraceptive services to adolescents.

Family Planning delegate agency staff will provide educational resources to parents about how to talk to their children about sexuality issues.

Family Planning delegate agency staff will provide counseling and educating 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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	54	54	54	55	56
Annual Indicator	53.6	53.6	53.6	53.6	53.0
Numerator	178	178	178	178	3738
Denominator	332	332	332	332	7052
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	53.5	54	54.5	55	55.5

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

The third grade basic screening survey conducted during 2004-2005 was completed in May 2005. Major findings included: more than half (53%) of North Dakota's children have received a protective sealant which exceeds the HP 2010 goal of 50%; minority children have poorer oral health; at the time of the screening, 5 percent of the minority children had decay so advanced that they had pain or an infection; 56 percent of third graders have experienced tooth decay; 17 percent have untreated tooth decay; 80 percent reported that they drank soda or sugared beverages during the week; 27 percent reported that they had not brushed their teeth that day; and 3 percent reported they did not have their own toothbrush.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Job desription developed for an Oral Health Program position. A portion of this position will be assessing the need/feasibility for a school based/linked sealant program.				X
2. The ND Oral Health State Plan and the ND Oral Health Burden Document were completed in June 2006. The ND Oral Health Burden document contains information/data from the third grade basic screening survey. An Oral Health Conference is scheduled for				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Job desription developed for an Oral Health Program position. A portion of this position will be assessing the need/feasibility for a school based/linked sealant program. Interviews conducted in June 2006, however, the position is on hold until the Oral Health Program Director position is hired. (Oral Health Program Director resigned June 30, 2006.)

The ND Oral Health State Plan and the ND Oral Health Burden Document were completed in June 2006. The ND Oral Health Burden document contains information/data from the third grade basic screening survey. An Oral Health Conference is scheduled for September 29, 2006 to unveil these two documents.

c. Plan for the Coming Year

Continue to promote use of sealants through the regional oral health consultants.

Present sealant information at the Health Tracks and regional local public health nurses meetings.

Hire an oral health program manager whos task will be to assess the need/feasibility for a school based/linked sealant program.

Continue the school mouthrinse program targeted to schools with an increased number of students eligible for the free and reduced lunch program and no access to adequately fluoridated water.

Collaborate with Head Start and Medicaid to conduct dental services focus groups facilitated by Health Systems Research (HSR). Focus groups will talk to parents of children 0 to 18 years regarding their experiences accessing dental service for themselves and their child and to obtain input on possible solutions for addressing the needs of North Dakotans who need dental services but are not receiving them.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	4.3	3.9	2.9	2.8	4.7
Annual Indicator	3.0	3.6	3.8	5.6	5.6
Numerator	11	13	14	21	21
Denominator	366056	366056	366558	374218	374128
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	4.5	4	4	4	4

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.

Notes - 2004
Three-year averages are used to calulate rate to avoid fluctuations. Will monitor and continue with future year's objectives.

a. Last Year's Accomplishments
The program applied for and received funding from the ND Department of Transportation to continue its child passenger safety program.

The program supported 43 local car seat distribution programs by providing 2812 car seats. 294 of the seats were provided to five Indian reservations or service units in the state. The Car Seat Distribution Program Policy & Procedure Manual was revised and four regional mandatory workshops were conducted for staff who distribute seats.

The program worked with the ND Department of Human Services, Temporary Aid to Needy Family (TANF) to provide reimbursement to distribution programs for TANF clients who receive car seats from them.

The program assisted with 73 car seat checkups, inspecting 1195 car seats. The program provided lead checkers, technicians, car seats and supplies for the events.

North Dakota's Governor proclaimed October 2004 as Booster Seat Awareness Month. Six booster seat distribution events were held with 236 booster seats distributed.

Four 32-hour NHTSA standardized child passenger safety courses were held, certifying 31 new technicians.

Program staff conducted 13 other child passenger safety workshops, ranging from 2-8 hours with 273 participants. Participants included certified technicians, car seat distribution program staff, law enforcement officers, domestic violence program staff, childcare providers, Head Start parents, and ambulance personnel.

Provided routine technical updates to technicians and assisted them in maintaining their certification status.

Coordinated legislative efforts to strengthen North Dakota's child passenger safety law. The legislation passed and North Dakota's law now requires children under age 7 to ride in a car seat or booster seat.

Developed educational materials relating to the revised law and distributed to law enforcement, public and private health, child care providers, ambulance services, Head Start programs, schools, Safe Community programs, and other agencies/organizations that work with families of young children. Prepared and distributed a statewide news release and responded to numerous calls from media, professionals, and consumers.

Child Passenger Safety Month was celebrated in February 2005 with development of a new Buckle Up curriculum for grades 3-6. During the month, local agencies provided a buckle up message and supporting materials to 31,965 children pre-school through 6th grade.

The program providing ongoing educational information through public information materials, displays, news releases, car seat bounty programs, the Buckle Up newsletter, updates at committees and task force meetings, and presentations at workshops and conferences.

The program coordinated bike safety activities by providing educational materials, observing May as Bike Safety Month, developing two bike safety educational displays, and providing technical assistance and referrals to local agencies on low-cost helmet purchase.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Re-apply for ND Department of Transportation funds to administer the state's child passenger safety program; monitor expenditures, complete reports as required.				X
2. Continue educational efforts to increase the proper use of car seats through use of pamphlets, posters, displays, etc. Sponsor Child Passenger Safety Week in February 2005.			X	
3. 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.			X	
4. Assist local agencies in conducting car seat check-ups by providing certified instructors, technicians, car seats, and checkup supplies.				X
5. Continue coordinating the "Boost, Then Buckle" Campaign to encourage the use of booster seats by children from 40 to 80 pounds. Provide booster seats to local agencies to enhance the campaign.			X	

6. Promote use of "Buckle Up With Bucky" videotape, curriculum and other materials for grades K-2.			X	
7. Continue educational efforts to encourage the use of seat belt by children 3-6 through development of videotape, curriculum and other educational materials.			X	
8. Conduct 2-3 four-day NHTSA Standardized Child Passenger Safety Courses to certify new child passenger safety technicians. Conduct 2-3 refresher courses for current technicians and assist current technicians in meeting requirements for re-certificati				X
9. On an ongoing basis, provide technical assistance and updated information to technicians to maintain technical knowledge on child passenger safety issues. Write the "Buckle Update" section of the "Building Blocks to Safety" quarterly newsletter to p				X
10. Coordinate a bike safety project by providing technical assistance, training, educational materials, and bike helmets to local agencies. Continue to expand public information and education activities relating to bike helmet use.			X	

b. Current Activities

Re-apply for ND 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, etc. Sponsor Child Passenger Safety Week in February 2006.

Develop an educational campaign to inform North Dakota parents and caregivers about changes in the state's child passenger safety law. Provide information on the appropriate restraint for their child's age, weight, height, and developmental level.

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.

Continue educational efforts to encourage the use of recently-developed curriculums and videos for children grades K-2 and grades 3-6.

Conduct 2-3 four-day NHTSA Standardized Child Passenger Safety Courses to certify new child passenger safety technicians. Conduct 2-3 refresher courses for current technicians and assist current technicians in meeting requirements for re-certification.

On an ongoing basis, provide technical assistance and updated information to technicians to maintain technical knowledge on child passenger safety issues. Write the "Buckle Update" section of the "Building Blocks to Safety" quarterly newsletter to provide current information on child passenger safety.

c. Plan for the Coming Year

Re-apply for ND 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, etc. Sponsor Child Passenger Safety Week in February 2007.

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.

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.

Continue educational efforts to encourage the use of recently developed curriculums and videos for children grades K-2 and grades 3-6.

Conduct 2-3 four-day NHTSA Standardized Child Passenger Safety Courses to certify new child passenger safety technicians. Conduct 2 refresher courses for current technicians and assist current technicians in meeting requirements for re-certification.

On an ongoing basis, provide technical assistance and updated information to technicians to maintain technical knowledge on child passenger safety issues. 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 child passenger safety and occupant protection conference with the Department of Transportation.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					34.1
Numerator					10459
Denominator					30670
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	35	36	37	38	39

Notes - 2005
The data source is the National Survey of Children's Health 2003. The data is weighted estimates.

a. Last Year's Accomplishments
The nutritionist played an important role in promoting breastfeeding in the worksite wellness initiatives and that effort also helped frame some legislative activity regarding employer support (HB 1456). The nutrition testified in support of the bill, but it was defeated.

The MCH nutritionist worked closely with the Third Party Payer Committee to promote reimbursement for lactation consultants and breastpumps. The Committee prepared a document for Medicaid that outlined the benefits, the cost, references, etc to initiate a change in their

policies.

The nutritionist and the committee prepared and presented legislation (SB 2261) protecting a woman's right to breastfeed in public. The bill was defeated.

In the late fall of 2003 a survey was conducted among all ND hospitals. This year the Committee reviewed the survey findings to help develop a plan of action.

In August of 2005, all WIC agencies were provided "20 Ideas of Things to Do" and bookmarks, to promote World Breastfeeding Week.

WIC supported six WIC and Public Health Nursing staff at the Breastfeeding Lactation Counselor training held in November 2004. This is the fourth time we'd supported this week long training.

The WIC/MCH nutritionist presented at the Region VIII Head start Early Childhood Professional Institute in November 2004 on supporting working breastfeeding mothers.

The WIC/MCH nutritionist provided training on breastfeeding promotion and support to Child and Adult Care Food Program sponsors.

WIC purchased 7 electric breastpumps for the two peer counseling WIC agencies.

The Health Department has spent most of the year planning changes to its web site. Once the new site is up and running (January 2006) we will have opportunity to suggest breastfeeding data be added to the site.

ND WIC received funding for a three year Peer Counseling Program. Rolette County and Southwestern District Health Unit were chosen as the sites. Seven Peer Counselors were trained at the two sites this past year.

This past year, was year 2 of our 3 year Motivational Interviewing Research Project. Two MI and two control agencies were selected and staff were trained on MI techniques. Participants began enrolling in the program in the fall of 2004 and one of the emphasis areas was breastfeeding initiation and duration.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH Nutritionist will continue as the Department's liaison to the Healthy North Dakota Breastfeeding Committee (HNDBC).				X
2. MCH nutritionist and other members of the HNDBC will work to assure that breastfeeding support is a component of worksite wellness initiatives of the Healthy North Dakota Worksite Wellness Committee.				X
3. MCH Nutritionist or other members of the HNDBC will work with the North Dakota Workforce Safety and Insurance Program to include a breastfeeding component into a Worksite Wellness Incentive Program, which is under development.				X
4. MCH Nutritionist or other members of the HNDBC will work with the HND Third Party Payer Committee to promote reimbursement for lactation consultant services and electric breast pumps.				X
5. MCH Nutritionist or other members of the HNDBC will promote the implementation of Breastfeeding Friendly Hospital procedure in North Dakota hospitals.			X	

6. The state WIC Program will provide local agencies with resources for promotion of World Breastfeeding Week.			X	
7. Provide training on breastfeeding support in a childcare setting to the Child and Adult Care Food Program (CACFP) Sponsors.				X
8. If funding permits, WIC will purchase additional electronic breast pumps for use by mothers who are returning to work or school.		X		
9. Work with the Department's CDC epidemiologist and other data programs to get breastfeeding data on the Department's website.				X
10.				

b. Current Activities
MCH Nutritionist will continue as the Department's liaison to the Healthy North Dakota Breastfeeding Committee (HNDBC).

MCH nutritionist and other members of the HNDBC will work to assure that breastfeeding support is a component of worksite wellness initiatives of the Healthy North Dakota Worksite Wellness Committee.

MCH Nutritionist or other members of the HNDBC will work with the HND Third Party Payer Committee to promote reimbursement for lactation consultant services and electric breast pumps.

MCH Nutritionist or other members of the HNDBC will promote the implementation of Breastfeeding Friendly Hospital procedure in North Dakota hospitals.

The state WIC Program will provide local agencies with resources for promotion of World Breastfeeding Week.

If funding permits, WIC will purchase additional electric breast pumps for use by mothers who are returning to work or school.

Work with Department's CDC epidemiologist and other data programs to get breastfeeding data on the Department's website.

WIC staff will continue implementing a WIC Peer Counseling Program in North Dakota (second year of a three-year project).

Evaluate WIC site the WIC Motivational Interviewing Research Project, which includes increased breastfeeding duration as one of the evaluation components (final year of USDA Grant).

As co-host, begin planning for the biennial statewide breastfeeding conference that will be held in October 2006 in Fargo.

c. Plan for the Coming Year
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.

Identify and promote community breastfeeding experts and support groups as a support resource for breastfeeding mothers.

MCH Nutritionist will continue as the Department's liaison to the Healthy North Dakota Breastfeeding Committee (HNDBC).

Pursue "right to breastfeed" legislation for the 2007 legislative session, if HNDBC supports.

MCH nutritionist and other members of the HNDBC will work to assure that breastfeeding support is a component of worksite wellness initiatives of the Healthy North Dakota Worksite Wellness Committee; will work with the HND Third Party Payer Committee to promote reimbursement for lactation consultant services and electric breast pumps; will promote the increase of baby friendly breastfeeding practices in North Dakota hospitals.

The state WIC Program will provide local agencies with resources for promotion of World Breastfeeding Week.

If funding permits, WIC will purchase additional electric breast pumps for use by mothers who are returning to work or school.

Work with Department's CDC epidemiologist and other data programs to get breastfeeding data on the Department's website.

WIC staff will continue the WIC Peer Counseling Program in North Dakota (third year of a multi-year project).

After evaluation of the ND WIC Motivational Interviewing Research Project, utilize findings related to increased breastfeeding duration component, as appropriate.

Co-host and begin planning for the biennial statewide breastfeeding conference that will be held in 2008.

Encourage MCH and WIC staff to participate in the 2006 biennial breastfeeding conference or other offered breastfeeding training. State staff will assist in the conference organization and planning.

Encourage local MCH staff to pursue the development of local breastfeeding coalitions.

Encourage MCH staff to receive training and become certified as International Board Certified Lactation Consultants (IBCLC). State staff will assist in providing the training opportunity.

Provide breastfeeding support in childcare settings by offering training at Early Childhood Professional Institute and/or Childcare Health and Safety Summit.

State MCH staff will offer input on the selection of speakers and presentation topics for all Women's Health Summit conferences.

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	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	45	75	95	95	95.2
Annual Indicator	41.7	54.1	91.3	95.1	95.1
Numerator	3693	4779	8104	8743	8951
Denominator	8847	8839	8877	9191	9408
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	96	97	98	98	98

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
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 at Minot State University. This staff member functioned as the state implementation coordinator. Work efforts during the year focused on training of new grant management staff, attendance at the national conference and participation in the development of the Request for Proposal for continuation of the ND EHDI program. ND also received a three-year CDC EHDI grant, which supports Project Kaylyn. This project focused on infants needing diagnostic evaluations 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 2004 that were reported on in 2005, 95% 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 acts as the information hub for any new information relating to EHDI programs.

A CSHS staff member continued to be involved with EHDI grant activities addressing screening and follow-up. The ND EHDI program received a continuation grant for the period 4-1-05 to 3-31-08. A CDC EHDI grant was also received to assist in the continuation of the ND EHDI program (7-1-05 to 6-30-08).

CSHS monitored other early screening and detection systems for young children. The screening ratio of children that received an EPSDT screening in 2005 was 59 percent. 903 children received a home-based developmental screening through the Right Track program in CY 2005.

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 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. CSHS will analyze newborn hearing screening data and conduct short-term follow-up when EHDI grant activities are completed.				X
5. CSHS will monitor other early screening and detection systems for young children (e.g.) Health Tracks.				X

6.				
7.				
8.				
9.				
10.				

b. Current Activities
A CSHS staff member will serve on the grant management team and function as the state implementation coordinator for the EHDI Program.

CSHS will administer an annual newborn hearing screening survey to all birthing hospitals in the state.

A CSHS staff member will serve as the Title V state EHDI contact.

A CSHS staff will participate in stakeholders meetings regarding the tracking of infants through the hearing screening, referral, and the diagnostic process.

CSHS will monitor other early screening and detection systems for young children (e.g.) Health Tracks, Right Track, etc.

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 EHDI Program.

If needed for monitoring purposes, CSHS will administer and analyze an annual newborn hearing screening survey to all birthing hospitals in the state.

A CSHS staff member will serve as the Title V state EHDI contact.

CSHS will explore potential legislation to sustain the state EHDI program.

CSHS will partner with the North Dakota Center for Persons with Disabilities on the HRSA improvement plan.

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.

Performance Measure 13: *Percent of children without health insurance.*

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	16.3	10.3	7.8	7.7	7.4
Annual Indicator	7.9	7.4	7.5	7.5	8.0
Numerator	12707	11903	12064	12064	12868
Denominator	160849	160849	160849	160849	160849
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	7.3	7.2	7.1	7	6.9

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 Covering Kids and Families (CKF) Program Director provided regular updates to the CKF Executive Committee and Board. A quarterly newsletter was distributed which included enrollment information.

The Title V Director serviced on the CKF Executive Committee.

CKF Program Director provided information on the CHIP and Medicaid enrollment and application process at the local public health administrators and director of nursing meetings.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V staff will continue to participate in CHIP and Medicaid outreach activities through a Robert Wood Johnson Family Foundation "Covering Kids and Families" (CKF) grant awarded to Dakota Medical Foundation.				X
2. Title V staff will monitor enrollment levels in CHIP and Medicaid.				X
3. MCH and CSHS staff will provide information to county social service staff and local public health departments about CHIP and Medicaid enrollment and application procedures.				X
4. Title V Directir participated in the CKF sustainabilty planning meeting in June 2006. The CKF grant will end September 30, 2006. A six month extension can be applied for with carryover funds.				X
5. On March 8, 2006, the Early Childhood Comprehensive Systems (ECCS) implementation plan was submitted. The plan was approved with no conditions, and ND moved from the Planning to the Implementation Phase. One of the goals in the plan is to influence				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Title V staff will continue to participate in CHIP and Medicaid outreach activities through a Robert Wood Johnson Family Foundation "Covering Kids and Families" grant awarded to Dakota Medical Foundation.

Title V staff will monitor enrollment levels in CHIP and Medicaid.

MCH and CSHS staff will provide information to county social service staff and local public health departments about CHIP and Medicaid enrollment and application procedures.

Title V Directir participated in the CKF sustainabilty planning meeting in June 2006. The CKF grant will end September 30, 2006. A six month extension can be applied for with carryover

funds.

On March 8, 2006, the Early Childhood Comprehensive Systems (ECCS) implementation plan was submitted. The plan was approved with no conditions, and ND moved from the Planning to the Implementation Phase. One of the goals in the plan is to influence systems change to increase and sustain comprehensive healthcare coverage for all North Dakota children, ages 0-8. In August 2006, the ECCS Steering Committee will be meeting to determine how to allocate implementation funds.

c. Plan for the Coming Year
Title V staff will continue to participate in CHIP and Medicaid outreach activities through a Robert Wood Johnson Family Foundation "Covering Kids and Families" (CKF) grant awarded to Dakota Medical Foundation. The CKF grant will end September 30, 2006. A six month extension can be applied for with carryover funds. Title V Director will be involved in the CKF sustainabilty planning.

Title V staff will monitor enrollment levels in CHIP and Medicaid.

MCH 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 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. A specific goal in the plan that relates to health insurance is to influence systems change to increase and sustain comprehensive healthcare coverage for all North Dakota children, ages 0-8.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					16.2
Numerator					1020
Denominator					6299
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	16	15.8	15.6	15.4	15.2

Notes - 2005
The source of data is from Pediatric Nutrition Surveillance System (PedNSS).

a. Last Year's Accomplishments
NA, new performance measure.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Encourage WIC staff to utilize the "Parents Provide, Kids Decide" video and education cards.				X

2. "Turn off the TV" segment (with activity ideas for young children) in the monthly ND WIC client newsletter, the PICKWIC Paper.			X	
3. Encourage WIC staff to educate mothers on low fat milk choices.				X
4. The Maternal and Child Health local public health nutritionists throughout the state have made "Fit Kids = Happy Kids" posters and handouts available to Head Start classrooms, child care centers, WIC and elementary classrooms K-6. The posters are in			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Encourage WIC staff to utilize the "Parents Provide, Kids Decide" video and education cards.

"Turn off the TV" segment (with activity ideas for young children) in the monthly ND WIC client newsletter, the PICKWIC Paper.

Encourage WIC staff to educate mothers on low fat milk choices.

The Maternal and Child Health local public health nutritionists throughout the state have made "Fit Kids = Happy Kids" posters and handouts available to Head Start classrooms, child care centers, WIC and elementary classrooms K-6. The posters are intended to promote healthy weight. They list six simple steps that encourage children and families to make healthy choices regarding food, physical activity and other daily routines.

c. Plan for the Coming Year
Encourage WIC staff to utilize the "Parents Provide, Kids Decide" video and education cards.

Continue "Turn off the TV" segment (with activity ideas for young children) in the monthly ND WIC client newsletter, the PICKWIC Paper.

Adopt proposed USDA VENA standards related to physical activity as appropriate.

Apply MI findings on TV viewing, low fat milk and juice consumption components, if applicable.

Encourage WIC staff to educate mothers on low fat milk choices.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					
Numerator					

Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	15	14.5	14	13.5	13

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
NA, new performance measure.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WIC, Optimal Pregnancy Outcome Program (OPOP) and Family Planning Program delegate agency staff will educate clients with positive pregnancy tests about the importance of not smoking and refer as appropriate.		X		
2. OPOP staff will conduct teaching and anticipatory guidance regarding pregnancy and smoking cessation and reduction strategies.		X		
3. OPOP staff will distribute information on local cessation programs and smoking effects on the fetus.		X		
4. Tobacco Cessation Coordinators and OPOP staff will use educational materials geared towards pregnant smoking women with information on the ND Quitline.		X		
5. OPOP and Family Planning staff will participate in the Partnership for Tobacco Prevention and Cessation for Women of Reproductive Age workgroup.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
WIC, Optimal Pregnancy Outcome Program (OPOP) and Family Planning Program delegate agency staff will educate clients with positive pregnancy tests about the importance of not smoking and refer as appropriate.

OPOP staff will conduct teaching and anticipatory guidance regarding pregnancy and smoking cessation and reduction strategies.

OPOP staff will distribute information on local cessation programs and smoking effects on the fetus.

Tobacco Cessation Coordinators and OPOP staff will use educational materials geared towards pregnant smoking women with information on the ND Quitline.

OPOP and Family Planning staff will participate in the Partnership for Tobacco Prevention and Cessation for Women of Reproductive Age workgroup.

c. Plan for the Coming Year
WIC, OPOP and Family Planning Program delegate agency staff will educate clients with positive pregnancy tests about the importance of not smoking and refer as appropriate.

OPOP staff will conduct teaching and anticipatory guidance regarding pregnancy and smoking cessation and reduction strategies.

OPOP staff will distribute information on local cessation programs and smoking effects on the fetus.

Tobacco Cessation Coordinators and OPOP staff will use educational materials geared towards pregnant smoking women with information on the ND Quitline.

OPOP and Family Planning staff will continue to participate in the Partnership for Tobacco Prevention and Cessation for Women of Reproductive Age workgroup.

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	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	19.5	15.7	11	10.5	9.8
Annual Indicator	11.2	8.7	6.2	9.9	10.6
Numerator	18	14	10	16	17
Denominator	160350	160854	160854	160854	160854
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	10	9.8	9.6	9.4	9.2

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
Coordinated and chaired six meetings of the ND Adolescent Suicide Prevention Task Force.

Coordinated development of an updated State Plan for Suicide Prevention, including obtaining and reviewing appropriate data, sub-contracting with a consultant to analyze and prepare the plan, coordinating task force meetings to develop recommendations and action steps, and providing general oversight for the plan.

Arranged for $15,000 of Preventive Health Block grant funds to be contracted to the Mental Health Association of North Dakota for gatekeeper training. Local trainers conducted 31 workshops with 1259 participants. Additionally, MHAND staff conducted 30 workshops (suicide prevention or mentoring) reaching 1696 individuals.

Arranged for $33,000 in State Health Department funds to be provided to Standing Rock Reservation because of epidemic suicide rates they were experiencing. Funds were used for home-based tracking and follow-up, gatekeeper training, teen leadership development, and community outreach.

Met with several legislators to discuss appropriation of general fund dollars for statewide suicide

prevention efforts. Funds were approved for $30,000, but were earmarked specifically for Standing Rock Reservation.

Attended a Congressional Hearing chaired by Senator Byron Dorgan to discuss high rates of suicide among Native Americans.

Received notice from the Epidemiology Section of the American Public Health Association that the ND Adolescent Suicide Prevention Project was awarded their 2005 Public Health Practice Award.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue coordinating and chairing the State Adolescent Suicide Prevention Task Force.				X
2. Assist the Mental Health Association of ND in identifying funding to continue its suicide prevention efforts.				X
3. Update the “State Plan for Adolescent Suicide Prevention” to include information on suicides for all ages.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Continue coordinating and chairing the State Adolescent Suicide Prevention Task Force.

Assist the Mental Health Association of ND in identifying funding to continue its suicide prevention efforts.

Continue work on the "State Plan for Adolescent Suicide Prevention" to include information on suicides for all ages.

c. Plan for the Coming Year
Continue coordinating and chairing the State Adolescent Suicide Prevention Task Force.

Apply for the State/Tribal Youth Suicide Prevention Grant.

Collaborate with the Mental Health Association of ND to coordinate use of State General Funds to the Standing Rock Indian Reservation.

Print and distribute the updated "State Plan for Adolescent Suicide Prevention."

Address suicide in the ND Injury Prevention Coalition's logic model.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	64	64	59	60	50
Annual Indicator	58.0	53.9	51.7	45.0	46.0
Numerator	51	48	46	50	46
Denominator	88	89	89	111	100
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	47	48	49	50	51

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
Reviewed data and monitored outcomes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to monitor.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Continue to periodically reassess.

c. Plan for the Coming Year
Continue to periodically reassess.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	86	86.5	85	85.5	86
Annual Indicator	84.5	85.5	86.5	84.9	85.1
Numerator	6478	6627	6900	6937	7130
Denominator	7664	7755	7976	8173	8381

Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	86.5	87	87.5	88	88.5

Notes - 2005
The source of this data is the North Dakota Department of Health, Division of Vital Statistics.

a. Last Year's Accomplishments
PRAMS data distributed December of 2005.

Funding is provided to the nine Optimal Pregnancy Outcome Program (OPOP) sites.

OPOP staff continue to provide educational resources to clients. Additional resources are available on our website.

OPOP data distributed statewide.

OPOP All-Staff meeting was held in September 2005.

MCH staff continue to participate with the March of Dimes and Healthy Pregnancy Task Force meetings.

MCH continues to provide funding for Spirit Lake Sioux program at Fort Totten to provide prenatal care, infant care and immunizations, and Trenton Indian Health Center to support Healthy Start and Indian Health Center coordination.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Distribute PRAMS data when available.				X
2. MCH will provide partial funding to the nine OPOP sites within the state. In 2005, a total of 450 clients were served through OPOP clinics. In November 2005, ND applied to and was accepted by the Graduate Student Internship Program with the purpose	X			
3. OPOP sites will provide educational material to clients.		X		
4. OPOP contact information and a resource guide entitled, “Services Offered to Women and Children by Public and Private Agencies Statewide” are posted on the MCH website.			X	
5. OPOP data will be distributed statewide on prenatal care and birth outcomes.				X
6. Coordinate statewide meetings of OPOP coordinators and staff.				X
7. MCH will continue to provide funding for Spirit Lake Sioux program at Fort Totten to provide prenatal care, infant care and immunizations, Trenton Indian Health Center to support Healthy Start and Indian Health Center coordination, and Healthy Start				X
8.				
9.				
10.				

b. Current Activities

PRAMS data distributed.

MCH will continue to provide partial funding to the nine OPOP sites within the state.

OPOP sites will continue to provide educational material to clients.

OPOP contact information and a resource guide entitled, "Services Offered to Women and Children by Public and Private Agencies Statewide" are posted on the MCH website.

OPOP data will be distributed statewide on prenatal care and birth outcomes.

Coordinate statewide meetings of OPOP coordinators and staff.

In 2005, a total of 450 clients were served through OPOP clinics. In November 2005, ND applied to and was accepted by the Graduate Student Internship Program with the purpose to evaluate the effectiveness of a multi-county maternal risk reduction program (OPOP). From June through August 2006, a graduate student will be working with the OPOP providing evaluation services. The final report will include evaluation procedures, findings, limitations and conclusions.

MCH will continue to provide funding for Spirit Lake Sioux program at Fort Totten to provide prenatal care, infant care and immunizations, Trenton Indian Health Center to support Healthy Start and Indian Health Center coordination, and Healthy Start and Indian Health Services Prenatal activities.

c. Plan for the Coming Year

WIC staff will screen for initiating of prenatal care and refer as needed.

OPOP Director will develop a plan of action from the evaluation recommendations and share results with appropriate staff.

OPOP staff will identify barriers to accessing prenatal care and explore options for overcoming barriers.

OPOP staff will distribute prenatal vitamins with folic acid.

OPOP staff will discuss hazards during pregnancy and the importance of prenatal care.

WIC, CSHS and OPOP staff will continue to participate in March of Dimes (MOD) meetings.

WIC staff participate in the MOD prematurity campaign.

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.

Healthy Start will remain active on one Indian reservation.

The Birth Review mailing will distribute a fact sheet promoting the importance of early and adequate prenatal care.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					53.4
Numerator					58064
Denominator					108671
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	54	55	56	57	58

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
This was a new state performance measure in FFY 2006.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Local MCH staff will participate in the development of local community walking programs.			X	
2. State and local MCH staff will participate in promoting the 5+5 Program.			X	
3. State and local MCH staff will be encouraged to participate in “low fat milk” campaigns within their community.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Local MCH staff will participate in the development of local community walking programs.

State and local MCH staff will participate in promoting the 5+5 Program.

State and local MCH staff will be encouraged to participate in "low fat milk" campaigns within their community.

c. Plan for the Coming Year
Local MCH staff will participate in the development of local community walking programs.

State and local MCH staff will participate in promoting the 5+5 Program.

State and local MCH staff will be encouraged to participate in "low fat milk" campaigns within their community.

MCH staff will promote breastfeeding through education opportunities, the creation of local coalitions, etc.

MCH nutritionist will hold two face-to-face meetings and one conference call with local public health nutritionists. Staff from Child Nutrition Programs, Prevention Block Grant Programs, 5 A Day, Cardiovascular Health, Midwest Dairy Council, NDSU Extension Service, etc. will be invited to participate in these meetings/calls.

Local MCH staff will continue to collaborate and promote the HND worksite wellness programs.

WIC and Family Planning staff will collect BMI information on clients and provide education/counseling as appropriate.

State MCH nutritionist will give nutrition and physical activity input on the "Healthy Women" brochure that will be available to clients through the family planning program at its 22 clinic sites.

State MCH nutritionist will continue to serve on CORE Team Plus for Coordinated School Health in which there is opportunity to give input on speaker selection for annual Rough Rider Health Promotion Conference.

State and local MCH staff will offer information on healthy eating and physical activity at the annual Rough Rider Health Promotion Conference.

Optimal Pregnancy Outcome Program (OPOP) will offer information on nutrition and physical activity.

State MCH nutritionist will collaborate with the State Women's Health coordinator to offer input on the selection of speakers and presentation topics for Women's Health Summit conferences.

State MCH staff will participate in and collaborate with the ND Diabetes Coalition and the ND Cancer Coalition to promote a healthy weight.

State MCH staff will continue to monitor the national and state BRFSS data.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					21.5
Numerator					5696
Denominator					26491
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	22	23	24	25	26

Notes - 2005
The source for this Medicaid data is the North Dakota Department of Human Services, Medical Services Division.

a. Last Year's Accomplishments
This was a new state performance measure in FFY 2006.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State Oral Health Program Director will work with Medicaid to gather baseline data.				X
2. Promote the use of Project Will Show materials to local public health units, social services and case managers.				X
3. Encourage/assist local agencies to provide access to oral health screenings.			X	
4. Encourage/assist local agencies with resources to assure access to a source of health insurance coverage.			X	
5. The ND Oral Health State Plan and ND Oral Health Burden Document were completed in June 2006. An Oral Health Conference is scheduled for September 29, 2006 to unveil these two documents.				X
6. Working with Bridging the Dental Gap Clinic in Bismarck to hire a Community Resource Coordinator (CRC). The CRC will assist clients in receiving appropraite care and referrals. Funding for this position is being partically supported with the HRSA S		X		
7.				
8.				
9.				
10.				

b. Current Activities
State Oral Health Program Director will work with Medicaid to gather baseline data.

Promote the use of Project Will Show materials to local public health units, social services and case managers.

Encourage/assist local agencies to provide access to oral health screenings.

Encourage/assist local agencies with resources to assure access to a source of health insurance coverage.

The ND Oral Health State Plan and the ND Oral Health Burden Document were completed in June 2006. An Oral Health Conference is scheduled for September 29, 2006 to unveil these two documents.

Working with Bridging the Dental Gap Clicic in Bismarck to hire a Community Resource Coordincator (CRC). The CRC will asssit clients in receiving appropraite care and referrals. Funding for this postion is being partically supported with the HRSA State Oral Health Collaborative Systems Grant.

c. Plan for the Coming Year
Implement the findings of the HSR Medicaid Focus Groups regarding access.

Collaborate with local public health, family planning and others to enforce preventive oral health messages including oral health and pregnancy.

Update Project Will Show materials.

Continue with the ND Oral Health Coalition meetings.

Release findings from the ND Oral Health Disease Burden Document.

Release the ND State Oral Health Plan to a broad audience.

Continue to support the CRC at Bridging the Dental Gap Clinic.

Continue to collaborate and offer support as needed to the Red River Valley Dental Access Project in Fargo, the Northern Valley Access Project in Grand Forks and Bridging the Dental Gap Clinic in Bismarck.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					66.7
Numerator					10
Denominator					15
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	67	67.5	68	68.5	69

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
This was a new state performance measure in FFY 2006.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Encourage/assist local agencies with resources to assure			X	

access to a source of health insurance coverage.				
2. Encourage/assist local agencies to encourage women to receive recommended preventive screening services such as blood cholesterol, bone mineral density, triglycerides and glucose, and body mass index.			X	
3. Encourage/assist local agencies to provide access to early and adequate prenatal care.			X	
4. Encourage/assist local agencies to provide access to mental health screenings, especially postpartum depression.			X	
5. Encourage/assist health professionals to screen and refer all women for family and intimate partner violence.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
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 and 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.

c. Plan for the Coming Year
Work with Women's Way, Family Planning, WIC, OPOP, and Cardiovascular Health to encourage/assist local agencies and health professionals to: 1) assure access to a source of health insurance coverage, 2) encourage women to receive recommended preventive screening services such as blood cholesterol, bone mineral density, triglycerides and glucose, and body mass index, 3) provide access to early and adequate prenatal care, 4) provide access to mental health screenings, especially postpartum depression, and 5) screen and refer all women for family and intimate partner violence.

Title V staff will particicapte on State Plan activities by serving on coalitions/taskforces (e.g., Cancer, Diabetes, Oral Health, Tobacco). These State Plans all have components relating to preventative services.

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	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					26.7
Numerator					47
Denominator					175804
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	25	24	23	22	21

Notes - 2005
The source of the data is the North Dakota Department of Health, Division of Vital Statistics.

a. Last Year's Accomplishments
Program staff provided technical assistance to local public health agencies, childcare providers, consumers, and others on a variety of injury prevention topics, including playground safety, poison control, product safety, all-terrain vehicle safety, etc.

The program established, coordinated and chaired the North Dakota Injury Prevention Coalition. The Coalition includes representatives of private and public health and safety agencies and organizations. The Coalition met four times and is in the process of developing a logic model to determine goals and outcomes.

The program coordinated the North Dakota Injury Prevention Conference with approximately 100 participants attending.

The program participated in the ND Child Fatality Review Panel by categorizing all childhood deaths, conducting in-depth review of motor vehicle deaths, and participating in panel meetings.

The program contracted with the US Consumer Product Commission to conduct 10 recall effectiveness checks and participated in public information and education campaigns.

The program assisted with development of the ND State Plan for Injury Prevention by providing data, writing sections of the plan, and reviewing the plan in its entirety.

The IPP coordinated poison prevention and consultation for the state. Consultation services (exposure calls) were contracted with Hennepin County Poison Control Center in Minnesota. Poison prevention services were carried out by the IPP.

The program coordinated with state and local Safe Kids Coalitions, Emergency Medical Services for Children, Native American Injury Prevention Coalition, School Health Interagency Workgroup, Title V Maternal and Child Health and others on injury prevention projects. Specific projects included assisting with Safe Kids Coalition needs assessments, reviewing Youth Risk Behavior Survey data, participating in Title V needs assessment retreat, providing guidance to public health agencies in Injury Prevention performance measures, and assisting the Department of Higher Education with a technical review of United Tribes Technical College Injury Prevention Program curriculum.

The program established and promoted shaken baby syndrome (SBS) prevention month in October. Letters were sent to public health agencies and the Department of Career and Technical Education inviting them to promote SBS prevention through materials supplied by MCH. Four counties utilized the SBS prevention display during this time and approximately 2,000 brochures and posters were distributed. SBS prevention was also promoted in the fall edition of the Building Blocks to Safety newsletter.

Monitoring of blood lead results is ongoing. The program received approximately 1,100 lead results statewide. Of this number, approximately 6 children were confirmed to have an elevated blood lead level. Worked with clinics, public health agencies and the Division of Air Quality to follow-up on the children with elevated lead levels.

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, i.e., playground safety, product safety, poison control, etc.			X	
2. Distribute media releases and produce a quarterly newsletter, "Building Blocks to Safety" with a "Buckle Update" section.			X	
3. Collaborate with state and local Safe Kids Coalitions, Emergency Medical Services for Children, Native American Injury Prevention Coalition and other private/public partners on injury prevention projects.			X	
4. Coordinate/contract with US Consumer Product Safety Commission to educate the public about product recalls, conduct recall effectiveness checks, and complete special projects as assigned.			X	
5. Participate in North Dakota Child Fatality Review Panel. Do a cursory review of all deaths to children under age 18, assign for further review as appropriate, and conduct in-depth review of all motor vehicle cases.				X
6. Coordinate and chair the North Dakota Injury Prevention Coalition.				X
7. Monitor blood lead levels reported to MCH. Track and manage elevated levels through local public health agencies.			X	
8.				
9.				
10.				

b. Current Activities

Provide technical assistance, training, data, and materials to local entities on injury-specific topics, i.e., playground safety, product safety, poison control, etc.

Distribute media releases and produce a quarterly newsletter, "Building Blocks to Safety" with a "Buckle Update" section.

Collaborate with state and local Safe Kids Coalitions, Emergency Medical Services for Children, Native American Injury Prevention Coalition and other private/public partners on injury prevention projects.

Coordinate/contract with US Consumer Product Safety Commission to educate the public about product recalls, conduct recall effectiveness checks, and complete special projects as assigned.

Participate in North Dakota Child Fatality Review Panel. Do a cursory review of all deaths to children under age 18, assign for further review as appropriate, and conduct in-depth review of all motor vehicle cases.

Coordinate and chair the North Dakota Injury Prevention Coalition.

Monitor blood lead levels reported to MCH. Track and manage elevated levels through local public health agencies.

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, etc.

Distribute media releases and produce a quarterly newsletter, "Building Blocks to Safety" with a "Buckle Update" section.

Collaborate with state and local Safe Kids Coalitions, Emergency Medical Services for Children, Native American Injury Prevention Coalition and other private/public partners on injury prevention projects.

Coordinate/contract with US Consumer Product Safety Commission to educate the public about product recalls, conduct recall effectiveness checks, and complete special projects as assigned.

Coordinate North Dakota's Poison Prevention education campaign. Work with Hennepin County Poison Control Center in Minnesota to assure poison consultation coverage for North Dakota.

Monitor blood lead levels reported to MCH. Track and manage elevated levels through local public health agencies.

Coordinate and chair the North Dakota Injury Prevention Coalition.

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 on 5 or more days during the past week.*

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					43.7
Numerator					18730
Denominator					42830
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	44	44.5	45	45.5	46

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 physcial 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
This was a new state performance measure in FFY 2006.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage local MCH staff to partner in healthy school environment activities such as the USDA school wellness initiative.				X
2. Encourage local MCH staff to participate in Healthy North Dakota Physical Activity Committee.				X
3. Local MCH staff will engage community childcare associations, Head Start and WIC in promoting physical activity.			X	
4. Approval received to hire a Healthy Weight Coordinator position into the Division of Nutrition and Physical Activity. Job description developed with an emphasis on physical activity. Position advertised in July 2006.				X
5. Coordinated School Health Strategy Fact Sheets developed in the topic areas of nutrition/physical activity and tobacco.			X	
6. Sessions on the importance of and strategies for physical activity presented at the annual Roughrider Health Promotion Conference.			X	
7.				
8.				
9.				
10.				

b. Current Activities

Encourage local MCH staff to partner in healthy school environment activities such as the USDA school wellness initiative.

Encourage local MCH staff to participate in Healthy North Dakota Physical Activity Committee.

Local MCH staff will engage community childcare associations, Head Start and WIC in promoting physical activity.

Approval received to hire a Healthy Weight Coordinator position into the Division of Nutrition and Physical Activity. Job description developed with an emphasis on physical activity. Position advertised in July 2006.

Coordinated School Health Strategy Fact Sheets developed in the topic areas of nutrition/physical activity and tobacco.

Sessions on the importance of and strategies for physical activity presented at the annual Roughrider Health Promotion Conference.

c. Plan for the Coming Year

Healthy Weight Coordinator position staffed.

Encourage local MCH staff to partner in healthy school environment activities such as the USDA school wellness initiative.

Encourage local MCH staff to participate in Healthy North Dakota Physical Activity Committee.

Local MCH Local MCH staff will engage community childcare associations in promoting physical

activity.

Encourage local MCH staff to partner with coordinated school health and support policies that provide for quality physical education and activity in grades per-K through 12.

MCH Nutritionist will participate in the Coordinated School Health Program and the Healthy School Nutrition Alliance.

State and local MCH staff will offer information on healthy eating and physical activity at the annual Rough Rider Health Promotion Conference.

State MCH nutritionist will contact DPI to inquire if physical activity is incorporated into available after school programs.

State MCH staff will offer input on the selection of speakers and presentation topics for all Women's Health Summit conferences.

State MCH staff will continue to monitor the national and state YRBS data.

State Performance Measure 7: *The percent of ND children age 2-17 with a BMI in the normal weight rage.*

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					0
Numerator					
Denominator					
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	0	0	0	0	0

Notes - 2005
The source of this data is from the 2003 National Survey of Children's Health. For children ages 10 to 17, the annual indicator for this measure was 68.3 percent. The numerator and denominator for the age group 10 to 17 is weighted, and hence is not utilized. The annual performance objectives have been set at 69 for 2006, 69.5 for 2007, 70 for 2008, 70.5 for 2009 and 71 for 2010.

a. Last Year's Accomplishments
This was a new state performance measure in FFY 2006.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Encourage local MCH staff to partner in healthy school environment activities such as the USDA school wellness initiative within their communities.				X
2. Encourage local MCH staff participation in Healthy North Dakota Physical Activity Committee.				X
3. State and local MCH staff will participate in promoting the 5+5			X	

Program.				
4. State and local MCH staff will be encouraged to participate in “low fat milk” campaigns within their community.			X	
5. For the past year, the HWC has been working on the development of a position paper titled "Measuring Heights and Weights in Schools." The position paper recommends that schools measure heights and weights of students only under special circumstances				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Encourage local MCH staff to partner in healthy school environment activities such as the USDA school wellness initiative within their communities.

Encourage local MCH staff participation in HND Physical Activity Committee.

State and local MCH staff will participate in promoting the 5+5 Program.

State and local MCH staff will be encouraged to participate in "low fat milk" campaigns within their community.

The State MCH Nutrition Director facilitates the Healthy Weight Council (HWC). For the past year, the HWC has been working on the development of a position paper titled "Measuring Heights and Weights in Schools." The position paper recommends that schools measure heights and weights of students only under special circumstances. The position paper was featured in the June 2005 Healthy Generations Newsletter, University of Minnesota, Maternal and Child Health Program School of Public Health. Numerous organizations (e.g., ND Department of Public Instruction, American Academy of Pediatrics) throughout the state are being asked to endorse the position paper. A fall 2006 dissemination plan is currently being developed.

c. Plan for the Coming Year

MCH nutritionist will continue to coordinate monthly meetings of the Healthy Weight Council who have drafted a position paper titled "Measuring Heights and Weights in Schools". MCH nutritionist also coordinated the distribution of nutrition, physical activity and obesity related e-mails to the Healthy Weight Council members.

The findings from the 3-year ND WIC Motivational Interviewing Research Project will be applied as appropriate within WIC clinics. We will also seek out opportunities to share the research findings on the effectiveness of decreasing TV viewing, increasing consumption of low fat milk, and breastfeeding initiation and duration.

Work with the Oral Health Program to get the results of the 2004 Oral Health Survey of 3rd graders on the Department's website.

MCH nutritionist will hold two face-to-face meetings and one conference call with local public health nutritionists. Staff from Child Nutrition Programs, Prevention Block Grant Programs, 5 A Day, Cardiovascular Health, Midwest Dairy Council, NDSU Extension Service, etc. will be invited to participate in these meetings/calls.

Encourage local MCH staff to partner in healthy school environment activities such as the USDA school wellness initiative within their communities.

Encourage local MCH staff participation in Healthy North Dakota Physical Activity Committee.

State and local MCH staff will participate in promoting the 5+5 Program.

State and local MCH staff will be encouraged to participate in "low fat milk" campaigns within their community.

State MCH staff will offer nutrition and physical activity information through the Early Childhood Alliance plan.

State and local MCH staff will offer information on healthy eating and physical activity at the annual Rough Rider Health Promotion Conference.

State MCH nutritionist will collaborate with the State Women's Health coordinator to offer input on the selection of speakers and presentation topics for Women's Health Summit conferences.

State MCH staff will continue to monitor the national and state YRBS data.

State MCH nutritionist will contact DPI to inquire if physical activity is incorporated into available after school programs.

Local MCH staff will engage community childcare associations, Head Start and WIC in promoting physical activity.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					7
Numerator					7
Denominator	9	9	9	9	9
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	7	8	9	9	9

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 assesment through the availability and use of data.
2.Relevant partners and stakeholders are involved in assesment 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
This was a new state performance measure in FFY 2006.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS and stakeholders will establish criteria to objectively rank each of the components in the performance measure.				X
2. A working definition of children with extraordinary medical needs will be established and agreed upon by stakeholders.				X
3. CSHS will estimate the prevalence of medically fragile children in the state using Medicaid claims data.				X
4. CSHS staff will participate as requested in the interim legislative study of children with special health care needs in the state.				X
5. CSHS staff will participate in the medical needs task force co-facilitated by state CSHCN and Disability Services staff to assess the status of children with extraordinary medical needs in the state.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CSHS and stakeholders will establish criteria to objectively rank each of the components in the performance measure.

A working definition of children with extraordinary medical needs will be established and agreed upon by stakeholders.

CSHS will estimate the prevalence of medically fragile children in the state using Medicaid claims data.

CSHS staff will participate as requested in the interim legislative study of children with special health care needs in the state.

CSHS staff will participate in the medical needs task force co-facilitated by state CSHCN and Disability Services staff to assess the status of children with extraordinary medical needs in the state.

c. Plan for the Coming Year
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.

CSHS will participate in writing and submitting a Medicaid waiver for children with extraordinary medical needs to increase access to home and community-based support services

CSHS staff will monitor any 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 possible Medicaid buy-in program for CSHCN's.

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	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					75.6
Numerator					264
Denominator					349
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	77	78	79	80	81

Notes - 2005
The source for this data is the 2003 National Children's Health Survey, question S5Q09A.

a. Last Year's Accomplishments
This was a new state performance measure in FFY 2006.

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 report on the percentage of families that reported that the clinic they attended has helped them manage their child's condition.				X
3. CSHS will review survey data to monitor specialty care access for CSHCN (e.g.) CSHCN survey, Child Health survey, etc.				X
4. CSHS will assess location and availability of pediatric specialists in the state.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCNs and their families.

CSHS will report on the percentage of families that reported that the clinic they attended has helped them manage their child's condition.

CSHS will review survey data to monitor specialty care access for CSHCN (e.g.) CSHCN survey, Child Health survey, etc.

CSHS will assess location and availability of pediatric specialists in the state.

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 support access to pediatric specialty providers through use of telemedicine or other technology and/or through promotion of outreach services such as Shriners clinics.

CSHS will provide state level care coordination to link CSHCN and their families to specialty health services in the state.

CSHS will disseminate guidelines of care with ND resource inserts.

CSHS will provide diagnostic and treatment services provided by participating specialists, to eligible uninsured and underinsured CSHCN.

CSHS will develop a list of participating providers including their current board certification status.

CSHS will explore potential reimbursement of transportation related expenses for eligible children and their families.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					89.7
Numerator					26
Denominator					29
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	91	92	93	94	95

Notes - 2005
The source for this data is the 2005 CSHS Public Information Report.

a. Last Year's Accomplishments
This was a new state performance measure in FFY 2006.

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 supported by CSHS.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
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 supported by CSHS.

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.

E. Health Status Indicators

#01A: The percent of live births weighing less than 2,500 grams.
Over the last five years, there has been minimal change with a low of 6.2 and a high of 6.6.

#01B: The percent of live singleton births weighing less than 2,500 grams.
Over the last five years, there has been minimal change with a low of 4.6 and a high of 5.0.

#02A: The percent of live births weighing less than 1,500 grams.
Over the last five years, there has been minimal change with a low of 1.1 and a high of 1.4.

#02B: The percent of live singleton births weighing less than 1,500 grams.
Over the last five years, there has been minimal change with a low of 0.8 and a high of 0.9.

#03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.
Over the last five years, there has been an increase from 4.6 to 13.9.

#03B: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger.
Over the last five years, indicators have varied from 0.8 to 6.2.

#03C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.
Over the last five years, indicators have varied from 13.4 to 30.7.

#04A: The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.
Access to the ND Trauma Registry provided baseline data for 2005.

#04B: The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.
Data from 2001 through 2004 remained relatively consistent. In 2005, the data provided by the Department of Transportation showed a significant increase from 244.1 to 506.

#04C: The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.
Over the last five years, indicators have fluctuated from 1667.3 to 2059.1.

#05A: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.
Over the last five years, indicators have varied from 11.6 to 16.2.

#05B: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.
Over the last five years, indicators have varied from 3.7 to 7.0.

#06A & B: Infants and children aged 0 through 24 years enumerated by sub-populations of age group, race, and ethnicity.
Generally, the child population aged 0 through 24 years has decreased slightly from 2004 to 2005. ND remains predominately white, with Native American the largest minority population. In addition, ND has a very small Hispanic population.

#07A & B: Live births to women (of all ages) enumerated by maternal age, race and ethnicity.
Generally, the live births to women of all ages increased slightly from 2004 to 2005. ND remains predominately white, with Native American the largest minority population. In addition, ND has a very small Hispanic population.

#08A & B: Deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race and ethnicity.
Generally, deaths of infants and children aged 0 through 24 years have increased slightly from 2004 to 2005. Native Americans have a higher rate of deaths than expected in proportion to the population. Deaths to the Hispanic population are very small.

#09A & B: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race and ethnicity.
Generally, infants and children aged 0 through 19 years have decreased slightly from 2004 to 2005. Increases were apparent in households headed by a single parent, SCHIP enrollment and WIC. For the majority of programs, ethnicity was not reported.

#10: Geographic living area for all resident children aged 0 through 19 years.
The majority of children aged 0 through 19 live in urban areas; closely followed by those in rural areas.

#11: Percent of State population at various levels of the federal poverty level.
The overall state population has deceased. Those at 50 percent of poverty or below have decreased.

#12: Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.
Generally, infants and children aged 0 through 19 years have decreased slightly from 2004 to 2005. Poverty levels have remained relatively consistent.

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.

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.