# Maternal and Child Health Services Title V Block Grant

## North Dakota

## FY 2026 Application/ FY 2024 Annual Report

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# Table of Contents

## I. General Requirements

## I.A. Letter of Transmittal

NORTH Dakota | Health & Human Services
Be Legendary.

July 1, 2025

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

To Whom It May Concern:

Enclosed are North Dakota's FY 2026 Title V MCH Grant Application and FY 2024 Title V MCH Annual Report.

The North Dakota Department of Health and Human Services serves as the grantee for the Title V MCH Grant. The Title V Program is administered by the Healthy & Safe Communities Section, which administers programs for mothers, infants, children, and adolescents, and programs for children with special health care needs and their families. Staff from the section work closely together in preparing the application and annual report.

Questions pertaining to maternal, infant, and child populations of the enclosed application may be directed to Ms. Kimberly Hruby, Title V Director and Special Health Services Director, Healthy & Safe Communities Section, North Dakota Department of Health and Human Services, 600 East Boulevard Avenue Dept. 301, Bismarck, ND 58505-0200. Ms. Hruby's telephone number is 701-328-4854. Questions pertaining to children with special health care needs should be directed to Ms. Danielle Hoff, Assistant Unit Director and CSHCN Director, Special Health Services Unit, North Dakota Department of Health and Human Services, 600 East Boulevard Avenue Dept. 301, Bismarck, ND 58505-0200. Ms. Hoff's telephone number is 701-328-4669.

Sincerely,

Kimberly Hruby, RN, DNP, Title V Director
Healthy & Safe Communities Section
N.D. Department of Health and Human Services

Danielle Hoff, RN, DNP, CSHCN Director
Special Health Services Unit
N.D. Department of Health and Human Services

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Enclosure

600 East Boulevard Ave. Dept. 301 | Bismarck, ND 58505-0200 | hhs.nd.gov
| 800.472.2622 | 711 (TTY)

### I.B. Face Sheet

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

### I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 2 of the 2026 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

### I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms",* OMB NO: 0915-0172; Expires: December 31, 2026.

## II. MCH Block Grant Workflow

*Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.*

## III. Components of the Application/Annual Report

## III.A. Executive Summary

### III.A.1. Program Overview

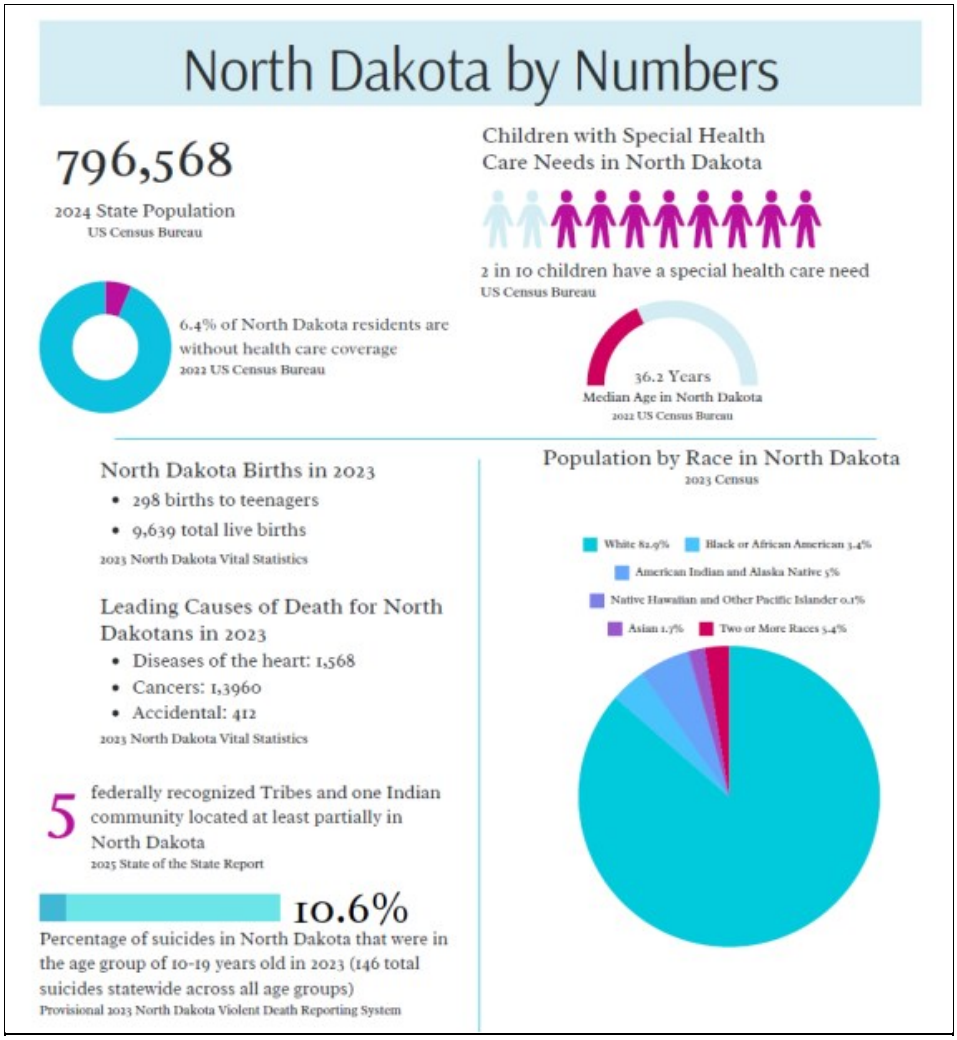
## Section III.A.1. Program Overview

North Dakota's Framework:
The vision of the North Dakota Department of Health and Human Services (NDDHHS) is to make North Dakota the healthiest state in the nation. The NDDHHS fosters positive, comprehensive outcomes by prompting economic, behavioral, and physical health, ensuring a holistic approach to individual and community well-being. This mission statement underscores the incredible work that is already underway across NDDHHS today. It also reflects the NDDHSS's commitment to keep the well-being of individuals and communities at the forefront of their efforts. To learn more about the NDDHHS strategic priorities and guiding principles, please visit https://www.hhs.nd.gov/2024-2025-business-plan

The Public Health Division within NDDHHS comprises five sections: 1) Healthy and Safe Communities, 2) Health Response and Licensure, 3) Health Statistics and Performance, 4) Disease Control and Forensic Pathology, and 5) Laboratory Services. Employees in these sections provide public health services that benefit North Dakota citizens and ultimately make the state a healthier place to live. The four core goals of the Public Health Division are to create healthy and vibrant communities; enhance and improve systems of care; strengthen population-based health interventions; and promote public health readiness and response.

The Healthy and Safe Communities section, within the Public Health Division, is responsible for administering the state's Title V program and has a mission to support individuals, families, and communities by providing quality preventive programs and services that equitably protect and enhance the health and safety of all North Dakotans. There are four units in the section which all have programs and/or funding that link to and promote Maternal and Child Health (MCH) priority areas: 1) Community Engagement, 2) Family Health and Wellness, 3) Health Promotion and Chronic Disease Prevention, and 4) Special Health Services (SHS). Title V also provides a portion of funding to the vital services of information technology, contract and grant management, and epidemiological support that assist MCH staff with critical job functions. The Title V Director also serves as the Unit Director for the Special Health Services Unit and is a member of the HSC leadership team, which helps foster collaboration and to promote and enhance visibility for MCH across the department.

The figure below details relevant indicators of the health and well-being of the North Dakota population, including the MCH population. This data is from the US Census Bureau, North Dakota Violent Death Reporting System, the 2025 State of the State Report, and the 2023 North Dakota Vital Statistics Report.




Five-Year MCH Needs Assessment

Overarching Title V priorities have been established following the 2025-2030 comprehensive Five-Year Needs Assessment. The Title V Leadership Team (Title V Director, Children with Special Health Care Needs (CSHCN) Director, Family Health and Wellness Unit's MCH Lead, MCH Epidemiologist, and the State Systems Development Initiative Grant Coordinator) meet regularly to ensure staff have the resources they need to implement these new priorities successfully. In addition to the Five-Year Needs Assessment, the 10-step conceptual framework will continue to be followed for the ongoing needs assessment process.

In the summer of 2023, planning began for the 2025 needs assessment and prioritization process. Acknowledging the critical need for a comprehensive data collection initiative to gather public input, the North Dakota Title V leadership team opted to engage North Dakota State University (NDSU) for assistance in this effort. In the fall of 2024, NDSU, in collaboration with Title V staff, developed a comprehensive online stakeholder survey encompassing a range of select-all-that-apply and short-answer questions pertaining to women, infants, and children across all MCH population domains. This survey was disseminated to over 200 stakeholders statewide, including a diverse array of providers, families, family support organizations, state personnel, community organizations, and other key leaders working closely with the women, infant, and child population. It is important to note that Prevent Child Abuse North Dakota (PCAND) administers the state's Maternal, Infant, and Early Child Home Visiting (MIECHV) program, and therefore, PCAND staff were also identified as stakeholders.

The survey remained open for just over two weeks, during which approximately 200 responses were collected, yielding a substantial amount of valuable public input. NDSU subsequently compiled a detailed report outlining the results of the online survey, which can be accessed in Section V Supporting Documents section. Next, in February 2025, the Title V Leadership Team convened to analyze the survey results alongside other relevant state and national

data to facilitate the prioritization process. This process involved an independent review of the data, ranking priorities, and determining the top priority for each domain. Once this independent work was complete, the team convened again and collaboratively compared insights. Following thorough discussion and prioritization, draft priorities and strategies were established.

In addition to the survey, other state and federal data sources were incorporated into the needs assessment to assist with completing the picture of the health and well-being of the North Dakota MCH population. These sources include the State Health Improvement Plan and State Health Assessment, The Pregnancy Risk Assessment Monitoring System Survey, the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Surveillance System, and the National Survey of Children's Health. Input from Title V staff and partners was obtained regarding the draft priorities, which helped the Title V Leadership Team confirm the North Dakota Title V MCH priorities that are in place today.

Lastly, it is recognized that the needs assessment process requires ongoing analysis of sources of information about MCH status, risk factors, access, capacity, and outcomes. Assessment of the MCH population is an ongoing collaborative process, one that is critical to program planning and development and enables the state to target services and monitor the effectiveness of interventions that support improvements in the health, safety, and well-being of the MCH population. Additionally, it is recognized that it is critical to continually evaluate Title V program staff capacity. Currently, each population domain has an assigned lead and co-lead. However, it is recognized that Title V staff wear multiple hats within their roles, which is an ongoing challenge.

Identified MCH Goals and Priorities:
The following National Performance Measures in each of the population health domains were selected by the North Dakota Title V team. Priorities were created within each priority to further delineate and communicate the most pressing needs for the populations identified in the 2025 comprehensive needs assessment.

**Women Domain NPM*: Postpartum Visit - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth and B) Percent of women who attended a postpartum checkup and received recommended care components***

- North Dakota Priority: Identify, reduce, or eliminate barriers preventing women from receiving recommended postpartum care components, including but not limited to mental health screening, breastfeeding support, care coordination, etc.

**Perinatal/Infant Domain NPM: *Safe Sleep: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult***

- North Dakota Priority: Utilize statewide resources to educate about/implement safe sleep best practices.

**Child Domain NPM: *Percent of children, ages 0 through 11, whose households were food sufficient in the past year***

- North Dakota Priority: Expand partnerships with existing community resources (schools, food banks, health units, etc.) to improve accessibility to healthy food options.

**Child Domain NPM*: Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination.***

- North Dakota Priority: Improve care coordination to link the MCH population to essential services and resources.

**Adolescent Domain NPM: *Percent of adolescents, ages 12 through 17, who receive needed mental health treatment and counseling***

- North Dakota Priority: Identify, reduce, or eliminate barriers preventing adolescents from receiving mental health treatment and counseling.

**Children with Special Health Care Needs (CSHCN) Domain NPM: *Medical Home***

- North Dakota Priority: Improve the system of care for children with special health care needs.

**Crosscutting Domain (SPM): *"Vision Zero" state initiative to eliminate fatalities and serious injuries caused***

***by motor vehicle crashes***

- North Dakota Priority: Reduce serious motor vehicle injuries and fatalities to North Dakotans younger than 21 years of age.

**Crosscutting Domain (SPM): *Implement North Dakota State Mandates for the Maternal Child Health Population***

- North Dakota Priority: To implement all North Dakota state mandates delegated to the NDDHHS Title V/Maternal and Child Health Programs.

**Crosscutting Domain (SPM): *Improve access to health-related services to improve health and well-being***

- North Dakota Priority: Increase awareness and the utilization of statewide services or resources.

Five-year action plans containing evidence-based, evidence-informed and/or promising practice strategies were developed with collaborative partnerships for all priorities. https://www.NDDHHS.nd.gov/north-dakota-mch-work-plans.

Assuring Comprehensive, Coordinated, Family-Centered Services

North Dakota places a high value on family-centered partnerships, family feedback, and collaboration to mitigate health inequities. An example includes the SHS Unit partnership and contracted services with Family Voices of North Dakota. Family Voices of North Dakota supports statewide family-centered care for all children and youth with special health care needs and are routinely involved in Title V work efforts. SHS also utilizes a Family Advisory Council composed of family members of individuals with special health care needs. This council advises SHS on the family/parent perspective regarding issues, needs, and services, influences the direction of policies, contributes to program improvement, and ensures a voice for families and individuals with special health care needs to improve the system of care. CSHCN programs use meetings with this council to gather feedback from families with experience to identify specific needs and future directions for meaningful services. Lastly, Title V staff provide care coordination to families to ensure access to education and resources is available, such as the Newborn Screening Long-Term Follow-Up program and routine care coordination/insurance navigation to families on the SHS Financial Coverage program.

Efforts to Improve Outcomes

The strength of North Dakota Title V is rooted in both established and emerging partnerships that enhance efforts to reach women, infants, children, CSHCN, and families. By leveraging federal and non-federal funding, the program is able to deliver comprehensive services and foster a statewide system of collaboration. However, it is important to acknowledge that the relatively small size of the state presents challenges in forming new partnerships within certain MCH domains. Each population domain has identified opportunities for integrating and optimizing funds and resources to improve outcomes for the population. These opportunities are detailed in the annual reports and plans, which highlight various collaborative initiatives and quality improvement strategies. Such efforts are essential to ensure that activities and strategies effectively address the needs of the MCH population. Title V program evaluation efforts will be continuously implemented based on evidence-based data and strategies, facilitating the identification of health issues and challenges in communities. This proactive approach ensures that Title V services and programs are both efficient and effective for the citizens of North Dakota.

## Section III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

The Maternal and Child Health (MCH) Block Grant program is vital in supporting the health and well-being of North Dakota's MCH population. By strategically combining federal and state funds, the program effectively addresses identified priorities in a complementary and coordinated way. Funding designated for federal priorities is distributed across multiple divisions within the Healthy and Safe Communities Section of the Public Health Division at the North Dakota Department of Health and Human Services (NDDHHS). Additionally, resources are directed to the Health Statistics and Performance Section to strengthen data collection and analysis efforts. Collaboration and integration occur not only within NDDHHS but also with other state agencies and local partners. Many grants to local partners require matching funds, highlighting how local investments further enhance and sustain MCH services across the state.

MCH Block Grant funding is also used to address state mandates. Funding to support these efforts epitomizes the successful federal/state partnership by honoring the state's priorities. North Dakota has several mandates addressing the health of the MCH population that direct Title V work. Effective and efficient use of available funding is needed at all levels of the MCH pyramid (infrastructure building, population-based services, enabling services, and direct health care services) to achieve desired health outcomes for the MCH population. One of North Dakota's strengths as a less-populated, rural state is its ability to collaborate for collective impact, extending the "reach" of the MCH program.

North Dakota thoroughly reviews how federal and state funds are used to support key Maternal and Child Health (MCH) populations, such as pregnant women, infants, children, and children with special health care needs. These comparisons help identify where federal funding can be used to address service gaps, enhance specialized care, and support targeted programs. The 2025–2030 MCH Needs Assessment is a strong example of how Title V funding has been utilized to conduct a state-led effort to improve services, promote health, and strengthen the public health infrastructure.

For the first time, North Dakota utilized a contractor to assist with the MCH Needs Assessment. The North Dakota Title V team partnered with North Dakota State University (NDSU), leveraging their expertise in conducting statewide assessments. This new collaboration, along with the involvement of the state Title V team, led to improved data analysis, stronger partnerships, which included involving families throughout the process, and more informed decision-making.

Work with NDSU is ongoing to continue the MCH Certificate Program. Additionally, the MCH Director and other Title V staff have been playing an integral role in updating the Public Health Division's workforce development plan and identifying ongoing training needs or opportunities for team members. Finally, through the strategic use of Title V funds, North Dakota is able to expand MCH services at both the state and local levels. This is achieved through strong collaborations, targeted programs, and partnerships.

## Section III.A.3. MCH Success Story

In Fall 2024, the Central Regional Education Association (CREA) partnered with Integrity Public Affairs, LLC to conduct an in-depth assessment and develop long-term recommendations to enhance the sustainability and effectiveness of school nurse services across North Dakota's public schools. The goal of this project was to understand the barriers faced by school nursing staff and propose actionable strategies that decision-makers could use to strengthen and support these essential services.

A multidisciplinary task force was assembled to guide the work, bringing together professionals from the fields of education, healthcare, Medicaid, Title V public health, special education, and government. Through stakeholder engagement, research, and policy analysis, the task force focused on three priority areas:

1. School Nurse Capacity Building – Recommendations were developed to improve staffing approaches, expand access to training and professional development, and increase day-to-day operational support for school nurses. Addressing staffing shortages and burnout was identified as a critical need to ensure school health services are reliable and effective.
2. Medicaid Eligible Services – A central focus of the work was identifying school nursing services that are already being delivered and could qualify for Medicaid reimbursement. Services such as medication administration, telehealth nursing visits, and care coordination were highlighted as key opportunities to secure long-term funding. By leveraging Medicaid, schools could access new revenue streams to support health services without relying solely on local resources.
3. Communication and Consistency Across School Districts – The task force recommended improved alignment and consistency in how school nurse roles are defined, implemented, and supported across school systems. Standardizing expectations and protocols would help reduce confusion, strengthen coordination, and improve the quality and continuity of care students receive, regardless of their school district.

After the task force concluded its work in December 2024, a smaller workgroup continued efforts related to Medicaid reimbursement. This team compiled data, clarified service definitions, and worked on a formal request to Medicaid for reimbursement of specific school-based nursing services. This request will help secure a sustainable funding mechanism to support school nursing and enhance health services for students.

This project serves as an example of the power of collaboration, strategic planning, and proactive policy development. It lays the foundation for a more consistent, efficient, and sustainable school nursing infrastructure that is better equipped to meet students' health needs and support their success in the classroom.

## III.B. Overview of the State

### III.B.1. State Description

### Section III.B.1. State Description

The state's demographics, geography, economy, and urbanization; unique strengthens and challenges that impact the health status of the MCH population; and components of the state's system of care:

North Dakota is a rural state located in the geographic center of North America, in the upper Midwest region of the United States (US). It encompasses a significant landmass (68,982 square miles) and is the 17th largest state by land area. According to the US Census Bureau, North Dakota is the 4th least populated state in the nation (783,926 residents estimated in July 2023), with a population density of approximately 11.3 persons per square mile. Most North Dakota counties possess a population base below 5,000 residents, including 36 counties considered "frontier", defined as having a population density of six or fewer residents per square mile. North Dakota's health status is confronted by a variety of challenges, including the unique geography and climate, socioeconomic factors, and demographics of the state (US 2020 Decennial Census).

The U.S. Census Bureau shows the state's population reached a new all-time high of 783,926 residents as of July 1, 2023. The 2023 estimate represents an increase of 4,665 residents from last year's estimate and is 4,847 residents more than the official 2020 census count. North Dakota was one of 42 states that saw their population increase in 2023.

North Dakota has traditionally been one of the leading agricultural producers in the nation. According to the US Department of Agriculture (USDA), North Dakota ranked 1st in the nation for the value of Grains, oilseeds, dry beans, and dry peas crops sold (2022 Census of Agriculture). Energy development also plays a large role in North Dakota's economy. Top industries for jobs in North Dakota in 2022 included government 17.5%, education and health 15.8%, retail trade 10.9%, leisure/ hospitality 9.5%, professional/ business services 8.4%, construction 6.2%, and natural resource/mining jobs 5.1% (North Dakota Compass-North Dakota Job Service Labor Market Information, Quarterly Census of Employment and Wages).

The oil and natural gas industry in North Dakota accounted for $42.6 billion in gross business volume, nearly 50,000 jobs, and over $3.8 billion in state and local tax revenues in 2021, according to a study conducted by North Dakota State University Department of Agribusiness and Applied Economics and Center for Social Research. (ND Petroleum Foundation).

After three years of little or no growth, North Dakota's economy started to recover in 2018 with the state's GDP increasing by 4.3%. In 2019, the state GDP slightly increased by less than one percent from the previous year (0.9%). In 2019, North Dakota ranked third among all states based on the economic output per working-age adult GDP ($112,454). The median household income in North Dakota in 2018-2022 was $73,959 (US Census). In 2021 North Dakota ranked 26th among the 50 states. In 2019, McKenzie County had the highest median household income in the state at $86,890 while Sioux County had the lowest at 37,133 (North Dakota Compass).

For decades, North Dakota experienced out-migration of its young adult population, making it an older-population state with about three-fifths of its population in the eastern half of the state. Over the past few years, North Dakota experienced a dramatic population shift. According to the US Census Bureau, the rapid population changes in the state was the result of an influx of people coming to work in energy development and related industries in the western part of the state. However, over the past year this trend is again changing. From July 1, 2021, to July 1, 2022, North Dakota experienced a larger number of residents leaving than entering the state, a negative net migration of 1,442 residents. The negative net migration is due to domestic out-migration of 2,710 residents and international in-migration of 1,268 residents. These changes reflect a slight recovery after the COVID-19 pandemic that impacted all components of population change in 2021 (US Census Bureau, Population and Housing Unit Estimates, Vintage 2022 Estimates).

While still young compared to most states, North Dakota is getting older. With a median age of 35.8 years in 2022 (ACS 5-year estimates), North Dakota is 3.1 years younger than the national average (median age 38.5 years), according to Vintage 2022 5-year released by the US Census Bureau. While North Dakota is still young overall, in

2022, the median age at the county level greatly varied, ranging from 28.0 (Sioux County) to 54.4 years (Sheridan County). Of the 53 counties, 43 have a median age older than the state (35.8 years), 39 counties have a median age older than the nation (38.9 years) and seven of those counties have a median age older than 50 years.

Racial and ethnic diversity in North Dakota continues to accelerate. According to ND Compass's 2023 data highlight, the population excluding non-Hispanic White nearly doubled, increasing from 74,600 in 2010 to 145,314, a 95% rise. Despite this increase, North Dakota remains less diverse compared to many states. In 2023, non-Hispanic White residents comprised approximately 83% of the population (647,059 individuals), while those identifying as white alone or in combination accounted for about 89%. (https://www.ndcompass.org/trends/Data-Highlight/Data-Highlight.php).

There are five federally recognized Tribes and one Indian community located at least partially within North Dakota. The five tribes include the Mandan, Hidatsa, and Arikara Nation (Three Affiliated Tribes), the Spirit Lake Nation, the Standing Rock Sioux Tribe, the Turtle Mountain Band of Chippewa Indians, the Sisseton-Wahpeton Oyate Nation, and the Trenton Indian Service Area. As of 2022, the median age of North Dakota's American Indian (AI) population was 25.8 (US Census Bureau 2022 ACS 5-year estimates), approximately nine years younger than North Dakota's overall median age of 35.4 years (US Census Bureau 2022 ACS, 5-year estimates). Unemployment and poverty remain ongoing challenges on the reservations in North Dakota. Challenges faced by the AI population include higher rates of diabetes, cancer, addiction, heart disease, and other public health issues, including unintentional injuries. According to 2023 America's Health Ranking, North Dakota had 8,532 years of life lost before age 75 per 100,000 population, compared to the national figure of 9,478. According to the 2025 County Health Rankings (https://www.countyhealthrankings.org/health-data/county-health-rankings-measures), all 12 North Dakota counties identified as "least healthy" are either within a tribal reservation or designated as rural/frontier.

Differences in poverty exist by race/ethnicity. Nationally, 21.7% of the AI population were estimated to be in poverty in 2022, compared to the overall national poverty rate of 12.6%. In North Dakota, the percent of poverty of AIs was 31.3 during 2016-2020, compared to the overall poverty rate of 10.5% in the state in 2020, and the 2018-2022 national poverty rate for AI was 21.7% (2022, ACS 5-year estimates). In the nation, North Dakota ranks 14$^{th}$ for the lowest poverty rate among the states in 2023 (2023 America's Health Ranking). North Dakota had the lowest jobless rate among the states in 2023, 1.9% (Regional and State Unemployment, 2023 Annual Average Summary).

There is a direct correlation between the rate of poverty for a given area and the percentage of households receiving public assistance. In North Dakota, Supplemental Nutrition Assistance Program (SNAP) benefits, ranged from over 11.51% in Sheridan, 44.73%, in Sioux (AI reservation area) to 5.57% in Mercer County. Counties with the highest rates of public assistance all had a high AI population. These same counties had the highest rates of poverty in the state. (North Dakota Department of Health and Human Services, SFY 2022 Unduplicated Count Report).

The health care delivery system in North Dakota consists of 52 hospitals – 37 smaller Critical Access Hospitals (CAHs) with 25 or fewer acute-care beds, six larger general acute-care hospitals located in the four largest cities, two psychiatric hospitals, two long-term acute-care hospitals, two Indian Health Service hospitals, two transplant-one specialty and one rehabilitation hospital – and more than 300 ambulatory care clinics. There are 34 facilities or programs statewide that provide mental health services and 96 licensed substance abuse programs. There are 54 federally certified rural health clinics and five federally qualified health centers (FQHC) with 19 clinic locations between them. All hospitals, including all 36 CAHs, except for one Indian Health Service (IHS) hospital, are designated as trauma centers. Each of the "Big Six" hospitals, located in the four largest cities in North Dakota, are home to a Level II trauma center. Most emergency medical service support in the state is ground-based and provide basic services, which is under duress because of its dependence on volunteers and funding challenges. There has been an expansion across the state in the deployment and use of electronic health records, but financial and other barriers to full implementation remain (Health Issues for the State of North Dakota, 2023, University of North Dakota).

Local public health units also provide valuable health care in North Dakota. The public health system is made up of 28 single and multi-county local public health units; all are autonomous and not part of the North Dakota Department of Health and Human Services (NDDHHS), although a close partnership exists between NDDHHS and local public health units. Many programs, including the maternal and child health (MCH) programs contract services through local public health (e.g., physical activity and nutrition, breastfeeding). Services offered by each health unit vary, but all provide services in the areas of MCH (Health Issues for the State of North Dakota, 2021, University of North Dakota).

Like the rest of the country, North Dakota is facing a major health care delivery challenge – how to meet a burgeoning

need for health care services now and in the future, with a supply of health care professionals that is not keeping pace with the growing demand; thereby, impacting the health status and needs of the MCH population. The supply of physicians in North Dakota lags behind the nation, especially in rural counties (6.6 physicians per 10,000 persons compared with 7.0 in other Upper Midwest states and 7.2 for the United States). Aging is a problem because more than half of North Dakota's physicians (51.4%) are 45 to 74 years old. Though a large proportion of North Dakota's physicians were IMGs and Canadian physicians (23.8%) in 2021, the state lacks large numbers of physicians from other states. As the physician population in the state continues to age, a large number will be retiring and will need to be replaced. As the North Dakota population also ages, there will be an increased need for physician care. (Health Issues for the State of North Dakota, 2023, University of North Dakota).

If the population of North Dakota does not expand at an increased rate but at the slower historical rate, the rate of physicians per 10,000 population will increase slightly until 2020 and remain stable through 2045. Part of the challenge in North Dakota is an inadequate number of providers; however, a larger portion of the challenge is a maldistribution of providers who are disproportionately located in the larger urbanized areas of the state. Frontier areas of the state face greater difficulties than rural areas in maintaining their health care workforce. These thinly populated regions cannot easily compete with the wages and amenities offered to health care providers by hospitals and clinics in urbanized areas. (Health Issues for the State of North Dakota, 2023, University of North Dakota).

According to the Center for Children and Families (CCF) 2023 health care coverage report (https://kidshealthcarereport.ccf.georgetown.edu/states/north-dakota/), health care coverage is important for children because it improves access to pediatrician-recommended care and services that support healthy development. When children get the health care they need, they are more likely to succeed in school, graduate from high school and attend college, earn higher wages, and grow up into healthy adults. In 2022, 5.5% of North Dakota children under the age of 19 were uninsured, compared to the national average of 5.1%. This report also showed that in 2022, AI children had a higher uninsured rate (17.8%) compared to White children (3.7%). The rate of uninsured non-elderly individuals under age of 65 was 7.5%, compared to the national average of 9.5%.

According to the most recent 2019–2023 American Community Survey (ACS) 5-year estimates, the majority of North Dakotans have health insurance coverage, with 95.5% of the total population insured and 4.5% uninsured. Among those insured, 80.8% had private health insurance, while 37.4% were covered through public programs such as Medicaid, Medicare, or VA benefits. These percentages include individuals with overlapping coverage, such as those dually enrolled in both private and public plans. Notably, 16.3% of insured North Dakotans had both public and private coverage, highlighting the blended nature of many insurance arrangements in the state.

Adults between the ages of 19 and 64—the non-elderly adult population—are the most likely to lack health insurance. While this group represents approximately 58.4% of North Dakota's population, they account for a disproportionate 74% of the state's uninsured residents. However, progress has been made: the uninsured rate among this age group dropped from 8.3% in 2022 to 6.1% in 2023, one of the most notable year-over-year improvements among U.S. states. In fact, North Dakota now ranks among the top states for private insurance coverage among non-elderly adults, with 85.1% of individuals in this category holding private plans.

Coverage rates vary significantly by race and ethnicity. White (non-Hispanic) residents had the lowest uninsured rate at 4.9%, while American Indian and Alaska Native (AI/AN) residents had the highest uninsured rate at approximately 23.0%. This disparity is especially concerning given that AI/AN individuals also face higher rates of poverty and chronic health conditions. Although AI/AN people make up just about 4.3% of North Dakota's population, they are disproportionately represented among the state's uninsured and medically underserved populations. Roughly 31.3% of AI/AN individuals in the state live at or below the poverty line, which contributes to ongoing barriers in accessing and affording care.

Among non-elderly adults, males continue to have lower insurance coverage rates than females, a trend seen across nearly all racial and ethnic groups. Men are also more likely to rely on employer-sponsored insurance or go uninsured altogether, while women are more likely to access coverage through Medicaid or other public programs—particularly during childbearing years.

For older adults aged 65 and over, access to Medicare drives near-universal coverage, with approximately 97% of seniors in North Dakota having some form of health insurance. This ensures that the vast majority of the state's elderly population are protected against catastrophic health costs, though gaps may still exist in supplemental coverage and out-of-pocket affordability.(US Census Bureau, 2020 ACS 5-year estimate).

Approximately 13.6% of North Dakota adults have a disability, compared to the national average of 13.6% (2023 ND Compass, https://www.ndcompass.org/). North Dakotans with disabilities, compared to those without disabilities, were more likely to be of AI descent at 16.0%, than of white descent at 11.5% (2018-2022 ACS, 5-year estimates). According to the 2022-2023 National Survey of Children's Health (NSCH), North Dakota provided similar coordinated and comprehensive care services within a medical home to children with special health care needs (CSHCN) 49.6%, compared to the nation (39.4%). Also, in the 2022-2023 NSCH, 63.1.1% of North Dakota families with CSHCN felt they received effective care coordination if they needed it, and 17.5% of families with CSHCN, ages zero through 17, reported to have difficulty paying medical or health care bills in the last twelve months. These results indicate the dynamic need for medical homes and adequate health insurance within the state (2022-2023 NSCH, https://www.childhealthdata.org).

North Dakota did not establish its own exchange, so enrollments are completed via https://www.healthcare.gov/ or an approved enhanced direct enrollment entity. A record high 34,130 people enrolled in private plans or Qualified Health Plans (QHPs) through the North Dakota exchange during the open enrollment period for 2023 plans. This beat the record high from the year prior, when there was a record high of 29,873 people enrolled in private plans (QHPs) through the North Dakota exchange and in 2021, when 22,709 people enrolled.

For 2024 coverage, there are three insurers that offer exchange plans in North Dakota: Blue Cross Blue Shield of North Dakota (Noridian), Sanford Health Plan and Medica (https://www.healthinsurance.org/health-insurance-marketplaces/north-dakota/). In most counties, plans are available from all three insurers for 2024, although there are six counties where only two insurers offer plans. Most enrollees receive subsidies, and their net premium changes depend on how subsidies change as well as how the rates for their plan change and whether they pick a different plan for 2024.

The American Rescue Plan, enacted in March 2021, increased the size of premium subsidies and made the subsidies more widely available. Fortunately for exchange enrollees, those subsidy enhancements have been extended through 2025 by the Inflation Reduction Act. Reductions of navigator funding began in 2017 and continued again in 2018. When navigator grants were announced in September 2018, only one organization in North Dakota — Family HealthCare Center — received funding, which was for $85,000.

The Family HealthCare Center has served as a navigator since 2015 and partners with Valley Community Health Centers to reduce the number of uninsured residents in North Dakota. They also provide outreach and education to seven northeastern and southeastern North Dakota counties with focus on residents at or below 200% of the federal poverty level (FPL), new Americans and refugees, pregnant women and new mothers, the AI population, the justice-involved population, disabled consumers, and Medicaid-eligible populations.

Navigator funding grew to record highs in 2021. In North Dakota, Minot State University received nearly $1 million in 2021 and continues to be active to this present day (https://ndcpd.org/ndnavigator/). Knowledge and awareness of children with special health care needs (CSHCN) has been an asset in supporting access to affordable care for families. Navigators who were supported in the past with Affordable Care Act (ACA) funding were employees of organizations that understood programs that could assist families of CSHCN. When approached by a family for health care options, they still provide navigational support and link families to resources.

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

Throughout the COVID-19 public health emergency, some households got coverage through Medicaid. They may still have this coverage even if income and households have changed. Medicaid and CHIP renewal applications have not been sent since early 2020. Starting in April 2023, North Dakota Medicaid began sending renewal information to Medicaid enrollees to update account information and verify current household income.

The decision to bring North Dakota's Medicaid expansion and Children's Health Insurance Program (CHIP) in-house to North Dakota Medical Services was passed during the 2019 Legislative Session. This transition took effect on January 1, 2020. North Dakota's CHIP and North Dakota Medicaid have been effective public programs in reducing the number of uninsured, low-income children in the state. CHIP/Medicaid for children provides premium-free, comprehensive health, dental and vision coverage. To qualify, a family's Modified Adjusted Gross Income (MAGI)

must be greater than the Medicaid level but cannot exceed 205% of the federal poverty level. As of February 2024, the total Medicaid and CHIP enrollment was 108,629. (https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html) North Dakota also provides twelve months of continuous Medicaid eligibility for children.

North Dakota Medicaid has various eligibility levels dependent upon population type. Parents and childless adults are both eligible at 138% of the FPL. Seniors and people with disabilities are eligible at 74% of the FPL. Pregnant women are eligible at 162% of the FPL. In January 2023, North Dakota adopted the Medicaid 12-month postpartum coverage extension. 1-877-KIDS-NOW is a toll-free resource line that helps uninsured families learn about low-cost and free health care coverage programs. A seamless eligibility process for health coverage programs has helped to assure coverage for North Dakota's children. In June 2023, the Kaiser Foundation indicated that approximately 10% of the North Dakota population was covered by Medicaid or CHIP. Additionally, 23% of births in North Dakota were covered by Medicaid.

Program data from the NDDHHS Special Health Services (SHS) Unit indicated that in Federal Fiscal Year 2024, 76.8% of the 1,056 children served by SHS had a source of health care coverage. Of these, about 43.09% were privately insured (455); 33.62% were insured by North Dakota Medicaid, 1.80% had no source of coverage, and 23.0% were unknown.

Behavioral health is a critical issue for NDDHHS, and partnership between the Public Health Division of NDDHHS (formerly the North Dakota Department of Health), the Behavioral Health Division, along with other key partners (e.g., Sanford Health, Family Voices of North Dakota, Children's Advocacy Center, medical systems), is essential to address these issues. In September 2018, North Dakota was awarded the Pediatric Mental Health Care Access (PMHCA) grant. The primary goals/objectives of North Dakota's PMHCA Program were to: 1) increase tele-behavioral health services to children and adolescents living in underserved areas of the state; 2) to extend knowledge to pediatric primary care professionals across the state for the early identification, diagnosis, treatment and referral of mental health disorders; 3) to include direct school-based delivery of telehealth services due to the shortage of health care providers and the lack of infrastructure for primary care clinics, and 4) to enhance existing partnerships and develop new relationships with entities that have similar goals and expectations to this program.

The PMHCA program is committed to increasing access to providers who can offer services including screening, referral, and treatment across our rural state. In addition, the North Dakota PMHCA Consultation Line became operational in March 2021. This consultation line connects primary care providers treating children and adolescents with a child and adolescent psychiatrist for consultation during daytime business hours. The consult line is funded by the PMHCA grant, and there is no cost to providers or families for this service.

In the spring of 2023, an additional funding opportunity became available to continue the projects of current PMHCA awardees whose projects began in FY 2018 and 2019. North Dakota received this additional opportunity under the leadership of the Behavioral Health Division. Title V staff have dedicated themselves to partnering in furthering these work efforts as they continue to evolve.

Within the Public Health Division of NDDHHS, several staff are engaged in the strategic planning process. Because of these work efforts, the division's mission, strategic initiatives, key objectives and indicators are updated annually. The 2022-2024 Strategic Plan can be found at:
https://www.hhs.nd.gov/sites/www/files/documents/DOH%20Legacy/PH%20administration/NDDoH%20Strategic%2(
The annually reviewed and revised strategic plan assists the department in communicating with partners, setting direction, motivating employees, making decisions, determining priorities and budgets, and monitoring progress and impact. All Public Health Division programs have been linked to strategic plan goals and objectives.

Title V programs align with the following goals and objectives:

Goal: Create Healthy and Vibrant Communities

- Reduce the risk of infectious disease
- Prevent and reduce chronic diseases
- Support communities in building resiliency
- Promote community driven wellness
- Increase healthy lifestyles and behaviors

Goal: Enhance and Improve Systems of Care

- Improve access to care in underserved and rural areas
- Enhance health care through technology
- Ensure access to and affordable health and preventative services
- Enhance quality and safety through regulation and education
- Promote health-in-all policies
- Foster system-level partnerships across continuums of care

Goal: Strengthen Population-based Health Interventions

- Prevent and reduce tobacco and other substance misuse
- Prevent violence, intentional and unintentional injury
- Reduce the risk of vaccine preventable diseases
- Reduce adverse health outcomes through early detection
- Promote healthy weight across the lifespan

NDDHHS recognizes the importance of public health accreditation and the alignment of accreditation efforts throughout the public health system to strengthen performance across the state. The former North Dakota Department of Health became a nationally accredited health department through the Public Health Accreditation Board (PHAB) on March 14, 2017. Reaccreditation took place on August 18, 2022, which is the first time since integrating as NDDHHS.

To increase the effectiveness of strategic planning and accreditation, NDDHHS has utilized a performance management system and continuous quality improvement (QI) process. These efforts assist to systematically monitor and improve the quality of programs, processes and services in order to achieve high levels of efficiency and effectiveness, as well as internal and external customer satisfaction.

Title V program staff have varying roles and responsibilities within the department's priorities and initiatives. The Healthy and Safe Communities Section Director, who also oversees Title V programs, holds a senior management position within the NDDHHS and is actively involved in strategic planning and accreditation activities. As a result, Title V issues are included in department discussions, planning and decision-making processes. In addition, the Title V Director and CSHCN Director provide regular updates and seek input and feedback on department issues through bi-monthly Title V meetings with all Title V team members.

To assist in translating data to action, the Public Health Division has created a public-facing webpage to house all public health statistical reports, data, and dashboards in one place at https://www.hhs.nd.gov/health/data-statistics. Currently, work efforts are underway for the creation of an MCH dashboard, which will be going live on this webpage soon.

Priority setting also is determined by state mandates; see Supporting Document – Title V-MCH State Mandates. A State Performance Measure has been developed to address the Title V responsibilities related to these mandates titled "Implement North Dakota State Mandates Delegated to the North Dakota Department of Health Title V/Maternal and Child Health Program." Information regarding these mandates is discussed in III.E.1. Five-Year State Action Plan Table and III.E.2.c State Action Plan Narrative by Domain – Cross-cutting/Systems Building.

The NDDHHS organizational chart can be found in Section VI. Organizational Chart.

#### III.B.2. State Title V Program

#### III.B.2.a. Purpose and Design

### Section III.B.2.a. Purpose and Design

Title V programs and priority areas set their own goals (refer to Section III.E.2. Five-Year State Action Plans). The overarching Title V goals were established as a result of the 2025- 2030 comprehensive Five-Year Needs Assessment. The Title V Leadership Team (Title V Director, Children with Special Health Care Needs (CSHCN) Director, Family Health and Wellness Unit, Injury Prevention Program Director, MCH Lead, MCH Epidemiologist, and the State Systems Development Initiative (SSDI) Grant Coordinator) ensures these goals are being met.

Title V success would not be possible without a well-functioning team and statewide partnerships. Serving as either a convener, collaborator, or partner is essential in addressing MCH issues. Key partners within each population domain were convened in April 2025 to develop the new five-year action plans and identify strategies, activities, and opportunities to braid and layer resources throughout North Dakota. Existing and new partners are convened annually to build upon existing activities and to create annual activities. Internally, the Title V Director also facilitates Title V team meetings every other month to review and discuss progress, successes, and challenges relating to the five-year state action plans, collaboration and integration opportunities, and emerging issues. Title V staff, along with partners, work collaboratively to move forward and implement the strategies and activities within the action plans. All program strategies are required to utilize innovative and evidence-based or evidence-informed approaches and incorporate the core public health functions of assessment, quality improvement/assurance, and policy development.

North Dakota is committed to building, sustaining, and expanding partnerships that contribute to or expand the state Title V and CSHCN programs' capacity and reach. Title V staff actively participate and provide leadership roles on a variety of committees/coalitions that impact the MCH population. These collaborative partners help identify common strategies to address priority needs identified through the ongoing needs assessment process within each of the six population health domains and strengthen Title V efforts to promote and protect the MCH population's health. Specific partnerships are discussed in Section III.E.3. State Action Plan Narrative by Domain.

State MCH support for communities is addressed through contracts with local public health units, nonprofits, tribal entities, schools, and universities. In addition, CSHCN support for communities is addressed through collaborative partnerships and contracts with health systems, universities, and nonprofits that support multidisciplinary clinics, family support services, and CSHCN systems development initiatives.

The State Health Improvement Plan (SHIP) for North Dakota is a strategic initiative designed through extensive data evaluation and collaboration with a wide range of partners throughout the state. It is updated every five years.

Anchored by a commitment to data-driven decision-making, this comprehensive plan is the cornerstone for guiding public health strategies.

The SHIP sets forth a vision for enhancing the health and well-being of all North Dakotans by identifying health priorities that will inform the development of associated goals, objectives, and activities. Within the framework of North Dakota's SHIP, each priority area is supported by dedicated workgroups and strategy teams. The priorities include strengthening workforce, cultivating wellness, expanding access and connection, and building community resilience. These teams execute strategic initiatives and continuously evaluate and adapt strategies to meet emerging health needs. This collaborative and adaptive approach ensures that North Dakota's health improvement efforts are effective and responsive, aiming to achieve the overarching goal of making North Dakota the healthiest state in the nation.

The North Dakota Children's Health Insurance Program (CHIP) falls under the North Dakota Medicaid program in the Medical Services Division within NDDHHS. The state CSHCN program has close ties with the Medical Services Division and participates in scheduled meetings to discuss policy, claims payment, and North Dakota Medicaid Management Information System (MMIS) issues or updates.

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

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

The North Dakota CSHCN program utilizes AMCHP's *National Consensus Standards for Systems of Care for Children and Youth with Special Health Care Needs* as a framework for supporting coordinated, comprehensive,

and family-centered systems of services at state and local levels. The SHS Director serves as the NDDHHS representative on the State Council on Developmental Disabilities. The CSHCN Director serves as a member of the Interagency Coordinating Council, focusing on systems that support individuals with disabilities and their families.

Annually, the state CSHCN program convenes a meeting between DDS, the local Social Security Administration office, North Dakota Medicaid, and key family organizations in the state to assure communication about any new developments that have occurred or that are expected during the year that might affect SSI eligible children. Procedures are in place between DDS and SHS to assure SSI recipients and cessations receive information about program benefits or services. DDS is located in the Human Services Division of NDDHHS.

The state CSHCN program and several of the state's universities have developed a mutually beneficial relationship to support multidisciplinary clinic services for CSHCN. SHS multidisciplinary clinics are often used as a source of pre-service training experience for various health disciplines. A collaborative relationship exists with the University of North Dakota (UND) Communication Disorders Department for administrative support of cleft clinics in the state's northeast region. In addition, a contract is in place with the Anne Carlson Center to support autism diagnostic clinics that are held throughout North Dakota.

A copy of the current cooperative agreement to ensure care and improve health status is in place between North Dakota Title V and North Dakota Medicaid. The most recent agreement was finalized in July 2020 and is included in Section III.B.3.c. Title V - Medicaid IAA/MOU. Work is currently being conducted to have a fully updated Intra-agency agreement by the end of July 2025.

#### III.B.2.b. Organizational Structure

### Section III.B.2.b. Organizational Structure

Governor Armstrong is the newly appointed 34th governor in the 145-year history of North Dakota, and brings a background in business, a love for the outdoors and a passion for volunteering and public service to the Governor's Office. Kelly is a lifelong, devoted North Dakotan and a tireless advocate for making North Dakota a better place to live, work, and raise a family.

Governor Kelly Armstrong appointed Dirk Wilke as HHS Interim Commissioner on Dec. 15, 2024. The Interim Commissioner oversees all divisions within HHS, the state's largest agency, operating eight regional human service centers, the Life Skills and Transition Center in Grafton, the State Hospital in Jamestown, and the State Laboratory in Bismarck. Dirk joined the North Dakota Department of Health in 2008 and served in various roles before becoming the department's Chief Operating Officer in 2017. Dirk was named Executive Director for the Public Health Division of Health and Human Services in 2022. However, on June 3, 2025, the new Interim HHS Commissioner, Pat Traynor, joined the department. Pat has served as the executive director of the Dakota Medical Foundation since 2000. Pat will work alongside Dirk as he steps back into his role as Executive Director for the Public Health Division.

"North Dakota is the Healthiest state in the nation" – these words are the shared vision of the approximately 2,800 team members employees of the North Dakota Department of Health and Human Services (NDDHHS). These team members are committed, compassionate individuals who are building the foundations of well-being for every North Dakotan. Effective September 1, 2022, the North Dakota Department of Health (NDDoH) and the North Dakota Department of Human Services integrated into the North Dakota Department of Health and Human Services (NDDHHS) which has enhanced partnerships between agency programs that serve similar populations. The programmatic divisions of the NDDHHS include the Divisions of Public Health (previously known as NDDoH), Medical Services (ND Medicaid), Behavioral Health, and Human Services.

NDDHHS has offices in the State's capital, plus operates eight regional Human Service Centers. The North Dakota State Hospital is located in Jamestown, the Life Skills and Training Center in Grafton and the North Dakota State Lab in Bismarck are also part of NDDHHS. Also, NDDHHS partners with nineteen human service zones the state to recruit talented, passionate individuals to provide their local communities with needed services and assistance. They also partner with local public health, tribal leaders, universities and providers to deliver public health education, outreach and response. Furthermore, NDDHHS utilizes a blended workplace model. Depending on the role, employees may work from home, on location, or travel to homes and community sites.

NDDHHS fosters positive, comprehensive outcomes by promoting economic, behavioral, and physical health,

ensuring a holistic approach to individual and community well-being. The HHS strategic priorities include: 1) Support the advancement of strong, stable, healthy families and communities; 2) Advance the foundations of well-being through access to high-quality services and supports closer to home; 3) Optimize disaster and epidemic response and recovery; 4) Advance excellence in agency infrastructure and operations; 5) Deliver best-in-class customer-centered experiences; 6) Foster a culture of excellence where every team member has a voice, adds value and is empowered to make a difference.

As of May 2025, the Public Health Division of NDDHHS employs 286 people, with 223 full-time employees (FTEs) and 61 non-permanent employees. The Public Health Division includes five Sections: 1) Disease Control and Forensic Pathology, 2) Healthy and Safe Communities (which includes the Title V Program), 3) Health Response and Licensure, 4) Laboratory Services, and 5) Health Statistics and Performance. The Public Health Division's mission is to improve the length and quality of life for all North Dakotans. To accomplish this mission, six goals, including two cross-cutting principles, help guide the work. The two cross-cutting principles are to Improve Health Outcomes and Use Evidence-based Practices to Make Data-Driven Decision. The Public Health Division aligns each of the cross-cutting principles to these four goals:

- Create Health and Vibrant Communities
- Enhance and Improve Systems of Care
- Strengthen Population-Based Health Interventions
- Promote Public Health Readiness & Response

The Healthy and Safe Communities Section provides support for individuals, families, and communities by providing quality programs that protect and enhance the health and safety of all North Dakotans. It is responsible for administering the state's Title V program. There are four units in the Section, which all have programs and/or funding that link to maternal and child health (MCH) priorities: Health Promotion and Chronic Disease Prevention, Family Health and Wellness, Community Engagement, and Special Health Services (SHS). Title V also provides a portion of funding to the vital services of information technology, contract and grant management, and epidemiological support that assists MCH staff with critical job functions. Refer to Section III.D.2. Budget and Section VI. Organizational Chart.

The Title V Director serves as the Unit Director for Special Health Services and serves as a member of the Healthy and Safe Communities Section Leadership Team; thereby increasing leadership and visibility for MCH within the section. The Health Statistics and Performance (HSP) Section (formerly titled the Office of the State Epidemiologist) has also undergone restructuring, resulting in three units and one office: 1) Special Projects and Health Analytics, 2) Surveillance and Data Management, 3) Vital Records, and the 4) Data Modernization Office. The MCH epidemiologist, State Systems Development Initiative (SSDI) Coordinator, Tobacco/Chronic Disease Epidemiologist, Autism Epidemiologist, Pregnancy Risk Assessment Monitoring System (PRAMS), and Behavioral Risk Factor Surveillance Systems (BRFSS) program directors/epidemiologists are all located within the HSP Section. The HSP Section provides epidemiological expertise, data analysis oversight, and enhanced data/technical support not only to MCH programs, but to the NDDHHS and external partners.

#### III.B.3. Health Care Delivery System

#### III.B.3.a. System of Care for Mothers, Children, and Families

### Section III.B.3.a. System of Care for Mothers, Children, and Families

North Dakota's system of care for mothers, children, adolescents, and families is supported by a network of state and local partners working collaboratively to meet the diverse needs of the Maternal and Child Health (MCH) population. North Dakota has established key components of a comprehensive system, including access to preventive and primary care services, prenatal and postpartum care, newborn screening and long-term follow-up, well-child visits, injury prevention initiatives, and behavioral and mental health services. Through targeted strategies and collaborative efforts, North Dakota has made significant progress in strengthening its public health infrastructure and enhancing services for the MCH population.

A significant strength of North Dakota's MCH system is its coordinated, multi-partner approach. Title V plays a key role in facilitating partnerships across state agencies, local public health units, and community-based organizations. Title V funding supports projects and initiatives that improve the ability to obtain quality care, reduce health gaps, and ensure critical services such as prenatal care, newborn screening, and early screening/intervention are available statewide. Efforts to reduce maternal morbidity and mortality, address stillbirth and infant mortality, and support bereavement care are growing through integrated programming and data-driven strategies with partners such as the University of North Dakota (UND), Maternal Mortality Review Committee (MMRC), Perinatal Quality Collaborative

(PQC), and the North Dakota Child Fatality Review Panel.

North Dakota Title V has also demonstrated innovation in addressing behavioral and mental health needs among mothers and youth, including collaborative efforts with the North Dakota Department of Health and Human Services (NDDHHS) Behavioral Health Division to expand mental health services and reduce stigma through statewide collaborative efforts like the Pediatric Mental Health Care Access grant, which the MCH Director sits on a workgroup and offers insight from Title V, and the Suicide Prevention Coalition. Additional preventative health services, such as car seat distribution, well-woman care, safe sleep education for parents, and school-based services, have further contributed to improved health outcomes across the MCH population.

Despite these strengths, challenges remain in ensuring all North Dakotans can obtain needed healthcare, particularly in rural communities. Geographic isolation, workforce shortages, and limited specialty care can impact timely access to essential services, such as high-risk prenatal care, pediatric mental health services, and substance use treatment. Transportation barriers, broadband access limitations, and socioeconomic differences further contribute to these gaps.

Additionally, there is a continued need to enhance healthcare services that can meet the needs of high-risk communities or populations. Data infrastructure improvements are also needed to inform responsive, community-driven solutions.

North Dakota's public health infrastructure, anchored within the Public Health Division of NDDHHS, is critical in supporting the health of mothers, infants, children, and families. The Healthy and Safe Communities Section and the Health Statistics and Performance Section provide leadership, data analysis, and programmatic oversight through offering programs and the data that support them to run successfully. These sections work collaboratively to ensure that public health initiatives are evidence-based, outcome-focused, and aligned with both state and national priorities.

Title V funding enhances the capacity of this infrastructure by supporting workforce development, technical assistance, and partnerships with academic institutions, like the state universities in North Dakota. This collaboration strengthens assessment, planning, and evaluation efforts, especially for populations that may have higher risks.

Through its leadership, funding, and partnerships, the Title V program remains at the heart of North Dakota's system of care, guiding efforts to address MCH priorities and promote optimal health across all communities.

#### III.B.3.b. System of Services for CSHCN

### Section III.B.3.b. System of Services for CSHCN

Children with special health care needs (CSHCN) either have or are at risk for having chronic physical, developmental, behavioral, or emotional conditions. According to the 2022 National Survey of Children's Health, 21.1% of children in North Dakota fall into this category, necessitating specialized health care services to thrive and ensure optimal health outcomes.

The North Dakota Public Health Division, part of the Department of Health and Human Services (NDDHHS), is committed to improving the length and quality of life for all North Dakotans, including CSHCN. Several key components of the state's system of care are designed to meet the needs of CSHCN, including a comprehensive array of services and extensive partnerships with stakeholders.

North Dakota has established a robust system of services aimed at enhancing the health and well-being of CSHCN. The Title V program plays a critical role in promoting and coordinating these services. This program enables staff to coordinate and fund various multidisciplinary clinics across the state, addressing specific diagnoses, including, but not limited to, asthma, cleft lip/palate, autism, metabolic conditions, and developmental evaluation clinics. Additionally, Title V staff support a medical home program at the state's largest hospital, which provides care coordination for CSHCN. Title V also has a contract with Family Voices of North Dakota to deliver essential care coordination, education, and training to CSHCN, their families, and health care providers. Furthermore, the program facilitates various initiatives, including a metabolic food program, a financial coverage program, a newborn screening program with long-term follow-up care coordination for any baby identified through newborn screening, a birth review program, and translation services aimed at ensuring health services for all and overcoming language barriers. Lastly, Title V staff engage with a Family Advisory Council composed of families with CSHCN and other stakeholders, collecting valuable feedback and expertise from family experiences to inform program and policy development.

In addition to the Title V program, North Dakota boasts a variety of other collaborative systems of care that significantly impact the lives of CSHCN. These include numerous programs within NDDHHS that offer assistance based on individual needs, such as health insurance navigation, direct care, and economic support through

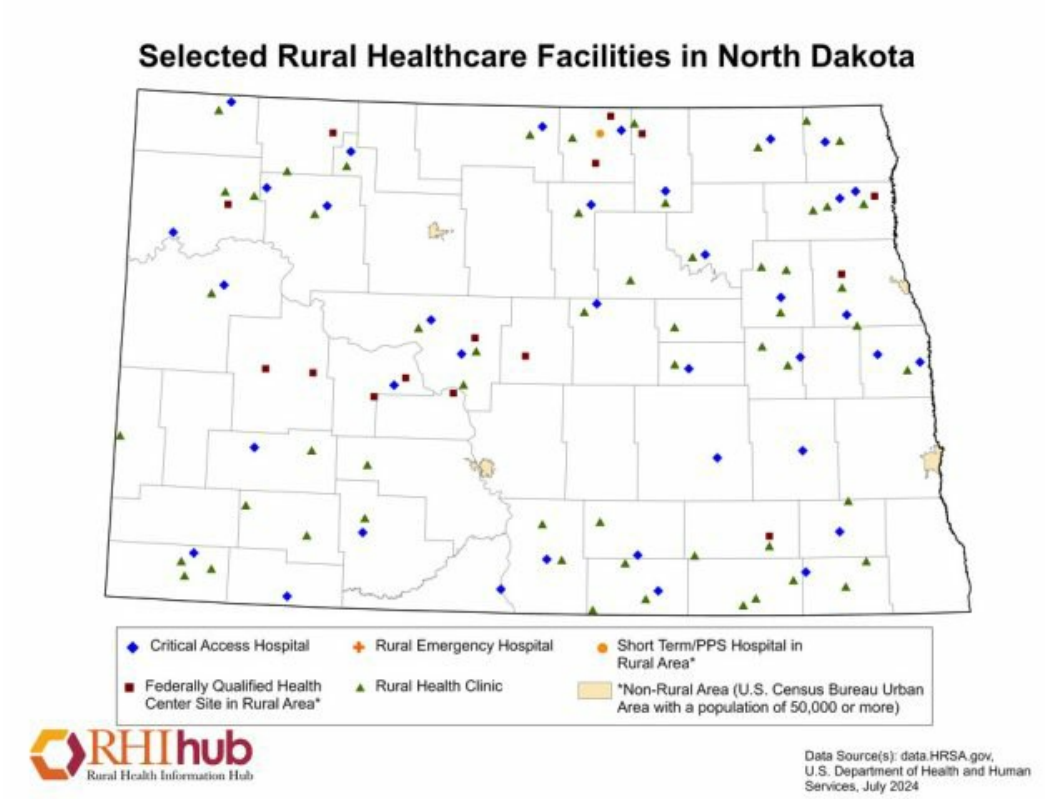
programs like North Dakota Medicaid, Emergency Medical Services for Children, Early Childhood services, Early Intervention, Vocational Rehabilitation, Developmental Disability services, Women, Infants, and Children (WIC), and Supplemental Nutrition Assistance Program (SNAP). Moreover, external organizations contribute to the comprehensive support system for CSHCN, including family support organizations (e.g., Designer Genes, Family Voices/Project Carson, Hands and Voices, First Link), educational support (e.g., Pathfinder Services, Department of Public Instruction, school nurse consultation), and other assistance programs (e.g., North Dakota Association for the Disabled, Federation of Families, Great American Bike Race, Easter Seals).

NDDHHS also prioritizes professional development. The Title V program offers various opportunities for not only NDDHHS staff but also external partners and stakeholders, including maternal and child health (MCH) lunch-and-learn sessions and an MCH Certificate program through North Dakota State University. Education and staff development are essential components of a systems-thinking approach to enhancing the care system. Additionally, North Dakota adheres to several state mandates executed by Title V staff, including program administration for CSHCN, which encompasses the provision of services and assistance to CSHCN and their families, as well as the development and operation of clinics for the identification, screening, referral, and treatment of CSHCN. Other mandates involve coordinating the newborn screening program and providing resources for children applying for Supplemental Security Income. Furthermore, North Dakota leverages innovative technology across health care systems to ensure high-quality care for CSHCN. For instance, the Health Information Network (HIN) facilitates the sharing of health care information among providers within a community or larger region, enabling the secure and accurate electronic exchange of clinical information across various health care systems utilized by a patient's different providers.

Partnerships and stakeholder engagement are vital to the system of care for CSHCN. Title V staff collaborate with other state agencies, committees, community stakeholders, and workgroups to advocate for effective and efficient systems of care. Their insights are invaluable in shaping and refining programs and services that meet the needs of CSHCN.

While North Dakota has strengths in its system of care for children with special health care needs (CSHCN), it also faces several significant challenges that may limit its capacity to address emerging issues. These challenges include:

- **Rural Issues**: The rural geography of North Dakota poses barriers to accessing healthcare services. According to the Rural Health Information Hub, 39.5% of individuals in the state reside in nonmetropolitan areas. As a result, it is common for CSHCN and their families to travel long distances to reach larger healthcare facilities.
- **Travel Barriers**: The necessity of traveling can impose financial burdens and result in time away from work for CSHCN and their families. To mitigate these challenges, it is essential to promote telehealth services, ensuring that CSHCN receive the necessary care for optimal health outcomes.
- **Shortage of Specialty Providers**: North Dakota experiences a lack of healthcare providers, particularly specialists. CSHCN often must travel across the state or even to neighboring states to access specialized care. Although the state offers a Healthcare Professional Loan Repayment program to attract providers, challenges remain in adequately staffing these essential services.
- **Limited Funding and Resources**: With constrained funding, healthcare leaders are required to accomplish more with fewer staff and resources. Title V staff and other stakeholders are actively working to streamline services and identify innovative strategies to meet the needs of CSHCN and their families despite these limitations.




In summary, North Dakota is committed to advancing a comprehensive system of care for CSHCN that fosters the healthy development and well-being of children and their families. The state has facilitated the establishment of family-professional partnerships, the promotion of the medical home model, the provision of effective health insurance navigation, and the delivery of early and continuous screening and surveillance. Additionally, efforts are being made to offer additional support services and to assist in the transition from pediatric to adult healthcare. Ongoing work in these areas will ensure that CSHCN have the ability to obtain the care they require.

**III.B.3.c. Relationship with Medicaid**

## Section III.B.3.c. Relationship with Medicaid

North Dakota's Medicaid and Title V share a common goal in working to improve the overall health of the Maternal and Child Health (MCH) population through affordable health care delivery systems and expanded coverage. Partnership and collaboration have allowed for effective leveraging of federal and state resources. Some examples of existing relationships between Title V and North Dakota Medicaid include but are not limited to:

- North Dakota Medicaid staff attend the annual Special Health Services (SHS) Medical Advisory Council meeting to advise on potential policy revisions or opportunities to partner.

- Because North Dakota Medicaid operates in a fee-for-service model, SHS has submitted suggestions and successfully partnered with members of the Medicaid Medical Advisory Committee to revise existing policy, particularly with items for children with special health care needs (CSHCN) not included in the existing North Dakota Medicaid plan. Most recently, work has taken place around improved reimbursement for school nurses by North Dakota Medicaid. For additional information about this project, see III.A.3. MCH Success Story.

- SHS has been assigned a unique health benefit plan to utilize North Dakota Medicaid's Health Enterprise Medicaid Management Information System (MMIS) to pay claims for CSHCN. Weekly claims payment reports are received by the North Dakota Department of Health and Human Services (NDDHHS) to ensure the accuracy of payments.

- SHS is an enrolled participating provider for North Dakota Medicaid and obtains reimbursement for services rendered to North Dakota Medicaid-eligible children through multidisciplinary clinics run by SHS staff (e.g., cleft lip and palate).

- The MCH women's health domain lead team member regularly meets with North Dakota Medicaid team members to discuss current work efforts and opportunities for collaboration. This is evolving into a new collaborative workgroup that will work on new state priorities in North Dakota MCH.

- The Title V Director/SHS Unit Director participates in scheduled meetings as a non-voting member for the Cross-Disability Advisory Council, which is a new potential Medicaid waiver being explored by North Dakota Medicaid.

- The SHS Claims and Eligibility Administrator and SHS Administrative Officer receive meeting invites for pertinent Medicaid Claims meetings and attend if claims issues impacting SHS are on the agenda.

- The HHS Public Health Division Designee attends the Medicaid Medical Advisory Committee meetings. Additional Title V staff attend these meetings to obtain information and provide input as requested.

- North Dakota Medicaid provides claim-level data through the NDDHHS Advantage Suite program, which pulls reports from the MMIS.

- When applying for the SHS Financial Coverage Program, the SHS Claims and Eligibility Administrator assists families of children with medical complexities to complete the application for the North Dakota Medically Fragile Waiver and routes the application directly to the waiver's administrator.

- Data sharing is currently taking place regarding state public health activities that align with the North Dakota Medicaid's Child Core Set reporting.

These initiatives set forth by the Title V align with the current Medicaid goals:

- Deliver preventive care to build resilience and elevate well-being.

- Foster a healthy start with prenatal and extended postpartum care.

- Coordinate comprehensive care for the management of chronic illnesses and behavioral health conditions.

- Integrate a forward-looking strategy that emphasizes health promotion and disease prevention.

Please refer to IV. Title V – Medicaid IAA/MOU for additional information relating to collaboration and partnerships between Title V and North Dakota Medicaid.

#### III.B.4. MCH Emergency Planning and Preparedness

**Section III. B. 4. MCH Emergency Planning and Preparedness**

The Health Response and Licensure Section is located within the Public Health Division in the North Dakota Department of Health and Human Services (NDDHHS). This section is home to the Emergency Preparedness and Response (EPR) Unit, which is dedicated to creating and promoting a state of readiness and prompt response to protect the health of North Dakotans during catastrophic events, large-scale disasters, and emergencies. This mission is accomplished by coordinating education, assessment, planning, response, and support services involving public health providers, private medical providers, public safety agencies and government officials.

The EPR Unit has a variety of resources related to its Public Health Emergency Preparedness and Response Program available on its website (https://www.hhs.nd.gov/health/emergency-preparedness-and-response/public-health-epr-program), which provides local and state public health guidance, planning, coordination, response, and

funding for large-scale emergencies. These activities include coordination and funding of incident command and control, disease control, laboratory services, communications systems, public information, medical supplies, equipment and pharmaceuticals and training. Funding for this division is provided by a cooperative agreement through the Department of Health and Human Services, Centers for Disease Control.

Also within this section is the Emergency Medical Systems (EMS) Unit. The mission of the EMS Unit is to integrate the processes, protocols, technologies, policies, and practices that are designed to provide the best possible health outcome for individuals and communities every day and during emergencies and disasters. These work activities also tie into the State Emergency Operations Plan (EOP) housed in the North Dakota Department of Emergency Services (ND DES). The Public Health Division of NDDHHS works closely with the ND DES on emergency planning and preparedness work efforts and planning activities.

Local, Tribal, and State EOPs establish direction for a systematic, coordinated approach to preparedness for, response to, and recovery from emergencies and disasters occurring within the state. The EOPs describe the policies and procedures for coordinating support and are designed to be consistent with the National Incident Management System (NIMS). North Dakota is required to update its plan every 5 years, and the ND DES is currently operating under the plan for 2024-2029. It is also noted by ND DES that disasters can impact underserved populations disproportionately. Intentionally leading with an impartial approach better allows emergency management to protect the whole community, creating a more resilient North Dakota. Additional resources and information about work being done to enhance emergency planning can be found at https://www.des.nd.gov/planning. This also includes the enhanced emergency mitigation plan for 2024-2029.

Other plans which are too sensitive to post on a public website (e.g., response to terrorism events), are available on request. All the plans on the NDDHHS website are technical descriptions that are intended for the use of response partners, including other North Dakota state and federal health agencies. The public can review the plans, ask questions, or make comments. These emergency response plans are a process of continuous improvement and are revised as procedures change or as more is learned through exercises, real events, and partner feedback. The plans provide guidelines for action during a disaster/emergency, rather than a set of rules that must be followed during an event. The plans do not have specific sections for the maternal and child health (MCH) population, but considerations for the MCH population are incorporated into aspects of the plans.

Title V program staff were not directly involved or consulted in the planning and development of the state's emergency operation plans. However, the Healthy and Safe Communities Section Director, who also oversees Title V within her section, is a member of the Public Health Division's Senior Leadership Team and provides insight and feedback into emergency preparedness planning.

When communication plans, tools, or strategies are developed as part of statewide preparedness for addressing impacts of disasters and emerging threats on the MCH population, Title V staff are consulted and involved in these efforts. Working with schools during COVID-19 is a good example of this involvement. During the height of the COVID-19 pandemic, the Healthy and Safe Communities Section Director was asked to form a COVID-19 school response team. The Title V School Health Specialist was assigned to lead the COVID-19 School Response Team, and several other Title V staff were actively engaged in this team (e.g., Title V/Special Health Services (SHS) Director, SHS Program Administrators, MCH State School Nurse Consultant, Community Engagement Director). Many processes, procedures, strategies, and tools were developed, disseminated, and implemented as part of the COVID-19 school response. Many of these tools can still be found on the NDDHHS website at https://www.hhs.nd.gov/health/coronavirus.

Title V program staff also participate in the development of coordination plans to enhance statewide preparedness for addressing the impacts of disasters and emerging threats on the MCH population. The need for a formalized contingency plan has been a longstanding conversation with partners at the University of Iowa's State Hygienic Lab, which currently processes North Dakota's newborn blood spot specimens. Contingency planning for an emergency helps to ensure the availability of critical resources, the continuity of operations, and sets standards for entities participating in the activation of the plan. Although it is anticipated that babies born in North Dakota during an emergency would continue to be screened through the Iowa State Hygienic Lab, efforts are being made to establish additional contingency plans if this process were to be interrupted at any point during such an emergency. In the past year, North Dakota has received additional newborn screening funding. Adhering to established standards and maintaining continuity of testing and follow-up play critical roles in the screening, diagnosis, referral, and treatment of disorders identified in newborn screening, especially during a public health emergency.

The SHS Unit also recognized that the pandemic resulted in health care disruptions and significant strain on families, especially those of children with special health care needs (CSHCN). SHS implemented advancements in programs to ensure that families have access to additional medications through special prior authorizations, direct shipping of necessary metabolic formula, and care coordination from state-level staff. Because of the positive response seen during the pandemic, many of these programmatic changes have remained in effect today, and efficiencies that would benefit families are continuously being explored.

## III.C. Needs Assessment

### III.C.1. Five-Year Needs Assessment Summary and Annual Updates

### III.C.1.a. Process Description

### Section III.C.1.a. Process Description

North Dakota's 2025 Title V Five-Year Needs Assessment was designed and executed as a comprehensive process, grounded in both data and stakeholder input, to identify priority maternal and child health (MCH) issues across the state. The state's approach exemplified four key characteristics that move beyond a purely data-driven analysis and toward a holistic, community-informed process: (1) a clear leadership structure, (2) robust stakeholder engagement, (3) a structured priority-setting process, and (4) collaborative planning and continuous improvement. This summary outlines the goals, framework, methods, and decision-making that shaped the assessment process and informed the development of North Dakota's Title V priorities and Action Plan.

#### Goals, Framework, and Methodology

The goal of North Dakota's Needs Assessment was to identify the most pressing needs of the state's MCH population across five population health domains: Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, and Children and Youth with Special Health Care Needs (CYSHCN). The assessment aimed to ensure that the state's Title V program reflects current trends, fills service gaps, and supports effective, evidence-based public health strategies.

The process was led by the MCH Core Leadership Team in partnership with North Dakota State University (NDSU), which was contracted to support facilitation, data analysis, and synthesis. Beginning in April 2024, the MCH and NDSU teams held biweekly meetings to coordinate roles, develop tools, and establish a shared understanding of timelines, evaluation expectations, and quality control measures. The formal scope of the assessment ran from May 2024 through June 2025. Domain-specific work began in July 2024, including meetings with each MCH Domain Lead to discuss programmatic priorities and data readiness.

A Microsoft Teams site was established to serve as a centralized repository for all relevant documents, tools, notes, and reports. This digital infrastructure supported real-time coordination across program areas.

#### Leadership and Stakeholder Engagement

North Dakota implemented a clearly defined leadership structure that coordinated internal staff, domain leads, family and community partners, and external evaluators from NDSU. This structure supported the gathering of data from a wide range of sources, including input from family organizations, tribal health partners, rural programs, and public health entities.

Stakeholder engagement was prioritized at every stage. The state developed and disseminated a statewide stakeholder survey, which was finalized in December 2024 and released in January 2025. Outreach was conducted broadly, targeting public, nonprofit, and private sector professionals working with MCH populations—including Family Voices of North Dakota (the state's Family-to-Family Health Information Center), tribal leaders, educators, healthcare providers, and individuals.

The results of the stakeholder survey achieved a 69% response rate. Among respondents, 20% represented Tribal affiliations. Respondents were from all regions of the state and represented all five population health domains. Input from families of CYSHCN, low-income individuals, and rural service providers was specifically sought and prioritized during outreach and analysis.

#### Quantitative and Qualitative Methods

The Needs Assessment integrated both quantitative and qualitative approaches. Quantitative sources included a

variety of state and federal data, including but not limited to:
- The National Survey of Children's Health (NSCH)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Vital Records and Birth/Death Certificates
- Medicaid claims data
- Statewide immunization and screening registries
- Previous MCH annual reports and epidemiological trend data

Qualitative data were collected through the stakeholder survey's open-ended questions, key informant interviews with domain leads, feedback from the MCH Core Leadership Team, and a March 4, 2025 multi-partner stakeholder meeting that reviewed survey results and draft priority measures. Public comments were also solicited following the release of preliminary priorities and contributed important contextual understanding of local challenges and perspectives.

**Structured Priority-Setting and Analysis**

The stakeholder survey focused on identifying the top needs for each MCH population. Participants ranked and described the top issues within their communities. The results were compared alongside program data to find areas of consensus.

Findings from the survey and data profiles revealed consistent needs across all domains: access to mental health services, family support and childcare, and health insurance coverage emerged as top concerns. Notably, access issues were more acute in rural and tribal communities, where provider shortages and logistical barriers persist.

From February to March 2025, internal workgroups composed of epidemiologists, MCH program staff, and other public health partners met to assess feasibility, capacity, and alignment with national and state performance measures. Structured prioritization took place using scoring criteria to guide decision-making. Draft priorities were shared for public comment in March 2025 through online postings and a statewide press release.

**Data-Informed Priorities and Action Plan Integration**

The priorities selected reflect the intersection of stakeholder voice, public health data, programmatic feasibility, and alignment with the Title V National Performance Measures (NPMs) or identified cross-cutting State Priority Measures (SPMs). These final priorities were translated into measurable objectives and performance measures, embedded in the state's Title V Action Plan:

*Women and Maternal Health*

NPM-Postpartum Visit: A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth, and B) Percent of women who attended a postpartum checkup and received recommended care components

Priority: Identify, reduce, or eliminate barriers preventing women from receiving recommended postpartum care components, including but not limited to mental health screening, breastfeeding support, care coordination, etc.

*Perinatal and Infant Health*

NPM-Safe Sleep: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult

Priority: Support services, programs, and activities that encourage safe sleep.

*Child Health*

NPM-Food Sufficiency: Percent of children, ages 0 through 11, whose households were food sufficient in the past

year

Priority: Improve accessibility to healthy food options through community resources (schools, food banks, health units, etc.)

NPM-Medical Home-Care Coordination: Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination.

Priority: Improve care coordination to link the MCH population to essential services and resources.

*Adolescent Health*

NPM-Mental Health Treatment: Percent of adolescents, ages 12 through 17, who receive needed mental health treatment and

Priority: Identify, reduce, or eliminate barriers preventing adolescents from receiving mental health treatment and counseling.

Children with Special Health Care Needs (CSHCN)

NPM-Medical Home-Overall: Increase the number of children with special healthcare needs engaged in medical home

Priority: Improve the system of care for children with special health care needs.

*Cross-Cutting*

SPM- “Vision Zero”: State initiative to eliminate fatalities and serious injuries caused by motor vehicle crashes

Priority: Reduce serious motor vehicle injuries and fatalities to North Dakotans younger than 21 years of age.

SPM-State Mandates: Implement North Dakota state mandates for the Maternal Child Health (MCH) population

Priority: To implement all North Dakota state mandates delegated to the NDDHHS Title V/Maternal and Child Health Programs.

SPM-Access to Services: Improve access to health-related services to improve health and well-being

Priority: Increase awareness and the utilization of statewide services or resources.

**Continuous Quality Improvement and Cross-Sector Planning**

This assessment built a foundation for ongoing quality improvement. Domain Leads and MCH staff will continue to meet regularly to track performance, implement strategies, and course-correct based on evaluation feedback. Cross-sector collaboration—particularly with Medicaid, tribal health partners, behavioral health, education, and early childhood networks—will support alignment and shared accountability.

**Enhanced Domain-Specific Descriptions**

Each of the five population health domains was carefully analyzed using both the quantitative and qualitative methods described above. These detailed assessments allowed the state to uncover critical gaps and opportunities that could be addressed through evidence-based programming.

*Women and Maternal Health*:

North Dakota's analysis of this domain included review of PRAMS data, and Medicaid data utilization. Stakeholders frequently cited housing instability, lack of postpartum care, and inadequate mental health support as critical barriers. Low-income women, particularly in rural areas, experience challenges accessing consistent postpartum follow-up and counseling. As a result, the state prioritized increasing the percentage of women attending postpartum visits and ensuring those visits include all recommended care components.

*Perinatal and Infant Health:*

Data revealed differences in breastfeeding initiation and duration rates, with rural and American Indian (AI) communities experiencing lower rates. The stakeholder survey also pointed to preventable risks in infant sleep environments. Many providers in the survey noted the need for more educational materials. North Dakota has responded by working with various health partners and public health units to increase training on safe sleep practices and breastfeeding support.

*Child Health:*

Food sufficiency was repeatedly highlighted as a barrier to healthy child development. SNAP participation data, school lunch program utilization, and qualitative comments through the stakeholder survey indicated that hunger remains a persistent issue. Based on these findings, North Dakota's Title V program may collaborate with new partners such as local food banks, early childhood programs, and rural health centers to increase access to healthy foods and other developmental supports.

*Adolescent Health:*

Adolescent mental health was identified as a crisis across all regions. Emergency department data, mental health referrals, and community feedback in the stakeholder survey pointed to increasing anxiety, depression, and suicide ideation among youth. The pandemic's lingering effects on social isolation and academic stress were also noted. The priority to increase access to needed mental health treatment will be addressed through projects such as telehealth expansion, school partnerships, and anti-bullying initiatives.

*Children with Special Health Care Needs (CSHCN):*

Families of children with special health needs reported difficulties navigating fragmented systems of care. Many cited a lack of consistent care coordination and communication across providers. Medical home data showed wide variation in access to family-centered services and transition planning for youth approaching adulthood and changing to adult health care. As a result, the state's focus will be on strengthening medical home infrastructure within the CSHCN domain and developing tools to support additional care coordination, which is an additional priority in the Child Health domain.

**Broader System of Care and Capacity**

The Needs Assessment also examined the broader public health infrastructure and service capacity to support these priority needs. Interviews with MCH Domain Leads and reviews of staffing models highlighted a need for cross-training and shared learning across domains. To address this, North Dakota is exploring updates to the Public Health Workforce Development Plan and implementing new trainings on topics identified as areas of need.

A particular strength of North Dakota's system is its tight coordination between state agencies, such as the North Dakota Department of Health and Human Services (NDDHHS), North Dakota Department of Public Instruction (DPI) and the North Dakota Department of Transportation (DOT). Through this coordination, Title V programming is better able to reach underserved populations and leverage shared data systems. However, gaps remain in rural workforce capacity, mental health provider availability, and family navigation services.

**Strategic Data Use and Accountability**

North Dakota leveraged multiple HRSA and MCHB-funded investments to inform its Needs Assessment. In addition

to the NSCH and PRAMS, the state utilized:
- Title V Information System (TVIS) benchmarking data
- Newborn screening outcomes, including long-term follow-up
- Data from program data reports and child find activities
- Findings from prior Title V and grant-funded projects

These data sources not only informed the identification of needs but also shaped performance measure selection. Data dashboards developed for internal use are now being adapted for public-facing transparency efforts. Many can be found on the NDDHHS website (https://www.hhs.nd.gov/health/data-statistics). North Dakota will report annually on each priority and use a continuous quality improvement (CQI) methodology to refine strategies.

**Forward Planning and CQI Integration**

The Needs Assessment laid the foundation for North Dakota's 2025–2030 Title V Action Plan. This plan will serve as a roadmap for investments, grantmaking, and statewide collaboration. Each priority area includes a table that outlines key objectives, strategies, and activities, resources available, evidence-based strategy measures, and expected outcomes over the five-year cycle.

North Dakota's approach integrates CQI at each stage of program implementation. Scheduled progress reports from grantees, performance audits, site visits, and other evaluation methods will be used to evaluate impact and guide any needed adjustments. Family and youth advisors will participate in this process through the SHS Family Advisory Council and potentially the Youth Advisory Board.

**Additional Stakeholder Engagement and Family Partnership**

Stakeholder participation was not limited to survey completion alone. Throughout the assessment period, partners were actively involved in shaping the process and outcomes. Family Voices of North Dakota provided critical input on the accessibility of services for families, barriers to care, and family-centered responsive strategies. These partners also participated in meetings regarding upcoming workplans and provided feedback on draft domain profiles and survey questions, especially via the Special Health Services Family Advisory Council.

**Alignment with Federal and State Priorities**

The final priority areas chosen through the Needs Assessment align with both the national Title V MCH performance framework and state-specific health transformation initiatives. For example, the focus on mental health access supports North Dakota's broader Behavioral Health Strategic Plan, which aims to close treatment gaps and expand community-based services. Similarly, the priority on food sufficiency aligns with the state's and childhood obesity prevention efforts outlined in the State Health Improvement Plan (SHIP) that can also be found on the NDDHHS website (https://www.hhs.nd.gov/sites/www/files/documents/DOH%20Legacy/Systems%20and%20Performance/ND%20Stat2029.pdf).

Additionally, safe sleep and breastfeeding promotion efforts contribute to broader maternal and infant health goals set forth in the Healthy North Dakota 2030 plan. Alignment with Medicaid's maternal health strategies, such as postpartum coverage extension, further strengthens the cross-program impact of the Title V work.

**Use of Technology and Innovation in Assessment**

Throughout the assessment, the MCH team embraced technology to enhance communication, data collection, and analysis. The Microsoft Teams platform housed version-controlled documents and real-time updates. NDSU developed interactive data visualizations and infographics through domain-specific wellness profiles to make findings more accessible to community partners and decision-makers.

Virtual meetings allowed for expanded engagement among rural and tribal stakeholders who might otherwise face geographic barriers to participation. A custom-built Qualtrics stakeholder survey instrument allowed for branching

logic, ensuring a tailored experience for different respondent groups while collecting comprehensive input.

**Lessons Learned and Opportunities for Improvement**

Several lessons emerged from North Dakota's Five-Year Needs Assessment process. First, early and sustained collaboration with family-led organizations led to more relevant questions and deeper engagement at Family Advisory Council meetings. Second, integrating qualitative and quantitative data revealed insights that would have been missed using a single method alone. Third, allocating time for internal prioritization and feasibility discussions allowed for a more practical and sustainable set of final priorities.

However, opportunities for growth remain. Despite strong outreach, some underserved populations, particularly non-English speakers and individuals with disabilities, remained underrepresented in the survey sample. To address this, future assessments will need to incorporate translated materials, interpreter support, and increased collaboration with disability advocacy groups, such as the State Council on Developmental Disabilities.

**Future Directions and Sustainability**

The findings and partnerships generated during the Needs Assessment will guide the next phase of North Dakota's Title V programming. Key next steps include:

- Developing workplans for each domain priority, with clear timelines and accountable leads.
- Updating the existing Title V dashboard to track progress toward new NPMs and SPMs.
- Hosting bi-monthly Title V meetings for public health staff and inter-agency partners to participate in.
- Investing in new partnerships to address behavioral health and care coordination, since these are new focus areas for the next five years.
- Explore supplemental funding opportunities that align with the identified priorities.

To sustain momentum, North Dakota's Title V team will integrate stakeholder engagement into its ongoing operations. Annual news releases seeking public comment on annual workplan activities, Family Advisory Council meetings, and data sharing via the various dashboards will ensure continuous feedback and course correction.

**Conclusion**

North Dakota's comprehensive Five-Year Needs Assessment process successfully combined leadership, stakeholder insight, structured analysis, and collaborative planning. By weaving together data, staff expertise, stakeholder feedback, and systems thinking, the state has identified a clear set of actionable priorities that reflect the realities faced by families and providers alike.

As North Dakota enters the next phase of MCH transformation, the lessons, partnerships, and data from this process will serve as a guidepost. Title V remains a vital lever for improving health outcomes and building a system of care that truly meets the needs of all mothers, children, and families in the state.

For further details about the North Dakota Five-Year Needs Assessment, see Section V. Supporting Documents or visit https://www.ndsu.edu/csr/research_and_evaluation to see the full report from NDSU.

**III.C.1.b. Findings**

**III.C.1.b.i. MCH Population Health and Wellbeing**

**Section III.C.1.b.i. MCH Population Health and Well-Being**

North Dakota's 2025 Title V Needs Assessment offers an in-depth examination of the health and well-being of the state's Maternal and Child Health (MCH) population across five defined domains: Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, and Children with Special Health Care Needs (CSHCN). This assessment compiles the most recent and relevant quantitative and qualitative data to evaluate the state's strengths, identify gaps in services and outcomes, and guide strategies supported by the Title V Maternal and Child Health Services Block Grant.

The assessment is grounded in comprehensive quantitative data sources, including the North Dakota Pregnancy Risk Assessment Monitoring System (https://www.hhs.nd.gov/prams), the North Dakota Behavioral Risk Factor Surveillance System (https://www.hhs.nd.gov/data/north-dakota-behavioral-risk-factor-surveillance-system), the National Survey of Children's Health (NSCH) (https://www.childhealthdata.org), and state vital records (https://www.hhs.nd.gov/vital), and available North Dakota Medicaid or Title V programmatic data.

Qualitative data was evaluated from stakeholder input from the State Health Improvement Plan (SHIP) (https://www.hhs.nd.gov/health/north-dakota-state-health-improvement-plan-ship), the most recent Title V MCH Needs Assessment stakeholder survey, interviews with MCH Domain Leads, and feedback through council and board meetings, such as the Special Health Services Family Advisory Council. These sources collectively present a high-level picture of how health and wellness vary across age, geography, payer source, and other demographic characteristics.

**Women and Maternal Health**

North Dakota has experienced continued shifts in maternal health indicators. In 2023, the state's fertility rate was 62.0 births per 1,000 women aged 15–44, remaining higher than the national average of 54.5 (https://www.marchofdimes.org/peristats/data?lev=1&obj=1®=38&slev=4&sreg=38&stop=1&top=2). Nearly half of all women of reproductive age reside in rural or frontier counties, increasing challenges in service delivery, particularly where facility closures and provider shortages have occurred.

As of 2024, 73.6% of North Dakota counties are classified as maternity care deserts, compared to approximately 35% nationally (https://www.marchofdimes.org/peristats/data/old?lev=1&obj=18®=38&slev=4&stop=641&top=23). This designation reflects limited or no access to obstetric care, contributing to delayed prenatal services and travel-related barriers. In 2023, 81.1% of women in North Dakota initiated prenatal care in the first trimester, an improvement from 80.9% in 2022 (https://www.marchofdimes.org/peristats/data?lev=1&obj=3®=99&slev=4&sreg=38&stop=20&top=5).

Maternal mortality and morbidity remain to be concerns for North Dakota. Between 2017 and 2022, 998 deaths occurred among women ages 18 to 44, with the leading causes including injury, suicide, and cancer (https://www.hhs.nd.gov/vital). Among these, 20 women were pregnant at the time of death, and 20 others had been pregnant within the previous year. These findings support expanded efforts around perinatal mental health screening and integrated behavioral health services.

Mental health challenges among women of reproductive age continue to rise. From 2017 to 2021, 19% of women reported frequent mental distress, defined as 14 or more days of poor mental health within the past month, with rates among American Indian (AI) women reaching 24% (https://www.hhs.nd.gov/data/north-dakota-behavioral-risk-factor-surveillance-system).

Postpartum visit attendance was selected as a priority area due to its direct connection to maternal health outcomes and continuity of care. Data and stakeholder feedback revealed that a significant proportion of women, particularly those with low income or living in rural counties, do not receive a comprehensive postpartum visit within the recommended six-week window. This gap hinders early identification of complications, mental health conditions, and chronic disease risks. Prioritizing postpartum visit follow-up presents an opportunity to address maternal mortality, promote long-term wellness, and improve infant bonding and breastfeeding support.

**Perinatal and Infant Health**

North Dakota's infant mortality rate has seen fluctuations in recent years. From 2020 to 2022, the average infant mortality rate was 4.4 per 1,000 live births, lower than the national rate of 5.6 (https://www.hhs.nd.gov/vital). However, differences persist, particularly among AI infants who experienced mortality rates approximately 1.5 times higher than the state average.

Low birthweight rates remain relatively stable at 7%, below the national average of 8%

(https://www.childhealthdata.org). Nonetheless, counties such as Rolette, Benson, and Sioux, where rates of inadequate prenatal care are highest, also demonstrate poorer infant health outcomes.

Access to perinatal care in rural areas continues to pose challenges. While 45.3% of North Dakota births take place in rural counties, only 26.9% of maternity providers are based in those areas. Women in rural settings travel an average of 32.4 miles to reach the nearest birthing hospital (https://www.marchofdimes.org/peristats).

Insurance coverage remains a key factor in access to care. In 2022, 22.3% of births in North Dakota were covered by Medicaid. Infant deaths among Medicaid-insured families accounted for 40.5% of total infant deaths, highlighting the need for enhanced case management (https://www.hhs.nd.gov/vital). The average number of prenatal visits for Medicaid-covered pregnancies ending in infant death remains below national recommendations.

Safe sleep practices were identified as a priority due to preventable infant deaths associated with unsafe sleep environments. North Dakota's mortality review and public health surveillance have consistently shown that sudden unexpected infant deaths (SUIDs) are linked to co-sleeping, prone positioning, and soft bedding. These patterns are most prevalent among certain populations. Community input during the MCH needs assessment highlighted a need for more safe sleep messaging and material supports like cribs and sleep sacks. This priority aims to reduce infant mortality and increase caregiver knowledge and confidence.

**Child Health**

From 2017 to 2022, North Dakota recorded 2,778 deaths among children ages 0 to 19. Of these, 56.5% occurred among males and 43.5% among females. White children accounted for 83.2% of deaths, while AI children represented 13%, which is a figure disproportionately high relative to their population. (https://www.hhs.nd.gov/vital).

While insurance coverage for children remains strong—93% had some form of insurance in 2021–2022, only 59.9% had continuous and adequate coverage (https://www.childhealthdata.org). Access and follow-up are particularly strained in rural counties, where behavioral and developmental screening rates are lower.

Food sufficiency and care coordination were selected as priorities for the child health domain based on growing evidence that unmet basic needs and fragmented services are contributing to poor health outcomes for children. Difficulty accessing nutritious food, especially in rural or low-income communities, is a barrier to a child's growth, school performance, and well-being. Additionally, providers and family leaders have highlighted that many children, especially those with developmental, behavioral, or chronic health needs, are not being connected across systems, resulting in missed referrals and caregiver stress. Prioritizing these areas supports both immediate and long-term child health stability.

**Adolescent Health**

Adolescents in North Dakota face rising mental and behavioral health concerns. According to 2021–2022 national data, 21.6% of adolescents reported experiencing a major depressive episode in the past year (https://www.samhsa.gov/data/report/2021-2022-nsduh-state-prevalence-estimates). The state also ranks 4th nationally in binge alcohol use among individuals aged 12 and older, with a prevalence of 26.7%.

Suicide continues to be a leading cause of death for adolescents in North Dakota. In 2022, the adolescent suicide rate was 22 per 100,000 population (https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm). Rural communities face significant limitations in access to in-school behavioral health services, and many students must rely on telehealth or external referrals.

The Title V program has supported several adolescent health initiatives, including a state school nurse consultant to support school nurses throughout the state, and school-based mental health telehealth services in some areas through Title V funding. However, continued efforts are needed to address the growing demand for workforce support, provider training, and peer-based engagement through evidence-based programs.

Mental health treatment was selected as a priority for adolescents due to the consistent increase in reported

depressive symptoms, suicide rates, and service access challenges across the state. Public health data, school health providers, and family stakeholder input all pointed to a significant unmet need for early intervention, treatment services, and crisis response for youth. Many adolescents, particularly those in rural communities, face long wait times, limited in-school support, or a lack of insurance coverage for therapy or psychiatry. Prioritizing mental health treatment aims to close these gaps and expand access to services and supports for adolescents.

**Children with Special Health Care Needs (CSHCN)**

Based on 2022–2023 National Survey of Children's Health data, 21.8% of North Dakota children were identified as having special health care needs (https://www.childhealthdata.org). Among system components, 68.3% of CSHCN received preventive medical and dental care, while 48.6% had continuous insurance. Just 42.0% were served through a medical home, and only 27.5% of adolescents with special health needs received transition planning to adult care.

Care gaps are most pronounced among children from single-parent households, low-income families, and rural communities. Children with multiple adverse childhood experiences (ACEs) are significantly less likely to receive coordinated services. Only 41.4% nationally of CSHCN with two or more ACEs had access to shared decision-making or effective care planning.

Title V investments have supported multidisciplinary clinics, family outreach through a contract with Family Voices of North Dakota, and pilot projects for bringing adolescent well-visits to a tribal community. Stakeholder input in the most recent needs assessment has called for improved navigation support, enhanced provider collaboration, and expanded behavioral health services for adolescents, especially those with special health care needs.

The medical home was selected as a priority for the CSHCN domain because of its critical role in delivering coordinated, continuous, and family-centered care. Despite relatively strong insurance coverage rates in North Dakota, fewer than 6 in 10 CSHCN are served by a medical home, with even lower rates among those living in rural areas, low-income households, or managing multiple chronic conditions. Families consistently reported difficulty navigating referrals, repeating their child's history across providers, and struggling with gaps in follow-up care. Strengthening access to medical homes aims to improve the overall quality and experience of care for CSHCN and reduce caregiver burden.

**Conclusion and Future Directions**

This highlights both measurable progress and ongoing challenges within North Dakota's MCH system. Women and mothers in rural, frontier, and tribal areas continue to face obstacles in accessing timely and adequate prenatal care. Differences in maternal and infant outcomes are particularly evident among AI populations and Medicaid-covered births, pointing to a need for expanded outreach and community-based navigation.

While health insurance coverage remains high among children, continuity of care, especially for those with behavioral health or developmental concerns, remains inconsistent, particularly in rural regions. Hospital utilization data shows significant demand for neonatal and psychiatric services, underscoring the importance of coordinated pediatric care and early behavioral health intervention.

Adolescent behavioral health continues to emerge as a critical concern. Rates of depression, suicide, and substance use among youth remain elevated, with rural communities facing distinct challenges in workforce availability and service delivery infrastructure. School-based supports are limited, and families often rely on telehealth or long-distance referrals. Strengthening early intervention, peer support, and in-school mental health services will be vital to addressing these needs.

CSHCN face the greatest challenges in care coordination, especially those with multiple ACEs or those living in single-parent or low-income households. Data shows that most children with complex needs are not being served in fully functional systems, pointing to an urgent need for comprehensive care models, provider collaboration, and targeted support for transition-aged youth.

The Title V program has made significant strides in addressing priority needs through responsive, data-informed programming. To build on these efforts, the following strategic priorities are recommended for the next five-year cycle:

- **Expand collaboration with Medicaid and other state funders** to align payment models and service delivery systems for MCH services, particularly in rural areas.
- **Strengthen the workforce**, with a focus on behavioral health professionals, maternal care providers, and pediatric specialists serving high-need regions.
- **Invest in technology and infrastructure** that supports real-time data reporting, care coordination, and family navigation tools to enhance system responsiveness.
- **Enhance engagement of families, youth, and community leaders** to guide program design, implementation, and evaluation, ensuring services are accessible, respectful, and aligned with community priorities.

North Dakota's Title V program remains committed to advancing the health and well-being of mothers, children, and families through a responsive and collaborative public health system. By leveraging partnerships, improving access, and addressing persistent gaps in services, the program will continue to serve as a vital force in promoting healthy development and equitable outcomes across the lifespan.

#### III.C.1.b.ii. Title V Program Capacity

#### III.C.1.b.ii.a. Impact of Organizational Structure

### Section III.C.1.b.ii.a. Impact of Organizational Structure

The organizational structure of the North Dakota Department of Health and Human Services (NDDHHS) has had a profound and largely positive effect on the state's ability to provide integrated, community-based health and human services. The 2022 unification of the Departments of Health and Human Services broke longstanding silos and facilitated coordinated care across physical, behavioral, and human service systems. This realignment led to shared staffing, centralized data infrastructure, and more efficient service delivery, minimizing duplication and enabling an organized response to statewide health needs.

The department's reach now extends through eight Regional Human Service Centers and 19 Human Service Zones, improving access in every region of the state. This model brings services directly to communities, especially rural and tribal areas, using a flexible, blended workforce of in-person, remote, and mobile staff. As a result, NDDHHS is better positioned to deliver quality, person-centered care that reflects the needs of all North Dakotans.

Strong data infrastructure housed in the Health Statistics and Performance (HSP) Section further supports the agency's mission. Through its specialized units and Data Modernization Office, HSP functions as the data backbone for real-time surveillance, evaluation, and epidemiological support, particularly for programs serving maternal and child health (MCH) populations. These tools enable data-informed decisions that contribute to better health outcomes at the population level.

MCH services are strategically integrated within the Healthy and Safe Communities Section under the leadership of Director Kim Mertz. Four critical units fall under her purview: Community Engagement, Family Health and Wellness (FHW), Health Promotion and Chronic Disease Prevention, and Special Health Services (SHS). The FHW Unit includes initiatives such as breastfeeding, nutrition, and childhood obesity prevention, child vehicle safety (Vision Zero), reproductive health, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Meanwhile, the SHS Unit houses Title V's Children with Special Health Care Needs (CSHCN) programs, including Newborn Screening and Long-term Follow-up, Coordinated Services, the Financial Coverage Program, and the CSHCN System Enhancement Program.

Leadership for MCH is embedded at multiple levels across both units. Title V Director Kimberly Hruby, located within SHS, ensures visibility and alignment of MCH priorities across agency initiatives. The CSHCN program is led by CSHCN Director Danielle Hoff, who oversees program administration and coordination of services for children and youth with special health needs. Within FHW, MCH program areas are overseen by Beth Oestreich, whose leadership supports cross-domain programming in injury prevention, nutrition, and reproductive health. These units work collaboratively to braid and layer resources and build inclusive, responsive services for families statewide.

By embedding public health functions within a broader human services perspective, NDDHHS is now more capable

of addressing health factors, including housing stability, food access, and mental and behavioral well-being. The agency's approach has shifted from fragmented, condition-specific interventions to long-term, community-wide strategies focused on prevention and resilience.

Through this structure, MCH has been elevated as a statewide priority. Title V leadership is engaged in strategic planning and interdepartmental teams, supporting a workforce culture that is empowered to innovate at the local and regional level. This positioning helps ensure that community input, data insights, and cross-sector partnerships guide both policy and practice.

The department’s large size and structural complexity can also present ongoing challenges. Coordination across multiple divisions, units, and teams can lead to communication lapses. To maintain effectiveness, NDDHHS must continue investing in cross-training, clear role definitions, and streamlined systems that encourage collaboration without overwhelming staff.

NDDHHS’s integrated, strategic, and responsive organizational design provides a strong foundation for achieving its vision of becoming the “Healthiest State in the Nation.” By fostering meaningful partnerships, addressing health challenges, and embedding evidence-based practices into operations, the department is well-positioned to support holistic well-being for all North Dakotans.

#### III.C.1.b.ii.b. Impact of Agency Capacity

### Section III.C.1.b.ii.b. Impact of Agency Capacity

The integration of the North Dakota Department of Health and Human Services (NDDHHS) in 2022 has significantly expanded the state’s capacity to address maternal and child health (MCH) priorities through the Title V program. By unifying programs such as behavioral health, public health, and human services the state strengthened its ability to support comprehensive, family-centered care for all North Dakotans. Title V programming now benefits from coordinated leadership, data-driven strategies, and an extensive service delivery network that reaches every part of the state through eight Regional Human Service Centers and nineteen Human Service Zones.

NDDHHS operates Title V programming within the Healthy and Safe Communities Section, divided across two key organizational units: Family Health and Wellness (FHW) and Special Health Services (SHS). These units coordinate across all five population health domains, including services for Children with Special Health Care Needs (CSHCN). Title V work efforts are led by a highly engaged group that includes the Title V Director, a CSHCN Director, the FHW MCH Lead, and additional program leads for each domain. This leadership structure ensures that MCH priorities have strong visibility and are embedded within broader strategic decisions across the agency.

The Health Statistics and Performance (HSP) Section plays a vital role by providing epidemiological expertise, tracking performance metrics, and supporting modernized data infrastructure. This data capacity enables the state to respond swiftly and appropriately to shifting community health needs. Title V also engages actively with partners across sectors, collaborating with local public health units, tribal communities through Tribal Health Liaisons, education systems, universities, and health care providers. These partnerships help advance goals like increasing access to reproductive health services, improving care coordination, and addressing the rising behavioral health needs of adolescents.

Despite its many strengths, the department faces challenges common to large, integrated systems. Coordination fatigue and the complexity of communication between numerous team members require careful planning and structure. Additionally, longstanding challenges in prenatal care access remain, particularly among mothers in tribal communities, who on average receive only five prenatal visits, and among rural mothers, who receive an average of six compared to seven in urban areas. There are also persistent coverage gaps: just under 60% of children have continuous and adequate health insurance, and only 5.6% of CSHCN receive care within a well-functioning system, below the national benchmark of 7.4%.

Across the five population health domains, NDDHHS has demonstrated targeted, responsive efforts. In the area of women and maternal health, the FHW unit leads key programs that support reproductive health, family planning, WIC services, breastfeeding promotion, and prevention of intimate partner violence. While most women are covered by

insurance, gaps remain in prenatal care use, which the department works to address through community outreach, health education, and partnerships with providers.
In perinatal and infant health, the state has made progress in reducing low birthweight, currently reporting a rate of 7%, below the national average. However, infant mortality continues to disproportionately affect Native American and adolescent mothers. Medicaid now covers a growing share of births associated with infant deaths, increasing from 26% in 2018 to over 40% in 2022. Title V programming addresses these risks through newborn screening and follow-up, safe sleep promotion, and culturally informed perinatal education initiatives.

North Dakota also continues to strengthen child health programming. Between 2017 and 2022, injuries, suicide, and cancer emerged as leading causes of child death. Hospital data show significant costs and long stays for children with serious illness or trauma, underscoring the need for prevention. Title V efforts include Vision Zero (child vehicle safety), injury and nutrition education, and partnerships with schools and pediatric providers to reach children early.

In adolescent health, the state confronts growing behavioral health concerns. Suicide is currently the third leading cause of death among teens, and binge drinking among youth ranks fourth highest nationally. Nearly one in five adolescents experiences a major depressive episode each year. In response, Title V supports school-based prevention efforts, peer-led programming, and mental health literacy initiatives to reduce risk and connect youth to care.

Services for Children with Special Health Care Needs (CSHCN) are administered through the SHS Unit with leadership from a medical director and dedicated program administrators. While 25% of adolescents with special health care needs report receiving support for their transition to adult care, only about half have access to a medical home or consistent health coverage. Title V continues to build systems that promote care coordination, provider collaboration, and family engagement, especially for underserved children.

In alignment with federal requirements, North Dakota's Title V CSHCN program also provides services for disabled children under age 16 receiving Supplemental Security Income (SSI) under Title XVI, when these services are not otherwise covered by Medicaid (Title XIX). This includes supports such as financial assistance through the Financial Coverage Program, along with referrals to specialty care, and referrals to early intervention services. Transition from pediatric to adult health care throughout the various CSHCN programs is a growing focus, with efforts to improve outcomes through targeted education, quality improvement, and communication between pediatric and adult providers.

#### III.C.1.b.ii.c. Title V Workforce Capacity and Workforce Development

### Section III.C.1.b.ii.c Title V Workforce Capacity and Workforce Development

### Title V Capacity

State Title V staff are able to avail themselves of various professional development opportunities in order to build their capacity as part of the maternal and child health (MCH) workforce. State staff have many strengths, including passion, dedication, and knowledge to ensure families receive high-quality services; strong interpersonal abilities required for partnership building, collaboration, and integration; and the capability to manage multiple priorities. To address specific training needs, state Title V staff develop career aspiration and professional development goals that identifies training opportunities to enhance needed knowledge and skills as part of their annual performance review process.

Leadership and professional development have been key initiatives at the state level for several years. The state even hired a firm to help build a more formal culture for leadership training based on John Maxwell's 5-levels of leadership and the behaviors of a cohesive team. A series of Leadership Everywhere trainings has been developed to strengthen personal leadership skills and support the ability to better serve North Dakota citizens. These trainings are easily available to all team members via the state's online employee portal, PeopleSoft.

### Strengths and Needs of the MCH Workforce

Building and enhancing public health workforce knowledge and capacity has been a priority for several years. Education and training to equip staff with technical, strategic, and leadership skills are imperative. Promoting a culture of lifelong learning in public health is also necessary. A large sector within the field of public health is MCH. The MCH Leadership Competencies, Version 4.5 (2023) explains that the essential ability to implement complex thinking requires identifying an issue or problem, framing it into a question, evaluating it from different perspectives, and then solving the problem. MCH public health workers should also know how to identify and propose promising practices and policies that can be used in situations where action is necessary.

Over the last several years, the demands placed on governmental public health workers to evolve from a clinical mindset to systems-based thinking have been constantly evolving. After the recent pandemic, it was even more evident that there is a need for public health staff to be trained and educated appropriately to deliver high-quality programs and address new and emerging health challenges using a population-health-based approach.

**Unique Skillsets and Composition of Title V Staff**

About 85% of North Dakota's Title V program staff have five or more years of experience working in MCH programs at the state level, compared to about 81% last year and 70% the year before. This is attributed to a trend of staff retention. Those with less than five years' experience have strong health care backgrounds working within health systems or for non-profits (e.g., March of Dimes).

Over the past several years, the Healthy and Safe Communities (HSC) Section Director who also oversees Title V programming (as part of the Public Health Division's leadership team), has had the opportunity to participate in quarterly Extended Cabinet Leadership (XCL) Team meetings organized and presented by the Governor and his staff. The objectives for the XCL team are focused on connection, learning and development as leaders.

Title V and all of the North Dakota Department of Health and Human Services (NDDHHS) are also committed to becoming the healthiest state in the nation. Gaps in health outcomes between populations can be addressed through the improvement of the quality of healthcare, increasing staff's capacity to serve all populations despite barriers, and strategizing ways to ensure all North Dakotans have opportunities to live their healthiest lives.

Since Krissie Mayer, the Community Engagement/MCH Partnership Coordinator, was hired on August 1, 2018, the newly formed Community Engagement Unit has continued to grow. In an effort to achieve overarching goals for NDDHHS in helping communities reach optimal health outcomes, Krissie's role was transformed to focus full-time as the Community Engagement Director, while the Community Engagement Assistant Unit Director participates in MCH work activities in the women's health domain.

The Community Engagement Assistant Unit Director's full-time equivalent (FTE) Public Health Specialist position was added in March 2020 in partnership with the HIV/STD/TB/Viral Hepatitis Program. This shared position between two sections and supervised by the Community Engagement Director, dedicates .5 time to the HIV/STD/TB/Viral Hepatitis Program and .5 to MCH. Current MCH activities of this position include achieving positive health outcomes in all North Dakota communities, reducing maternal mortality, and other women's health initiatives.

Key components of the MCH grant include promoting positive, healthy lifestyles for all individuals. Hence, this position is located within the NDDHHS Public Health Division's HSC Section. The Community Engagement Unit reports directly to the HSC Section Director, who also oversees all units responsible for MCH programming. This is vital to address and coordinate efforts that improve health outcomes for North Dakotans.

A summary of MCH and children with special health care needs (CSHCN) workforce, including those serving in leadership roles, tenure of staff, and projected shifts in the workforce over the next five years is included in Section V. Supporting Documents.

**Organizational Changes: The Creation of the NDDHHS**

On September 1, 2022, the North Dakota Department of Health integrated with the North Dakota Department of

Human Services to create the new state agency, NDDHHS. This merger was meant to further foster positive, comprehensive outcomes by promoting economic, behavioral, and physical health and ensuring a holistic approach to individual and community well-being. The overarching vision of this relatively new department is to make North Dakota the healthiest state in the nation.

In addition, staff at the NDDHHS use guiding principles to inspire decisions, fuel a passion for service, and shape an overall agency culture. These include:

- **Continuous improvement and innovation:** We embrace continuous improvement and innovation as ways to streamline the delivery of services, drive efficiencies and promote best-in-class customer-centered experiences.
- **Responsible stewardship:** Our organizational effectiveness and impact is enhanced by our strategic and efficient management of agency funding, assets, and resources.
- **Transparent and open communication:** We prioritize transparent and open communication to facilitate trust, organizational and stakeholder awareness, collaboration, and unity.
- **Engaged collaboration:** We bring a spirit of teamwork and accountability to every interaction, using our combined strengths to drive solutions and success.
- **Data-centered decisions:** Our decisions are grounded in data; we use facts and metrics to inform and guide our actions and evaluate outcomes.

An imperative component of NDDHHS is the Public Health Division, which is home to Title V. This newly formed division is dedicated to improving the length and quality of life for all North Dakotans. More details about the overall department and the Public Health Division can be found in Section VI. Organizational Chart.

**Parent/Family Involvement in Title V**

The Special Health Services (SHS) Unit supports a ten-to-twelve-member Family Advisory Council that meets two to four times each year. Membership is diverse and comprised of various, races, genders, and socioeconomic statuses to ensure representation from different types of families. Father involvement has improved through the participation of a father on the council offering a different perspective. Members are reimbursed for mileage, meals, and lodging (if applicable) and are paid a $75.00 consultation fee for each meeting they attend. The SHS Family Advisory Council assures family involvement in policy, program development, professional education, and delivery of family-centered care for CSHCN and their families. SHS staff encourage active family engagement in council activities (e.g., leading ice-breaker activities, sharing of family stories, and representation at the annual Medical Advisory Council meeting). Council members have the opportunity to provide input with development of the MCH Block Grant application and are encouraged and supported to attend the annual block grant review. The application for individuals interested in joining and becoming a member of the Family Advisory Council is now available online on the SHS website to ensure the opportunity to join is open to individuals across the state.

**Recruitment and Retention of Qualified Staff**

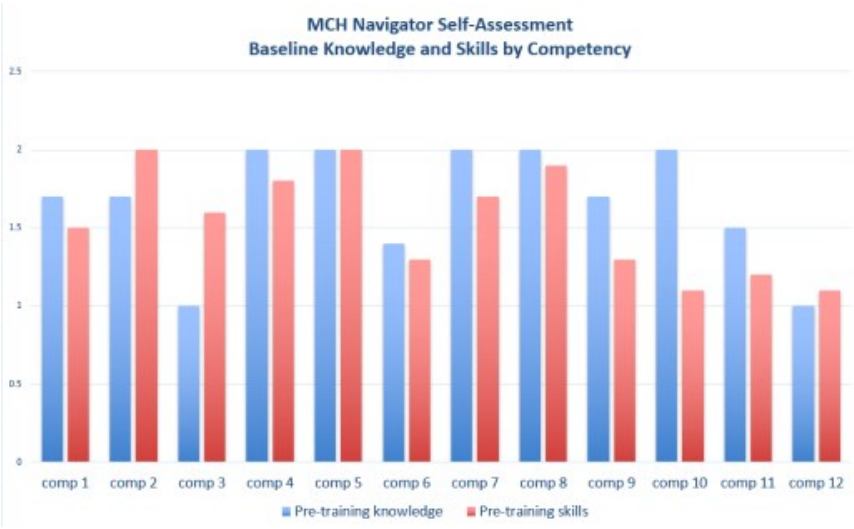
NDDHHS offers challenging and enjoyable work opportunities and a full range of employee benefits, including a fully paid health insurance plan, paid leave, and a retirement plan. In addition, the department has a reputation for being family-friendly and accommodating with flexible work schedules. Infant-at-work, everyday casual dress, and worksite wellness policies are attractive recruiting and retention tools. NDDHHS policies for reimbursement for professional licensures and tuition reimbursement are also positive recruiting and retention tools. Since COVID-19, staff have been encouraged to continue telecommuting full-time, with the ability to “hotel” on-site as needed. These policies have increased job satisfaction, work productivity, and morale. An Employee Assistance Program is also available for staff who need support.

Workforce development to advance the capacity of local staff is also important. To build capacity of the local workforce, State Title V staff provide technical assistance with program implementation on an ongoing basis.

**Assessment of Training and Professional Development Needs**

In May 2024, the Maternal and Child Health (MCH) Navigator team at the National MCH Workforce Development Center informed the state MCH Director that the self-competency assessments were going to be improved and made available for states later in 2024. The state MCH Director then gathered the names and contact information for all MCH staff at the state level so that the links for the self-competency assessments could be shared, and results could be tabulated, both individually and for the entire state team. The self-competency assessments were sent to staff on October 29, 2024, and they were given over two weeks to complete them. Once submitted and compiled, the following results (Figure 1) were shared with the MCH team. These were organized using a bar graph, which helped with prioritizing findings along with appropriate recommendations/interventions. This visualization also helped the MCH core leadership team to systematically examine underlying drivers of performance gaps. Individual results were also emailed privately to each MCH staff member. Further information regarding these competencies can be found at https://www.mchnavigator.org/trainings/competencies.php.

*Figure 1 – Staff Self-Assessment*




The analysis revealed staff knowledge gaps in ethics (competency 3), negotiation and conflict resolution (competency 6), and policy (competency 12). Skills were weakest in interdisciplinary team building (competency 10), systems approach (competency 11), and policy (competency 12).

**Training the Next Generation of Professionals**

The Title V Director aims to establish a specific training protocol, designed to enhance the skills and knowledge of both new and existing MCH staff members. This protocol is hoped to focus on fostering systems-level thinking and effective planning for the annual activities outlined in MCH work plans. Additionally, efforts will be made to integrate MCH training into ongoing workforce development initiatives within the broader framework of NDDHHS. Recognizing the critical importance of workforce development in the state, these endeavors seek to address not only MCH concerns but also broader public health challenges.

Furthermore, state MCH staff will continue to be encouraged to seek out both state and national training opportunities tailored to their specific areas of expertise or interest. These additional avenues for professional development, combined with the aforementioned initiatives, aim to cultivate a robust and diverse MCH workforce in North Dakota. By prioritizing high-quality education and training, the state endeavors to equip its workforce with the necessary skills and insights to effectively tackle the unique challenges faced by women, infants, children, CSHCN and families across North Dakota.

**The MCH Certificate: An Innovative Approach to Enhancing MCH Workforce**

Since May 2021, collaboration has occurred between the state's MCH program and the North Dakota State University (NDSU) Department of Public Health (DPH) to enhance the knowledge and skills of the current MCH workforce, build workforce capacity, and facilitate collaboration across the academic and practice communities. This partnership has been providing much-needed support to address NDDHHS – and statewide – MCH leadership's key concerns regarding the low percentage of MCH staff with formal public health training, low levels of preparedness to meet local and state MCH needs, limited access to expertise for quality community-based or applied public health research, and the need for MCH innovation among public health professionals in academic and practice environments. In August 2022, NDSU DPH successfully developed and implemented an eight-credit MCH Certification Program. This program was geared to build the MCH workforce and innovation capacity. Credits from this MCH Certification Program could also be applied to a Master of Public Health (MPH) degree.

An additional contract then offered other learning opportunities for staff to further their learning outside of college-level courses. Throughout 2024, a four-part lunch-and-learn series around key MCH topics, such as diverse families and public health communication, was offered to team members and partners. Continuing education credits are available for these trainings until September 2025, and they can be found on the North Dakota Public Health learning platform, ND TRAIN. The MCH curriculum will also continue to be offered, and staff are encouraged to participate if they are able.

NDDHHS has a tuition reimbursement policy that may pay up to 80 percent of tuition and fees, depending upon budget. The college course must be directly job-related and have a stated public health purpose or benefit. This policy makes it more attainable for staff to consider enrolling in the program and advancing their learning and education. In addition to supporting state MCH staff to enroll in the MCH Certificate Program, the program will continue to be promoted statewide.

#### III.C.1.b.ii.d. State Systems Development Initiative (SSDI)

### Section III.C.1.b.ii.d. State Systems Development Initiative (SSDI)

The State Systems Development Initiative (SSDI) supports maternal and child health (MCH) data collection, analysis, translation, and reporting in the North Dakota Title V MCH Block Grant program by:

- Supporting the Title V MCH Block Grant program data needs associated with the annual needs assessment, the 5-year needs assessment process and updates.
- Assisting the Title V MCH Block Grant programs with development, selection, refinement, and/or tracking of data and performance and outcome measures that are associated with the Title V MCH Block Grant performance measure framework.
- Supporting data needs associated with annual preparation of the Title V MCH Block Grant application/annual report.
- Accessing, developing, enhancing, and implementing plans for overcoming barriers to data access and/or data linkage with MCH datasets across the 5-year project period.
- Enhancing information exchange systems and data interoperability across MCH programs, state agencies, programs, and partners.
- Developing and tracking performance measures that will be used to assess the progress of Title V programs, policies, and initiatives addressing factors that influence health outcomes.
- Synthesizing and translating MCH data into products of analysis across the five-years project period to enhance state MCH data capacity and facilitate informed decision-making to drive improved MCH outcomes.
- Developing surveillance systems, utilizing existing Health Information Exchange and North Dakota Health Information Network (HIN) to provide support to MCH data collection, analysis, reporting, and visualization to inform rapid state program response and policy action related to emergencies, epidemics, endemic, and pandemics.

Annually, the SSDI Coordinator organizes, partners, and links the multiple data sources available. This access to

timely and organized electronic MCH health data serves to inform and support MCH staff in program monitoring, assessment, developing strategies, and planning.

During the grant period, the SSDI coordinator assisted the Health Statistics and Performance Section, the Community Engagement Unit, and the Family Health and Wellness Unit within the Healthy and Safe Communities Section by providing data from the current Federally Available Data (FAD) for the MCH programs, North Dakota State University, University of North Dakota, and state partners and collaborators. North Dakota Medicaid data were used to determine Evidence Based/Informed Strategy measure for the Women's Health domain of the MCH Title V team. FAD data, paid claims, and service utilization data were used as key metrics for grant applications, dashboards, assessments, program planning, and policy development among MCH programs. For example, North Dakota Medicaid data analyses were conducted to provide supportive information for the biennial legislative session to the Women's Health Domain team within Title V.

#### III.C.1.b.ii.e. Other Data Capacity

### Section III.C.1.b.ii.e. Other MCH Data Capacity Efforts

Other MCH epidemiological and data enhancement activities that support the Title V needs assessment and performance measuring are addressed in the following table:

| Activity/Project | Description |
|---|---|
| Pregnancy Risk Assessment Monitoring System (PRAMS) | North Dakota (ND) was funded by the Center for Disease Control and Prevention (CDC) For Component A: Core PRAMS surveillance in 2016. In 2021, ND was funded again to implement CORE PRAMS surveillance through 2026. Also, since 2021, ND PRAMS continues to oversample American Indian women and also oversamples women of other races to adequately monitor health risk behaviors of rapidly growing populations in the state. |
| North Dakota Fatherhood Survey | Beginning in 2023, with support from the North Dakota Title V Program and the North Dakota Community Engagement Unit, the state launched a pilot project to survey fathers corresponding to the mothers participating in the ND PRAMS survey. Data analysis is in progress and will be used to guide the ongoing Title V state action plans, focused on early infancy and maternal health outcomes. |
| Newborn Screening Systems Co-Propel Project | The North Dakota Newborn Screening and Long-Term Follow-Up Program was funded by the Association of Public Health Laboratories for a new grant project, projected to run from July 2024 though July 2028. Goals for this program are:<br>• Enhance, improve, and expand North Dakota's (ND) newborn screening (NBS) system by increasing education and awareness.<br>• Improve interoperability within ND health systems, Vital Records (VR) |

| | |
|---|---|
| | and the NBS laboratory.<br>• Increase timely collection and reporting of NBS specimens to improve early diagnosis and treatment for individuals with heritable conditions identified through NBS screening, short-term follow-up, and diagnostic confirmation.<br>• Identify, support and evaluate quality improvement opportunities for children enrolled in the ND Long-term Follow-up (LTFU) program. |
| Maternal Mortality Surveillance | During the 2021 North Dakota Legislative Session, a bill to establish a Maternal Mortality Review Committee (MMRC) was passed. The committee includes representation from the North Dakota Department of Health and Human Services (NDDHHS) (Public Health Specialist and MCH Epidemiologist), obstetricians/gynecologists, health care entities, mental health experts, and others. The Vital Records Unit in the Health Statistics and Performance Section will continue to maintain the source file for case reports and predisposing factors leading to maternal deaths. In the upcoming year, the epidemiology team will formalize the data linkage and reporting process to the CDC Maternal Mortality Review Information Application (MMRIA). |
| National Violent Death Reporting System (NVDRS) | ND was funded by the CDC for the National Violent Death Reporting System (NVDRS) in 2018. The NDVDRS is a state-based surveillance (reporting) system that links data on violent deaths from multiple sources into a useable, anonymous database. These sources include state and local medical examiners, coroners, law enforcement, toxicology, and vital statistic records. NDVDRS collects information from violent deaths, including homicides, suicides, deaths of undetermined intent, unintentional firearm deaths, legal intervention, and terrorism. NDVDRS provides detailed information on circumstances precipitating violent deaths, combines information across multiple data sources, comprehensively describes violent deaths, and links multiple deaths to one another. The purpose of NDVDRS is to create and implement a plan to collect and disseminate accurate, timely, and comprehensive surveillance data on all violent deaths in ND to increase violence prevention efforts and reduce morbidity |

| | |
|---|---|
| | and mortality related to violence. |
| State Health Assessment (SHA) and State Health Improvement Plan (SHIP) | The SHA is conducted every three to five years in North Dakota. Findings of the SHA, with stakeholder input is then used to create the SHIP. SHIP priorities established in 2024 that align with maternal and child health include:<br>• Strengthening workforce<br>• Cultivating wellness<br>• Expanding access and connection<br>• Building community resilience |

#### III.C.1.b.iii. Title V Program Partnerships, Collaboration, and Coordination

### Section III. C.1.b.iii. Title V Partnerships, Collaboration, and Coordination

Title V programs in North Dakota use a collaborative systems-based approach to ensure access to quality health care and needed services for the maternal and child health (MCH) population. North Dakota is committed to building, sustaining, and expanding partnerships. Title V staff actively participate on a variety of committees and coalitions that impact the health of mothers and children, including those with special health care needs.

### Other MCH Investments

North Dakota's State Systems Development Initiative (SSDI) grant helps to develop, enhance, and expand state Title V MCH data capacity. Prevent Child Abuse North Dakota (PCAND) administers the state's Maternal, Infant, and Early Child Home Visiting (MIECHV) grant. The Title V Director serves as the North Dakota Department of Health and Human Services (NDDHHS) representative on the State Council on Developmental Disabilities and the children with special health care needs (CSHCN) Director serves on the Interagency Coordinating Council (ICC), both of which focus on systems that support individuals with disabilities and their families. In addition, North Dakota Title V funds "Count the Kicks," which is an evidence-based stillbirth prevention public health campaign created by the non-profit organization, Healthy Birth Day, Inc. to build awareness and provide a simple daily method for tracking fetal movement in the third trimester of pregnancy.

During the 2023 legislative session, funding for the Alternative to Abortion (A2A) Program was increased from $600,000 to $1,000,000 per biennium and expanded services from assisting pregnant women and women who believe they may be pregnant, to also include parents or other relatives caring for children twelve months of age or younger. The Human Services Division of the NDDHHS had historically administered the A2A Program. To align services more effectively, NDDHHS executive leadership made the decision to move the A2A Program to the Public Health Division. Funded through state funds and the Title V grant, a Maternal Health Specialist position was hired to manage the program. This position also assists with other various women's health initiatives, such as maternal mortality and postpartum care.

### Other Federal Investments

Title V staff collaborate with other federally funded programs, such as Women, Infants, and Children (WIC), family planning, and immunizations. Safe sleep education is being provided in all WIC sites and 43 Cribs for Kids Programs throughout the state of North Dakota. If additional funds are available, cribs are typically purchased for these numerous sites. Information about the various sites can be found at https://www.hhs.nd.gov/health/prevention-healthy-living/injury-prevention/cribs-kids.

### State and Local MCH Programs

State MCH support for communities is addressed through contracts with selected local public health units, universities, schools, non-profits, and tribal entities. The funds are used for services such as maternal care, newborn home visits, genetics, car seat safety programs, school health/wellness, nutrition and physical activity education,and injury prevention. The state CSHCN program supports cooperative administration of programs for CSHCN along with partners such as human service center zones, health facilities, family support organizations, and universities. In addition, CSHCN support for communities is addressed through contracts with health systems, universities, and nonprofits that support multidisciplinary clinics, family support services, and CSHCN systems development initiatives.

**Other Programs within the NDDHHS**

Additional partnerships within the NDDHHS, not previously mentioned, that address the priority needs of the MCH population but are not funded by the state Title V program include the autism database, cancer programs, chronic disease prevention (e.g., Diabetes, Heart Disease), tobacco prevention and cessation, oral health, and domestic violence/rape crisis. In 2023, the Youth Risk Behavior Survey (YRBS) was moved from the North Dakota Department of Public Instruction (DPI) to the Public Health Division, Health Statistics and Performance Section within NDDHHS.

**Other Governmental Agencies**

The North Dakota Medicaid program is co-located with the Children's Health Insurance Program (CHIP) in the Medical Services Division within NDDHHS. The state CSHCN program has close ties within the Medical Services Division and participates in scheduled meetings to discuss policy, claims payment, and any North Dakota Health Enterprise Medicaid Management Information System (MMIS) issues. Annually, the State CSHCN program convenes a meeting between the Disability Determination Services (DDS), the local Social Security Administration Office, ND Medicaid, and key family organizations to assure communication about any new developments that have occurred or that are expected during the year that might affect Supplemental Security Income (SSI) eligible children. Procedures are in place between DDS and SHS to assure SSI recipients and cessations receive information about program benefits or services. NDDHHS implements a public awareness campaign to provide information, public service announcements, and educational materials regarding the state's Baby Safe Haven Law to the public, including medical providers, law enforcement, and social service agencies. Title V and the North Dakota Department of Public Instruction (DPI) have a strong partnership and work collaboratively on many projects. Periodically, the ICC meets jointly with the DPI Individuals with Disabilities Education Act (IDEA) advisory group to better coordinate services for young children with disabilities. CSHCN staff are also involved with the Transition Community of Practice led by Special Education staff within DPI. The NDDHHS State School Nurse Consultant also works closely with DPI to support school nursing initiatives and promote the connection between health and academic achievement.

**Tribes, Tribal Organizations, and Urban Indian Organizations**

Recognizing the need to strengthen relationships between NDDHHS programs and tribal reservations, the Community Engagement Unit has established a contract with North Dakota State University (NDSU) to hold quarterly meetings with Tribal Health Directors, which began in the fall of 2021. The meetings have been initiated to define the tribal consultation process to protect sovereignty, improve tribal and state relationships to uplift and address Indigenous health challenges, unpack, and develop processes for assuring applicable treaty rights and trust responsibilities are honored, coordinate efforts to address broad-reaching public health issues across Tribal Nations, and assess the feasibility of a North Dakota Tribal Health Board.

Since 2021, Tribal Health Liaisons have been employed at NDDHHS in the Public Health Division. The primary purpose of these positions is to act as liaisons to the department on tribal health needs and concerns. The positions assist the NDDHHS Community Engagement Unit and the Disease Control and Forensic Pathology Unit in conducting education activities for the five federally recognized tribes in North Dakota and surrounding urban areas.

On an annual basis state-level MCH staff attend the annual MCH Tribal Health Symposium, which is facilitated by NDSU and tribal health partners from across the state. If available, additional funds are set aside for small tribal health grants to focus on MCH priorities.

**Public Health and Health Professional Educational Programs and Universities**

North Dakota State University (NDSU) and the University of North Dakota (UND) collaboratively offer a Master of Public Health (MPH) program. In addition, the Department of Indigenous Health is the first department of its kind in the world and is based at the UND School of Medicine and Health Sciences. NDDHHS promotes synergy across research, education, service, and training, and focuses on Indigenous health and offers the world's first Ph.D. in Indigenous Health. The state CSHCN program and several of the state's universities have developed a mutually beneficial relationship to support multidisciplinary clinic services for CSHCN. University personnel participate as team members in many SHS cleft lip and palate clinic locations. SHS multidisciplinary clinics are often used as a source of pre-service training experiences for various health disciplines. A collaborative relationship exists with the UND Communication Disorders Department for administrative support of cleft clinics in the northeast region of the state.

### CSHCN Family Leadership

There are several family-led organizations in North Dakota that provide leadership and support to families. The state CSHCN program contracts with Family Voices of North Dakota (FVND) to provide emotional support, health information, and training for families.

SHS has a strong partnership with several family-led organizations that provide leadership, support, and advocacy for families. Specifically, this contract includes providing education and training on the transition from pediatric to adult health care and the importance of medical home, including comprehensive care coordination.

#### III.C.1.b.iv. Family and Community Partnerships

### Section III.C.1.b.iv Family and Community Partnerships

The North Dakota Title V program is committed to building and strengthening family and consumer partnerships across all levels of the health care system for identified maternal and child health (MCH) population groups. Family partnerships are valued, and an integral component of many Title V programs as described in the narrative below.

The North Dakota Children with Special Health Care Needs (CSHCN) program utilizes the Association of Maternal and Child Health Programs (AMCHP) *National Consensus Standards for Systems of Care for Children and Youth with Special Health Care Needs* as a foundational framework. This approach aims to foster coordinated, comprehensive, and family-centered service systems at both state and local levels. The Special Health Services (SHS) Unit facilitates a Family Advisory Council, comprised of ten to twelve members who convene two to four times annually. This council is characterized by its wide scope, representing various races, genders, and socioeconomic backgrounds to ensure a broad spectrum of family experiences. The inclusion of a father on the council has significantly enhanced father involvement, offering valuable insights. To support participation, council members are reimbursed for mileage, meals, and lodging (when applicable) and receive a consultation fee of $75.00 for each meeting attended. The SHS Family Advisory Council plays a pivotal role in promoting family involvement in policy formulation, program development, professional education, and the delivery of family-centered care for CSHCN and their families. SHS staff actively encourage family engagement in council activities, which may include leading ice-breaker sessions, sharing personal family narratives, and representing the council at the annual Medical Advisory Council meeting. Council members are also invited to contribute to the development of the MCH Block Grant application and are encouraged to participate in the annual block grant review process. Lastly, to facilitate openness, the application for individuals interested in joining the Family Advisory Council is available online on the SHS website, ensuring that membership opportunities are open to individuals throughout the state.

North Dakota's Title V program has established robust partnerships with several family-led organizations dedicated to providing leadership, support, and advocacy for families. Among these organizations, four notable ones include Family Voices of North Dakota, Pathfinder Services of North Dakota, Federation of Families, and Designer Genes. Additionally, other organizations within the state actively support targeted populations, particularly families involved in the early intervention system and individuals with conditions such as Down syndrome, autism, or hearing loss. These family-led organizations serve as vital resources for the Title V program, frequently being consulted by various domains to gather valuable feedback and insights from the family perspective. This collaborative approach ensures that the voices of families are heard and integrated into the program's initiatives and decision-making processes, ultimately enhancing the support provided to families in North Dakota.

The SHS Unit provides funding to Family Voices of North Dakota to provide a family-led health information, education, consultation, and support program for families. This includes operation of a Family Health Information Center, a Parent-to-Parent Program, education/training opportunities for families, providers, and other partners, and consultation to the SHS Unit through participation in advisory meetings, MCH Block Grant activities, and other ongoing work. Title V staff work very closely with Family Voices to provide additional care coordination to families with children with complex medical needs. Family-led organizations routinely collaborate on a variety of CSHCN-related projects. Examples include:

- **Project Carson** – This program connects families who receive a prenatal or at-birth diagnosis to parent-to-parent support and provides assistance to connect families to services.
- **Parent Leadership Institute** –This annual event trains parent leaders.
- **Other training/educational activities** – Families are offered training on various topics (e.g., importance of well-visits, transition from pediatric to adult health care, etc.).

Family representatives are actively involved in several other Title V program initiatives, including the Newborn Screening Advisory Committee. Family members participate in meetings and are invited to attend conferences alongside state staff, fostering collaboration and shared learning. Moreover, family representatives contribute significantly to strategic planning, program development, and quality improvement activities related to newborn screening. Their insights and experiences are invaluable in shaping policies and practices that directly impact families and children, ensuring that the program remains responsive to the needs of the community it serves. This collaborative approach enhances the effectiveness of the Title V program and reinforces its commitment to family-centered care.

Next, the CSHCN Director actively participates as a member of the North Dakota Interagency Coordinating Council, which includes family representatives from various regions throughout the state. This council is tasked with advising and assisting the North Dakota Department of Health and Human Services (NDDHHS) in establishing a comprehensive statewide system for delivering appropriate services to at-risk children and children with disabilities, specifically those aged birth through five, along with their families. Through this engagement, the CSHCN Director has the opportunity to collaborate with family partners and integrate their feedback and insights into MCH initiatives. Because Title V staff are encouraged to actively involve families in the development and implementation of their annual MCH work efforts to ensure a family-centered approach that supports the needs of children and their families across the state, collaborations such as this are pertinent to the overall success of our Title V program.

Efforts to engage families in quality improvement initiatives are actively pursued within the Title V-funded programs. These programs continuously assess family and consumer satisfaction to ensure that services align with the needs of the families they serve. The SHS Unit mandates that service contracts and annual reports include detailed descriptions of specific quality assurance strategies, which encompass client satisfaction assessments when available. In addition, at the departmental level, ongoing feedback is systematically solicited through the organization’s website and staff email correspondence. This proactive approach has significantly raised awareness of customer feedback across the entire department, fostering a more "citizen-focused" culture among staff members. As a result, the commitment to incorporating family perspectives into service delivery and quality improvement processes has strengthened, ultimately enhancing the overall effectiveness of the programs.

Families are also involved in resource and material development for several Title V programs. They routinely participate and present at SHS training events for local staff and are involved alongside state staff in conference planning. SHS also routinely solicits family input with resource material development and has engaged families in “family story” messaging projects or assisted with facilitating presentations of various family stories. Recently, the Newborn Screening program staff collaborated with Family Voices of North Dakota to revise a Family Care Notebook that helps families keep track of important information about their child’s health care.

Next, the Family Planning program supports an Information and Education Committee comprised of individuals broadly representative of the population or community for which the materials are intended. The Family Planning program encourages family participation in the decision of minors to seek family planning services and provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.

For working families, access to breastfeeding support and the establishment of Infant Friendly Workplaces are of paramount importance. Title V staff acknowledge the impact of advocating for these initiatives on behalf of families throughout the state. They collaborate with Local Public Health Units to facilitate the designation of workplaces that support breastfeeding. Furthermore, Title V staff engage closely with the WIC program to ensure effective collaboration and to share feedback from local families across various programs. Additionally, it is important to recognize that obtaining services poses a challenge for many families, particularly given North Dakota's rural landscape. To ensure clients have the means to obtain services, Title X staff work with the Upper Missouri District Health Unit (UMDHU), who provide family planning services in the southwest corner of the state utilizing Title V funds and technical support. UMDHU provides an outreach clinic in Dickinson at least once per month, adding an additional day per month if the need arises. On days the clinic provider is not in the Dickinson area, telemedicine visits are offered. The UMDHU will also offer outreach and support throughout the community by attending community events and meeting with local providers and clinics. Furthermore, Women Empowering Women is working with the Dickinson clinic to assist with marketing and outreach, targeting the Spanish community, to enhance awareness of these services.

Next, to promote poison prevention, families can access a "Build Your Own Poison Look-Alike Kit," which can be printed to raise awareness about items that may appear safe but are not suitable for consumption. Additionally, a range of educational materials is available in the poison prevention domain, including stickers, magnets, and brochures, to further educate the public on this important issue.

In addition, staff members provide education to families regarding Child Passenger Safety (CPS) through the NDDHHS CPS program website, which features a variety of educational materials, car seat checkups, and car seat distribution initiatives. The CPS program website offers up-to-date educational materials reflecting best practices in CPS, as well as the CPS Online Resource Maps. These maps provide current locations in North Dakota where families can access assistance for their CPS needs. Through the maps, families can identify where to obtain a car seat if needed, find CPS car seat checkup events, and locate certified CPS technicians for hands-on assistance with car seats. Additionally, the maps indicate birthing hospitals that offer CPS classes for first-time caregivers. All car seat distribution programs are staffed by certified CPS technicians and are available in most counties across North Dakota. State-provided car seats, distributed by the North Dakota Department of Transportation (NDDOT), are made available to the public in accordance with the guidelines established by NDDHHS and NDDOT.

The NDDHHS collaborates annually with Bismarck State College and North Dakota’s Gateway to Science to host the Gateway to Health public event. This initiative promotes the health and well-being of children, families, and community members by offering hands-on activities, free access to Gateway to Science exhibits, and opportunities to sign up for various services. In 2024, Title V staff from multiple domains participated in the event to provide education and resources to the community. The event was free for the public, and due to its success and the positive feedback received from attending families, it will continue to be held. To learn more, please visit https://bismarckstate.edu/continuingeducation/professional/Conferences/gatewaytohealth/

Lastly, the NDDHHS recognizes the importance of training team members to help the various populations in North Dakota. In response to this need, the NDDHHS has initiated training designed to equip professionals across the state with the knowledge and skills necessary to provide resources to North Dakotans. Training is available to anyone interested, as it can be accessed on *ND TRAIN,* a platform that can be accessed by all individuals following the creation of a username and password.

Family and community partnerships play a crucial role in the success of North Dakota’s Title V program. Partnerships will continue to be established and fostered to ensure Title V is reaching the entire maternal and child health population and needs are continually being identified and addressed.

#### III.C.1.c. Identifying Priority Needs and Linking to Performance Measures

### Section III.C.1.c Identifying Priority Needs and Linking to Performance Measures

The North Dakota Department of Health and Human Services (NDDHHS) and the North Dakota State University (NDSU) Center for Social Research (CSR) conducted a comprehensive statewide needs assessment focused on

Maternal and Child Health (MCH) populations across North Dakota. This assessment aimed to better understand the needs and challenges related to the health and well-being of women and children. The findings from this needs assessment helped to guide and inform program planning and development by highlighting both the strengths and needs of North Dakota's MCH populations, prioritizing relevant programs and resources, and assessing community assets.

The selection of priority needs was informed by a survey of stakeholders and well-being profiles corresponding to each MCH Title V population domain. The results of this survey facilitated discussions among MCH leadership, leading to the identification of nine priority needs based on what the data revealed. The survey received positive feedback, with strong participation from stakeholders, yielding a total of 196 responses. Data analysis was conducted using standard descriptive statistical methods, including frequency analysis (mean, median, and frequencies) to determine consensus among respondents. Additionally, qualitative data from open-ended survey questions was content-coded to identify key themes and priorities.

Alongside the stakeholder survey, five well-being profiles were developed, each corresponding to one of the five defined MCH population domains. These profiles provide a snapshot of current conditions, contextualized by comparisons to regional and national averages. Data for the well-being profiles was sourced from multiple vetted resources, including the North Dakota Pregnancy Risk Assessment Monitoring System (ND PRAMS), Youth Risk Behavior Surveillance System (YRBSS), Maternal and Child Health Bureau Federally Available Data (FAD), National Survey of Children's Health (NSCH), and North Dakota Immunization Information System (NDIIS).

NDSU provided the MCH team with frequency analyses of each stakeholder survey question and the population domain well-being profiles. The MCH Epidemiology Team also reviewed the survey findings, performance measure data, and well-being profiles to aid in identifying and selecting North Dakota's priority measures. MCH Leaders also considered factors such as staff capacity, feasibility, and potential resource constraints in determining the priority measures for 2025-2030. A draft of the MCH priorities was made available for public comment, with a press release soliciting feedback. Following the review of public comments, the MCH Priorities for 2025-2030 were finalized.

Several emerging issues were identified that, while not included in the established priority needs, will be addressed through collaboration and partnerships that are formed over the next five years. These issues include childcare, access to insurance, and access to health and wellness resources, which were discovered through the stakeholder survey.

Changes in the state's priority needs since the previous five-year reporting cycle were driven by the analysis of state and national data, stakeholder survey results, and well-being profiles. Additionally, the presence of mandatory measures within two domains significantly influenced the prioritization process. While state priorities are evolving, efforts related to previous domain priorities will continue as appropriate.

The selected priorities, along with their relationship to national and state performance measures aimed at driving improvement, are outlined below:

1. **Women's Health**: The priority need identified is to identify, reduce, or eliminate obstacles preventing women from receiving recommended postpartum care components, including but not limited to mental health screening, breastfeeding support, care coordination, etc. The NPM selected is Postpartum Visit: A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth and B) Percent of women who attended a postpartum checkup and received recommended care components. Because the data revealed various challenges women face when receiving postpartum care, this priority is overarching to ensure a variety of matters are addressed.

2. **Perinatal/Infant Health**: The priority need identified is to support services, programs, and activities that encourage safe sleep as data identified several opportunities for improvement around safe sleep in North Dakota. Therefore, the NPM selected is Safe Sleep: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult. In addition, while safe sleep was selected as the NPM, it was recognized that breastfeeding also plays a key role in contributing to

safe sleep. As a result, breastfeeding work efforts will be braided into various work efforts.

3. **Child Health**: The priority needs identified are to improve accessibility to healthy food options through community resources (schools, food banks, health units, etc.), and to improve care coordination to link the MCH population to essential services and resources. The first NPM selected is Medical Home-Care Coordination: Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination. The second NPM is Food Sufficiency: Percent of children, ages 0 through 11, whose households were food sufficient in the past year. While Medical Home work efforts will be housed within the CSHCN domain, care coordination will similarly be incorporated into Child Health as care coordination is essential for all children. Achieving food security for children is critical and will require care coordination efforts.

4. **Adolescent Health**: The priority is to identify, reduce, or eliminate obstacles preventing adolescents from receiving mental health treatment and counseling. This is an emerging need that was identified by an overwhelming number of stakeholders who took the survey. Therefore, the NPM selected is Mental Health Treatment: Percent of adolescents, ages 12 through 17, who receive needed mental health treatment and counseling.

5. **Children with Special Health Care Needs (CSHCN)**: The priority is to improve the system of care for children with special health care needs. Both state and national data, along with the survey results, detect the need for more care coordination for CSHCN. Thus, the NPM selected is Medical Home-Overall: Increase the number of children with special healthcare needs engaged in medical home.

6. **Cross-Cutting Priorities (State Priority Measures)**:

    - **Motor Vehicle Safety**: The priority is to reduce serious motor vehicle injuries and fatalities to North Dakotans younger than 21 years of age as this remains a state priority to ensure the safety of all young adult drivers. The SPM selected is “Vision Zero”: Eliminate fatalities and serious injuries caused by motor vehicle crashes.

    - **Implementation of State Mandates**: The priority is to implement all North Dakota state mandates delegated to the NDDHHS Title V/Maternal and Child Health Programs. The SPM selected is to Implement North Dakota state mandates for the Maternal Child Health (MCH) population, which aligns with MCH work efforts as there are several state mandates in North Dakota that are housed in the Healthy and Safe Communities Section of NDDHHS and are carried out by MCH staff.

    - **Awareness and Utilization of Services**: The priority is to increase awareness and the utilization of statewide services or resources. There are numerous services and programs available to North Dakotans that are not well-recognized. To ensure women and children are receiving all necessary services for optimal health is vital. The SPM selected is to Improve access to health-related services to improve the health and well-being of the MCH population.

Lastly, stakeholders, including families and family-led organizations, actively participated in identifying needs and selecting the state’s final priorities. The stakeholder survey included various questions, including open-ended items, to capture unmet needs effectively. The dissemination of this survey was widely discussed with family-led organizations and families, such as the Special Health Services Family Advisory Council members.

In conclusion, North Dakota's priority approach relies heavily on data and evidence-based best practices to drive meaningful change. The selected priorities are supported by data collected through various methods, emphasizing the importance of addressing health care delivery gaps to meet the needs of all North Dakotans.

### III.D. Financial Narrative

| | 2022 | | 2023 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| Federal Allocation | $1,750,204 | $1,759,550 | $1,750,204 | $1,786,380 |
| State Funds | $1,257,805 | $1,448,832 | $1,257,806 | $1,394,023 |
| Local Funds | $55,000 | $75,043 | $55,000 | $105,023 |
| Other Funds | $0 | $0 | $0 | $0 |
| Program Funds | $0 | $0 | $0 | $0 |
| SubTotal | $3,063,009 | $3,283,425 | $3,063,010 | $3,285,426 |
| Other Federal Funds | $40,667,386 | $30,021,431 | $39,204,700 | $377,750 |
| Total | $43,730,395 | $33,304,856 | $42,267,710 | $3,663,176 |

| | 2024 | | 2025 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| Federal Allocation | $1,759,550 | $1,790,674 | $1,786,380 | |
| State Funds | $1,264,816 | $1,206,398 | $1,239,942 | |
| Local Funds | $55,000 | $133,527 | $100,000 | |
| Other Funds | $0 | $0 | $0 | |
| Program Funds | $0 | $0 | $0 | |
| SubTotal | $3,079,366 | $3,130,599 | $3,126,322 | |
| Other Federal Funds | $182,094 | $213,889 | $345,000 | |
| Total | $3,261,460 | $3,344,488 | $3,471,322 | |

| | 2026 | |
|---|---|---|
| | Budgeted | Expended |
| **Federal Allocation** | $1,790,674 | |
| **State Funds** | $1,243,162 | |
| **Local Funds** | $100,000 | |
| **Other Funds** | $0 | |
| **Program Funds** | $0 | |
| **SubTotal** | $3,133,836 | |
| **Other Federal Funds** | $345,000 | |
| **Total** | $3,478,836 | |

## Section III.D.1. Expenditures

Historically, the budget has been developed based on the previous grant awards. Expended resources link to the state's maternal and child health (MCH) priority needs and meet the requirements of Title V legislation.

The number and percent of the MCH population served by Title V is reflected on Forms 3a and 3b. Continued efforts in increasing program integration and collaboration as described in the state action plan narratives will assist to expand reach.

Information on annual expenditures for Federal Fiscal Year (FFY) 2024 is contained in Forms 2, 3a and 3b.

**Form 2:**
The FFY 2024 budgeted amount was $1,759,550. However, the actual Federal Allocation of $1,790,674 was entirely expended.

The amounts expended for Preventive and Primary Care for Children ($596,692 ~ 33.3%); Children with Special Health Care Needs ($805,305 ~ 44.9%); and Title V Administrative Costs ($124,180 ~ 7%) comply with the 30%-30%-10% requirements.

State funds expended were less than budgeted ($1,206,398 vs. $1,264,816).

Local maternal and child health (MCH) funds expended were also more than budgeted ($133,527 vs. $55,000). Local MCH funds include grantees other than local public health that provide a match. The number of contracts awarded resulted in more local MCH funds being expended.

Total Federal and State funds expended for FFY 2024 were $3,334,488 vs. the budgeted amount of $3,261,460. This increase in total expended funds was due to increased state fund allocation and increased federal funds awarded.

Other federal funding expenditures for FFY 2024 were slightly higher than budgeted ($213,889 expended vs. $182,094 budgeted) due to new grant opportunities for the Newborn Screening and Follow-up Program overseen by the Title V Director. These grants also had the opportunity to spend carry-over funding.

**Form 3a:**
Federal and non-federal expenditures are reported separately by the types of individuals served. Combined federal and non-federal expenditures include:

- Pregnant women – $254,107
- Infants < 1 year – $324,983
- Children 1 through 21 years – $1,008,654
- CSHCN – $1,288,218
- All Others – $39,416

The Federal-State MCH Block Grant Partnership Expenditures total is $2,915,378 which includes $1,666,494 in federal funds and $1,248,884 in non-federal funds.

**Form 3b:**
Federal and non-federal expenditures are reported separately by types of services. Combined federal and non-federal expenditures for FFY 2024 includes $568,714 for direct services (18.7%) of the federal and non-federal total) for the following population groups:

1. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One – $213,005
2. Preventive and Primary Care Services for Children – $143,960
3. Services for CSHCN – $211,749

The expenditures for FFY 2024 also includes:

- $1,035,211 for Enabling Services (34.1%) of the federal and non-federal total)
- $1,435,633 for Public Health Services and Systems (47.2%) of the federal and non-federal total)

The Federal-State Title V Block Grant Partnership Total is $2,915,378 which includes $1,666,494 in federal funds and $1,248,884 in non-federal funds.

Direct Services are broken out by the each of the three legislatively defined MCH population groups: Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One; Preventive and Primary Care Services for Children; and Services for Children with Special Health Care Needs (CSHCN).

Direct health care services for CSHCN's include claims payments to providers for gap-filling services for eligible children and the purchase of formula and low-protein modified food products for the metabolic food program. Local Title V grantees utilized a portion of Title V funds to provide well-visits to adolescents on the Standing Rock Reservation, adolescent telehealth services, direct services for women from certain populations, and gap-filling support for Family Planning services in the western side of the state. State Title V also funded laboratory support for the Family Planning Program.

Direct Service expenditures listed on Form 3b, Section 4 include combined federal and non-federal funds:
Pharmacy – $69,604 for CSHCN
Physician/Office Services (Charges) – $53,785 for CSHCN
Hospital Charges (Includes Inpatient and Outpatient Services) – $15,819 for CSHCN
Dental Care – $3,164 for CSHCN
Durable Medical Equipment and Supplies – $11,073 for CSHCN
Laboratory Services – $44,162 for primarily Family Planning Program laboratory support
Other – $371,107 for CSHCN medical food, direct contract services for women's health services/visits, tribal adolescent well-visits, and school telehealth services.

Title V is the payer of last resort and the services listed above were not covered or reimbursed through another provider.

## Section III.D.2. Budget

In accordance with Section 505, the North Dakota (ND) Title V Program will use funds allocated under this title to meet the needs for preventive and primary care services for pregnant women, mothers, infants, and children, including those with special health care needs. Allocation requirements for children (30%) and children with special health care needs (30%), administration (10%) and Federal Fiscal Year (FFY) 1989 maintenance of effort ($1,206,293) will be met.

As required in Sections 505(a)(5)(A), 505(a)(5)(D), 506(b)(1), the state will identify and apply a fair method to allocate funds to groups, localities, and individuals, and will apply guidelines for appropriate frequency and content of referrals and follow-up. The state will publish charges for services. If charges are imposed, they will be adjusted based on income and resources. At least every two years, the state will audit expenditures and submit a copy of the audit report.

Title V funds are allocated to a variety of local providers who serve families through local public health departments, Indian Reservations, health systems, schools, universities, etc. The majority of these agencies match federal dollars received with state or local funds. Title V assures that no charge will be made to “low-income” families. All agencies receiving funds must assure the state Title V Programs that if any charges are imposed for the provision of health services, such charges will not be imposed on services to low-income families and will be adjusted to reflect the income, resources, and family size of the individual. No North Dakota Title V Program will refuse services to anyone because of inability to pay. Some agencies may accept donations for services.

Budget information is contained in Forms 2, 3a and 3b.

**Form 2:**
Historically, the budget has been developed based on the previous final grant award.

FFY 2026 Maternal and Child Health (MCH) federal allocation of $1,790,674 is based on the previous year’s funding award. Population percentages, match, and maintenance of effort requirements are met. The budget allocates $787,023 (43.9%) to Preventive and Primary Care for Children and $573,443 (32%) for Children with Special Health Care Needs (CSHCN’s). Administrative costs budgeted at $160,234 (9%) do not exceed 10 percent of the allocation. This amount is based on projected indirect costs that are expected to be charged to the Title V Block Grant. The unobligated balance is $0 as the full grant award is expected to be expended in the allotted time frame.

State MCH funds of $1,243,162 meet the 4:3 match requirement. State match historically has exceeded the minimum match requirement. In North Dakota, local public health, schools, universities, and human service zones (formerly county social services) are considered entities of the state. The majority of these agencies match federal dollars received with state or local funds. Local funds of $100,000 also meet the 4:3 match requirement. Local MCH funds include grantees other than those listed above (e.g., non-profits, tribal).

The total state match is $1,343,162, which exceeds the 1989 maintenance of effort requirement of $1,206,293.

The state’s MCH budget total (Federal-State Title V Block Grant Partnership Subtotal) is $3,133,836.

**Form 3a**
The following figures represent combined federal and non-federal funds by types of individuals served. Per grant guidance, these amounts do not include administrative costs:

- Funds budgeted for pregnant women of $272,172 support efforts such as breastfeeding education and support; collaboration on emerging issues such as preventative health care in pregnant women and maternal mortality; postpartum visits and comprehensiveness of care, and a variety of other state and local programs.
- Funds of $385,484 for infants under 1 year support state and local programs such as infant mortality initiatives, infant and child death services, safe sleep activities, injury prevention, and breastfeeding.
- Funds for children ages 1 through 21 years of $1,113,431 support state and local programs such as school health, injury prevention, nutrition education, well-visit promotion, and physical activity initiatives.

Budgeted figures for these population categories are based on funding allocation that aligns with state and national priorities areas, in addition to supporting state mandates.

- Funding allocated for children with special health care needs (CSHCN's) of $1,003,575 will support a variety of state and local programs including the coordinated services, financial coverage, newborn screening and follow-up and CSHCN system enhancement programs. Budgeted figures for CSHCNs are based on past expenditures.
- Funds for other types of individuals served of $78,750 include state laboratory expenses to support the Family Planning Program.

The Federal-State MCH Block Grant Partnership total is $2,853,412 which includes $1,630,440 in federal funds and $1,222,972 in non-federal funds.

**Form 3b**
The following figures represent combined federal and non-federal funds by types of services:
The budget for FFY 2026 includes $775,154 for direct services (24.2% of the federal and non-federal total) for the following population groups:

1. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One of $393,153
2. Preventive and Primary Care Services for Children of $250,929
3. Services for CSHCN of $131,072

The budget for FFY 2026 also includes:

- $911,574 for Enabling Services (28.5% of the federal and non-federal total)
- $1,512,486 for Public Health Services and Systems (47.3% of the federal and non-federal total)

The Federal-State Title V Block Grant Partnership total is $3,199,214, which includes $1,790,674 in federal funds and $1,408,540 in non-federal funds. Budgeted figures for these population categories are based on state historical trend data for allocation of funds based on the pyramid level of services, and on funding allocation that aligns with state and national priority areas.

Direct Services are broken out by the each of the three legislatively defined MCH population groups: Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One; Preventive and Primary Care Services for Children; and Services for Children with Special Health Care Needs (CSHCN).

Direct health care services for CSHCN's include claims payments to providers for gap-filling services for eligible children and the purchase of formula and low-protein modified food products for the metabolic food program. Local Title V grantees utilized a portion of Title V funds to provide well-visits to adolescents on the Standing Rock Reservation, adolescent telehealth services, direct services for women from certain populations, and gap-filling support for Family Planning services in the western side of the state. State Title V also funded laboratory support for the Family Planning Program.

Enabling services for CSHCN's include service contracts for family information, training, consultation, and support; care coordination services provided by providers at statewide cleft lip and palate clinics; and contracted multidisciplinary clinic services. State and local Title V staff also provide referrals, transportation support, eligibility assistance, translation/interpretation assistance, health education for individuals and families, environmental health risk reduction, health literacy, and outreach.

Public health services and systems include salary, fringe benefits, and operating expenses for state and local staff to carry out core public health functions and the ten essential public health services. Examples include program planning, implementation, and evaluation; policy development; quality assurance and improvement; workforce development; and population-based health promotion campaigns.

Additional detail relating to the types of services described above can be found throughout the grant application.

## III.E. Five-Year State Action Plan

### III.E.1. Five-Year State Action Plan Table

**State: North Dakota**

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

**III.E.3 State Action Plan Narrative by Domain**

***If a Priority Population is selected for an NPM, then this section will display only the data associated with the Priority Population in the charts, data tables, and field notes. Additional NPM data are available in the Form 10 appendix.***

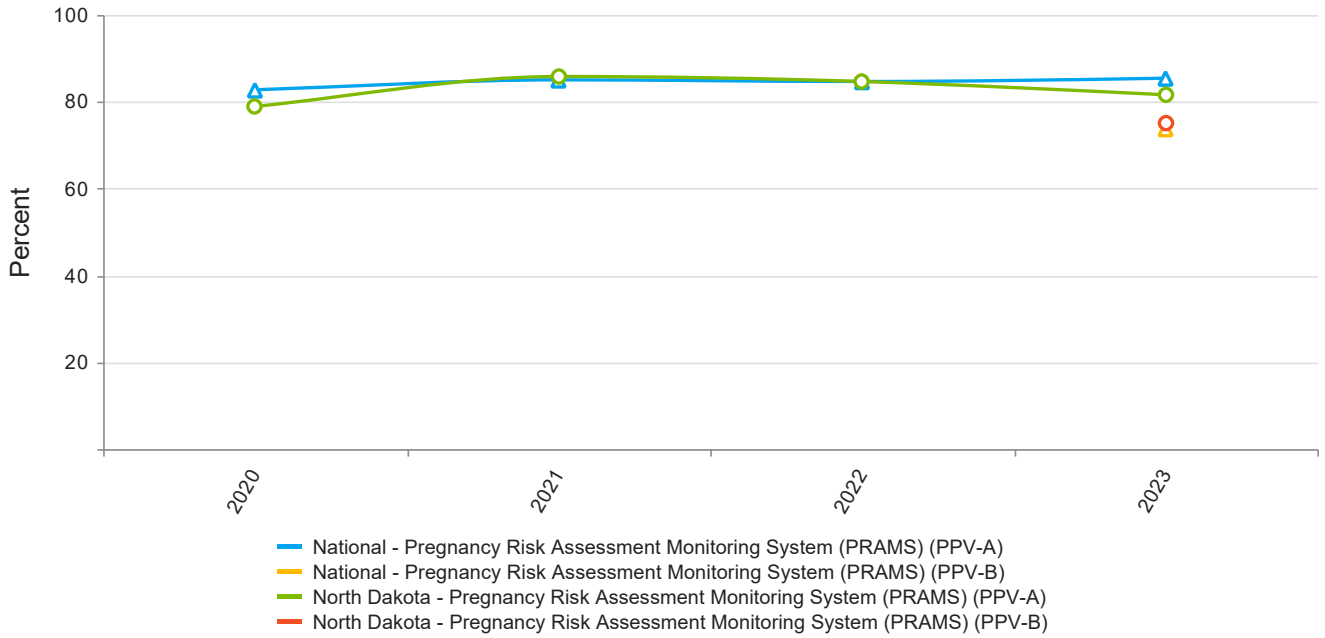
**Women/Maternal Health**

**National Performance Measures**

**NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV**

**Indicators and Annual Objectives**

**Priority Population: Health Insurance - Medicaid**




**NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV**

**Priority Population: Health Insurance - Medicaid**

| Federally Available Data | |
|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 81.5 |
| Numerator | 1,800 |
| Denominator | 2,208 |
| Data Source | PRAMS |
| Data Source Year | 2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Field Level Notes for Form 10 NPMs:**

None

**NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV**

**Priority Population: Health Insurance - Medicaid**

| Federally Available Data | |
|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 74.9 |
| Numerator | 1,337 |
| Denominator | 1,785 |
| Data Source | PRAMS |
| Data Source Year | 2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Field Level Notes for Form 10 NPMs:**

None

**Evidence-Based or –Informed Strategy Measures**

None

**State Action Plan Table**

| State Action Plan Table (North Dakota) - Women/Maternal Health - Entry 1 |
|---|
| Priority Need |
| Postpartum Visit: A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth, and B) Percent of women who attended a postpartum checkup and received recommended care comp |
| NPM |
| NPM - Postpartum Visit |
| Five-Year Objectives |
| By September 30, 2030, identify and address challenges to postpartum follow-up in Medicaid-enrolled women |
| By September 30, 2030, Title V will increase partner participation in postpartum visits through the implementation of a family-centered postpartum care program. |
| By September 30th, 2030 Title X clinics will be engaged and partnering to expand access and care for postpartum clients by implementing core relationships and staff development. |
| Strategies |
| Identify and address challenges for Medicaid-enrolled women to attend the postpartum visit within 90 days. |
| Identify and address challenges for Medicaid-enrolled women who attend the postpartum visit within 90 days to receiving the postpartum depression screening at their postpartum visit. |
| Develop a family-centered postpartum care program that includes father involvement during the postpartum period. |
| Leverage relationships with partners to find new ways to reach postpartum women through Title X (Family Planning). |

| ESMs | Status |
|---|---|
| No ESMs were created by the State. | |

## NOMs

Maternal Mortality

Neonatal Abstinence Syndrome

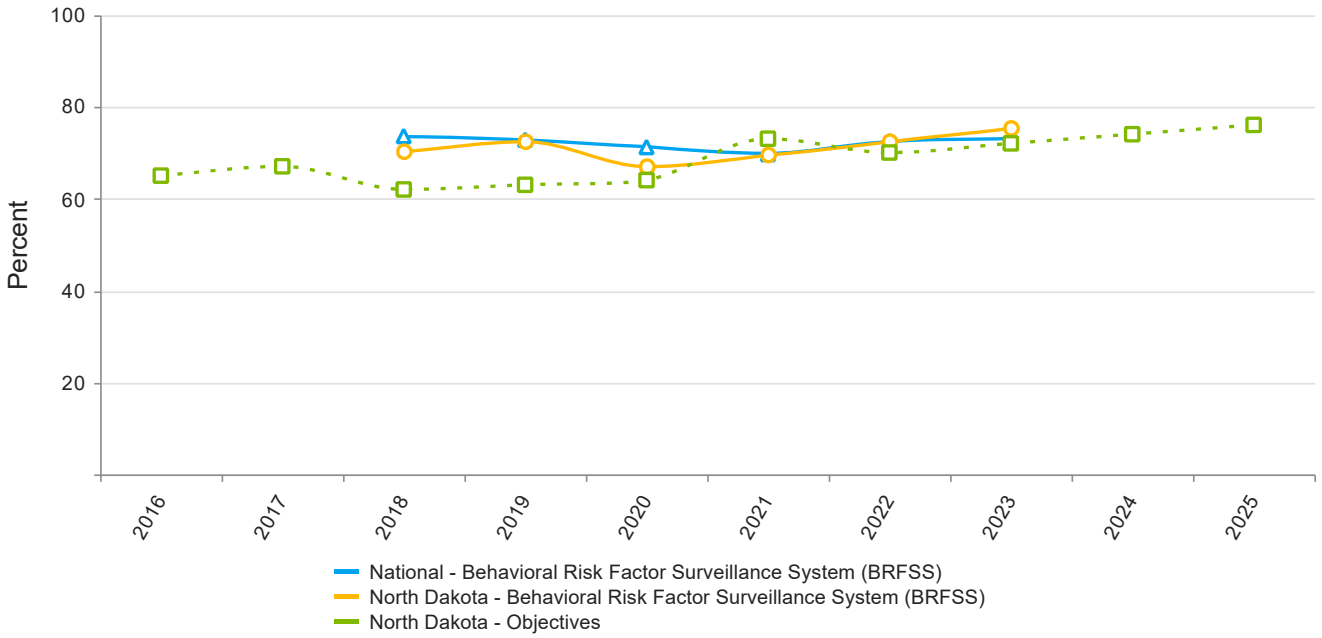
Women's Health Status

Postpartum Depression

Postpartum Anxiety

### 2021-2025: National Performance Measures

**2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV Indicators**




| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: Behavioral Risk Factor Surveillance System (BRFSS)** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 64 | 73 | 70 | 72 | 74 |
| Annual Indicator | 72.3 | 66.8 | 69.4 | 72.3 | 75.2 |
| Numerator | 96,797 | 89,779 | 94,912 | 99,011 | 103,481 |
| Denominator | 133,888 | 134,347 | 136,859 | 137,010 | 137,519 |
| Data Source | BRFSS | BRFSS | BRFSS | BRFSS | BRFSS |
| Data Source Year | 2019 | 2020 | 2021 | 2022 | 2023 |

**2021-2025: Evidence-Based or –Informed Strategy Measures**

**2021-2025: ESM WWV.3 - Number of women ages 18 through 44 receiving a preventative health visit through services provided by MCH grantees.**

| Measure Status: | Active | | | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | | 78 | 88 |
| Annual Indicator | 0 | 68 | 77 | |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | The North Dakota Department of Health, Division of | The North Dakota Department of Health and Human S | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | |

**2021-2025: ESM WWV.4 - The percentage of women receiving women's preventative health educational materials.**

| Measure Status: | Active | | | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | | 50 | 60 |
| Annual Indicator | 0 | 68 | 28 | |
| Numerator | 0 | | 13,984 | |
| Denominator | 100 | | 50,009 | |
| Data Source | Data Source-The North Dakota Department of Health, | The North Dakota Department of Health and Human Se | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | |

## MCH Population Domain: Women/Maternal Health

### NPM: Percent of women, ages 18 through 44, with a preventative medical visit in the last year

### North Dakota Priority Goal: To increase the percentage of women who have an annual preventative visit.

### FY2024 Annual Report Narrative (October 1, 2023-September 30, 2024)

The North Dakota Department of Health and Human Services (NDDHHS) Title V team employed three key strategies to enhance well-woman care in 2023-2024. The most robust strategy for the team was creating targeted programs to engage women in diverse settings to better access care and services, such as women new to the country, pregnant and postpartum women, and those supported by Community Health Workers. This strategy was combined with the Team's second strategy: collaborating with local Community-Based Organizations (CBOs) and public health units to extend outreach efforts. A third strategy included partnering with state-wide organizations to amplify their collective impact.

The team's strategies are based on data over the past years that shows rates for well-woman visits have increased over the last years and are comparable to national rates, but specific subgroups of North Dakotans may not be keeping pace with the overall rates in North Dakota. For example, according to the Behavioral Risk Factor Surveillance System (BRFSS), overall, North Dakotan women ages 18-44 have rates of well-woman visits that are on par with national rates. In 2023, 73.5% of women ages 18-44 in North Dakota had a well-woman visit compared with the United States rate of 72.9%. Rates of well-women visits of women ages 18-44 are increasing in North Dakota; up from 66.3% in 2020, 68% in 2021, 71.3% in 2022 to 73.5% in 2023. This data does not give the full picture, however, as data cannot be evaluated based on race, ethnicity, or other demographic characteristics, where variation may occur in preventative health. In particular, evaluating women who have just given birth can be important in understanding rates of well-woman care.

The Pregnancy Risk Assessment Monitoring System (PRAMS) provides a unique perspective, as it evaluates only those women who have given birth, which is an important subset of North Dakota women. Also, unlike BRFSS, PRAMS collects race data, so progress can be evaluated across racial groups. In 2020, 41.3% of women (46.6% of American Indian (AI) women, 41% of White women, and 42.3% of women of other races) reported a routine checkup in the year prior to becoming pregnant. There has been an increase from 41.3% in 2020 to 45.2% in 2021, but rates are overall very low. While AI women seem to have higher rates than their White counterparts and women of 'other' races (50.6%, compared to 44.7% and 47.5%, respectively), the data for women completing PRAMS—those who have recently given birth—underscore the importance of reaching out to women 'where they are', and particularly, connecting with women when they are pregnant, between pregnancies, and just after giving birth to maximize impact. The data also suggest that it is essential to leverage moments when women are addressing their immediate health needs (particularly in and around pregnancy) to guide them toward a continuum of preventive care. Pregnancy and other times of acute need present unique opportunities to engage women and move them along this continuum. As women address urgent health concerns—such as postpartum depression—they may not yet be ready to consider preventive care, like scheduling an annual exam. Additionally, individuals who are not regularly engaging with the healthcare system are unlikely to proactively seek preventive care. However, times of acute need, such as during labor and delivery, provide critical entry points into the healthcare system where barriers can be identified and addressed. By ensuring positive experiences, offering appropriate follow-up services, and providing peer support, there is a greater likelihood that women will seek preventive care in the future. To this end, the Title V team in North Dakota will continue to implement strategies that connect with women during these pivotal moments, particularly during pregnancy and the postpartum period, to guide them into the healthcare system and encourage ongoing preventive care.

The team identified several key points in time when they could intersect with the most women: in pregnancy, in the postpartum period, and between pregnancies when women may be visiting Family Planning clinics or receiving other services.

Pregnancy represents a key time when women are most likely to engage with the healthcare system, as mentioned above. North Dakota data also highlights that a higher number of women have insurance coverage, such as Medicaid, which enables access to preventive health services. Additionally, the state's new postpartum extension initiative has expanded access to essential preventive health services for women who have recently given birth.

This data underscores the importance of reaching out to women during pregnancy and the postpartum period to

bridge the gap between pregnancy-related care and critical preventive services, especially when women are most likely to have Medicaid coverage. Furthermore, the pregnancy and childbirth phases present a unique opportunity to connect women with the healthcare system, making it an ideal time to encourage ongoing preventive care.

Activities that reached women in the pregnancy and postpartum period in the 2023-2024 year included:

- Developed tailored prenatal education to women new to the country, to address specific cultural needs during and after pregnancy. The third trimester materials ensured that women were aware of the importance of preventative care after pregnancy.
- Developed and expanded group support programs during pregnancy that specifically served Indigenous communities.
- Increased the availability of postpartum doula support, particularly for women of various backgrounds.
- Explored the 'hand off' between the obstetric provider and the primary care physician.

During pregnancy, women may be seeking information to help answer their questions about pregnancy and the health care system's process and services. Therefore, in 2022, the Title V team convened a group to begin developing prenatal education materials that were tailored to the needs of specific groups, such as women arriving from Ukraine. The group paused their efforts due to changing staff and shifting workloads, and the work began again in 2023-2024 in collaboration with Refugee Health Services within NDDHHS. The educational materials have been designed to help women build confidence around what to expect during pregnancy, alert them to symptoms such as postpartum depression, make them aware of resources available, such as doulas and postpartum Medicaid coverage, and remind them to make an appointment with their primary care physician for preventative care.

The educational materials have been customized for women new to the country, catering to their unique needs and provided in their preferred language. These materials focus on preventative care, symptoms to look for during and after pregnancy, available resources such as Doulas and Medicaid coverage, and the transition to primary care. Staff members and partners with experience with this population review the materials to ensure the content is straightforward, concise, and easily comprehensible. The first and second trimester materials have received approval from NDDHHS's Women, Infants, and Children (WIC) Program and the immunization teams and are currently awaiting finalization and branding by the communications team. Development of educational materials will continue for the third trimester and postpartum periods.

In addition to these new educational materials, the Title V team helped develop and implement a variety of programs to support women where they are during pregnancy and postpartum. The team focused on adding new group prenatal care and postpartum doula trainings and collaborated with ongoing efforts in North Dakota to expand mental and emotional support available to pregnant and postpartum women.

In 2023, a new group prenatal care program was launched at Sacred Pipe, a nonprofit agency that serves urban AI women in Mandan, North Dakota. While the program has struggled with attendance—as is typical in group care programs initially—the program has gained visibility and recognition in the area and has developed curricula that is engaging for those in attendance. They have hired a nurse practitioner who can offer prenatal care during the groups, while women have the opportunity to learn about health topics, have discussion on pregnancy-related topics, enjoy refreshments and participate in cultural activities.

Elbowoods Memorial Health Center, located at Three Affiliated Tribes in North Dakota, also launched their group prenatal care program after many years of working closely with Title V on piloting various iterations of group support for pregnant women. While the program has also struggled with gaining momentum, anecdotally, the obstetric provider feels that a higher-need group of women has been reached through these groups and it has helped her gain trust among women who may be engaging in riskier behavior, such as substance use.

In 2023-2024, a third, new group began providing group support for pregnant women, Mni Wichoni Health Circle, was established. This group has provided purposeful care that models, teaches, and nurtures our people at every stage and in every role in the circle of life. Mni Wichoni has promoted holistic community wellness by uplifting Indigenous ancestral knowledge systems while integrating contemporary practices to build spiritual, emotional, physical, and mental balance. They serve families near the Standing Rock Sioux Tribal Nation. Through the support of Title V staff, Mni Wichoni developed a curriculum for their new program and held multiple groups with pregnant women to provide education, deepen their social ties in their communities, and support their connections with their culture, to achieve optimal wellness in pregnancy. See photos below showing the outdoor area for the groups to take place and several photos of groups in progress.

In addition to group-level peer support during pregnancy and postpartum, individualized support is also an important way to reach women. Continuing the work began several years before, in 2023-2024, the Title V staff focused on doula trainings, Medicaid reimbursement models, and partnership opportunities to expand postpartum doulas in the state. Building a bridge between doulas and obstetric providers was identified as an important way to expand doula access. In particular, obstetric providers identified a gap in services between when a woman gives birth and when she returns for follow-up care at about six weeks postpartum. A postpartum doula could help support a woman during this particularly vulnerable postpartum period, ensuring postpartum symptoms such as hypertension are identified and addressed, providing lactation support, and giving women the emotional support needed.

In 2023-2024, the team supported two pilot postpartum doula trainings. One of these trainings recruited Indigenous women or those serving primarily Indigenous women. The training was conducted in partnership with the Indigenous Association, and an Indigenous lactation consultant organized the training. A DONA-certified (Doulas of North America) trainer from Seattle flew in to conduct the four-day training. After participating in the intense training, to gain certification, participants had to complete significant paperwork, conduct several visits with postpartum women, read multiple books, and pay a variety of membership fees. The support through Title V and the Indigenous Association has helped the participants through the process. An additional benefit of the training was the cohort's personal connection with one another. See the photo below of women who trained with the Indigenous Association to become

doulas.


Also in 2024, the team worked closely with an ethnic-based organization (EBO), New American Consortium (NAC), to share introductory information about doulas with women new to the country who might be interested in becoming doulas. NAC is a non-profit organization founded by leaders of three ethnic community-based organizations in the Fargo-Moorhead Area. It works to promote wellness and empowerment by building bonds among people and serves to bridge gaps between diverse communities to organizations. During the grant cycle, NAC recruited NFI (New American, Foreign Born, Immigrant) women from different cultures and backgrounds to be trained by DONA as postpartum doulas. Nine women completed the four-day training with the same DONA-certified trainer that conducted the training with the Indigenous Association in May. See photos below of women training as doulas.

The 2023-2024 initiative to train postpartum doulas aligned with the Title V team's ongoing emphasis on the postpartum period in recent years. The team has broadened its efforts in this area in several key ways, including the continuation of the 2022-2023 training focused on screening for postpartum depression during well-child visits. This training was available throughout 2023-2024 and offered Continuing Medical Education (CME) credits as well as Continuing Education Units (CEUs).

To further strengthen the connection between the postpartum period and preventive care, the team launched a collaboration with the Women's Health Coordinator at Sanford Health Fargo. This partnership addresses the gap in postpartum follow-up care with primary care providers (PCPs). By developing strategies and resources to ensure timely and effective postpartum check-ups, the initiative has aimed to improve continuity of care and enhance health outcomes for new mothers in the community.

Building on this comprehensive focus on the postpartum period, the Title V team also participated in a statewide workgroup to discuss the growing momentum around doulas in North Dakota. Additionally, one team member joined the board of Postpartum Support International's North Dakota chapter, ensuring alignment and coordination across state postpartum initiatives.

Another strategy of the Title V team was to leverage grant funds to support specific community-based organizations (CBOs), local public health units (LPHUs), and partnering with Family Planning to reach diverse women. The team offered Title V grant funds for organizations serving in the western part of the state to reach the women who most need preventative health services. Two applicants were awarded: Women Empowering Women (WEW) and the First District Health Unit.

WEW is a nonprofit organization and long-time partner with the Title V Team. Over the last few years, WEW has utilized Title V funds to pilot several programs to reach Hispanic immigrant communities in the area. Over time, and with continued support from the Title V team, WEW has gained trust among the community and has expanded programming to meet the needs of Spanish speakers in the area. In the 2023-2024 year, WEW was well-positioned to expand this work to reach more people in the community. With the new contract for $39,970 in Title V funding, WEW expanded its programs to reach a variety of immigrational communities in their service area beyond Hispanic communities. They organized a Women's health fair on April 13th, 2024, with approximately 50 attendees, and 22 programs had booths at the event. Their Lay Health Ambassadors program allowed multilingual ambassadors to connect with African American, Latino, and Ukrainian populations. This program has helped with outreach services such as home visiting and community events. The ambassadors program completed 256 women visits, serving 189 Hispanic, 53 African American, and 15 White women. They also assisted with many women's health services such as Women's Way enrollment referrals (41), scheduling appointments (60), immunizations (42), interpretation assistance at appointments (82), mammogram information (35), pap smear (32), and others.

The other Title V grantee was First District Health Unit, based in Minot and providing a variety of public health services such as preventative health care, environmental health protection, nutrition counseling, and health promotion

and safety education programs. With their Title V funds, they developed six Women's Health Clinics in the Towner office to bring preventive health services to rural areas that have limited health care providers. They scheduled clinics for Jan, March, May, July, September, and November 2024 to cover a one-year span. Their philosophy was to set a schedule far enough in advance to give time for word-of-mouth advertising and let the community know they were committed to the project for one year. They put up posters around town, placed some paid advertising in the local newspaper, and put messaging out on social media. The two staff they had in Towner did an excellent job of getting the information out to community partners, including social services in the county. Despite their efforts to promote the clinics, they were only able to reach two clients.

In addition to working with CBOs like WEW and local public health units in the western part of the state, Title V staff have focused on expanding family planning services to women with the highest need in the state, focusing on the southwestern part of the state. Since the closure of a Title X family planning service site in 2019, the southwest corner of North Dakota has been without services. The prior service site served 500 unduplicated clients annually. Family Planning clinics provide confidential, preventive health services for women and men of reproductive age. In 2023, a new clinic in Dickinson, North Dakota, opened to serve men and women of reproductive age. A collaboration between Title V and Title X made it possible to expand services and to meet women where they are at. The goal of Title X is to provide confidential services to men and women that allows them to prevent or achieve a healthy pregnancy. Over the last year, a lot of hard work was poured into the clinic. The clinic space was completely remodeled and updated to meet the needs of the community. From March until July, no patients were seen as the provider was out on maternity leave, but after July, 10 patients were seen in the clinic.

The Title V Maternal Child Health Block grant provided funding in the amount of $15,000 to Upper Missouri District Health Unit (UMDHU), an existing family planning subrecipient, to travel to Dickinson, North Dakota, 1-2 days per month. Clinic hours have been from 9 am – 3 pm, with walk-in clinic appointments available, along with telehealth visits also available as needed. The clinic has been open on the second Tuesday of each month at UMDHU unless the weather prohibits traveling or if no patients are scheduled that day. However, on days that they don't have patients, the nurse and midlevel clinician will do marketing and outreach.

Over this last year, there have been some challenges, such as getting more men and women into the clinic, marketing, and community buy-in. Despite facing these challenges, the continuous quality improvement efforts have allowed many positive community connections and outreach efforts to emerge. WEW has worked with UMDHU to enhance outreach in the Dickinson area and beyond, with a major focus on the Hispanic population. This facility was a previous hospital that was renovated to accommodate a variety of services and businesses. These include substance use disorder treatment services, daycares, boutiques, restaurants, a barber shop, and a martial arts studio, making it an optimal location to meet the needs of the community. UMDHU's clinician and nurse collaborated with local public health, Dickinson State University, PCPs, Obstetrics & Gynecology, and Human Service Zones to increase awareness of the services now available in the community.

Finally, beyond local, targeted approaches, the team wished to further impact North Dakota residents through strategic collaborations with other organizations, particularly those with a state-wide influence. In 2023-2024, the team focused on two activities to achieve this: creating a state-wide women's health task force and partnering with the Maternal Mortality Review Committee (MMRC).

In late 2023, NDDHHS contracted with a state-wide nonprofit organization to develop a women's health task force. The goal was to identify a diverse team of leaders across the state to advance preventative women's health, develop preventative health messaging, and identify five pilot sites to distribute the materials. Unfortunately, the contracted entity encountered turnover, had new leadership during the funding period and was unable to fulfill its contracted responsibilities. In the next year, the team hopes to find alternative entities that could help develop preventative materials and support statewide distribution. In fact, during the 2023-2024 year, the team began working regularly with the North Dakota chapter of Postpartum Support International and began to explore partnering on the distribution of materials around postpartum support. In addition, the team continued to meet regularly with Medicaid to ensure alignment with strategies to reach North Dakotan women with health messages, particularly around the newly established one-year postpartum Medicaid extension benefit for women.

Though the contract was terminated, the Title V team has been utilizing life.nd.gov to meet their goal of disseminating preventative health materials and other valuable resources to women in North Dakota. This comprehensive resource hub offers vital information on social services, financial assistance, parenting guidance, maternal and childbirth services, and planning resources, along with details about care centers and agencies. It has been connecting users with both public and private resources to support maternal health. To amplify the reach and impact of this valuable tool, a targeted communications and media campaign was launched, aimed at increasing awareness and encouraging utilization of the website among expectant and new mothers across the state. As part of this media

campaign, a total of 2,075 life.nd.gov postcards have been strategically distributed across various locations in the state, including women's clinics, maternity homes, and adoption services. These postcards have also been distributed at events such as the North Dakota Immunization Conference, the North Dakota State Fair, Gateway to Health, and the Behavioral Health & Children and Family Services Conference. This widespread distribution aimed to reach a diverse audience, increasing awareness and engagement with the life.nd.gov website and its valuable resources.

The Title V team also had another state-wide partner in 2023-2024. The Title V team has been intimately involved with the MMRC for several years and saw an opportunity to support the committee in reaching its primary goal of publishing recommendations for improving maternal health in North Dakota following case review and committee consensus. The team hoped to leverage funding from Title V to offer a strategic plan that would accelerate the MMRC's work and streamline its effectiveness.

While the Title V team ultimately did not use Title V funding for the MMRC, they collaborated with the North Dakota State Health Officer to issue a letter supporting a grant opportunity for the MMRC in 2023. Unfortunately, the committee lacked the capacity to complete the application in time. In 2024, Title V staff became part of a subcommittee focused on identifying and applying for grants to support the MMRC. This subcommittee has been meeting regularly to prepare for future grant opportunities. Also, in 2024, Title V staff joined the Maternal Case Review Subcommittee, which is scheduled to start reviewing cases in 2025.

During the past federal fiscal year, the Title V team has had great success in implementing its strategies to improve women's preventative care. The team has focused on increasing momentum in women's preventative care through increasing collaboration and strategic alignment with partners, particularly working closely with community organizations that are already reaching women who most need preventative care. Despite challenges and many changes in direction, the team has reached women where they are, improving preventative care for North Dakota residents.

**MCH Population Domain: Women/Maternal Health**

**NPM: Postpartum Visit: A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth, and B) Percent of women who attended a postpartum checkup and received recommended care components**

**North Dakota Priority Goal: Identify, reduce, or eliminate barriers preventing women from receiving recommended postpartum care components, including but not limited to mental health screening, breastfeeding support, care coordination, etc.**

**FY2026 Annual Plan Narrative (October 1, 2025- September 30, 2026)**

The postpartum period, often called the "fourth trimester", is a critical time for both maternal and infant health, laying the foundation for long-term well-being. Nationally, more than half of pregnancy-related deaths occur during this period, from seven days to up to a year after birth. Among pregnancy-related deaths with known causes, Maternal Mortality Review Committees (MMRCs) determined that 8.4% were due to suicide. North Dakota maternal mortality findings also show concerning trends, identifying preventable deaths from conditions such as gestational diabetes, pre-eclampsia, cardiomyopathy, hemorrhage, postpartum depression (PPD), and substance use. PPD is the most common complication of childbirth, affecting 1 in 8 to 1 in 10 mothers nationally, and between 10% and 16% of women in North Dakota in the past five years, according to PRAMS data.

The American College of Obstetricians and Gynecologists (ACOG) now defines postpartum care as an ongoing process rather than a single visit. They recommend an initial provider contact within 3 weeks postpartum, followed by a comprehensive visit by 12 weeks to address physical recovery, chronic conditions, mental health, contraception, and infant care.

Despite its importance, postpartum care is underutilized. Nationally, only 60% of women attend a documented postpartum visit, although more than 90% self-report attending one. While North Dakota 2022 PRAMS data show 93.2% of mothers self-reported attending a postpartum visit and 84.6% of those enrolled in Medicaid attended a visit, documented Medicaid claims data reveals a much bleaker picture. Of the 2,083 women enrolled in Medicaid in 2023, only 535 of them, 25.7%, had a postpartum visit within 90 days.

North Dakota’s Title V MCH team will prioritize Medicaid-enrolled women, who have historically had lower postpartum visit rates. Previous studies show that women on Medicaid are 5–10 percentage points less likely to attend postpartum visits and are nearly twice as likely to report symptoms of postpartum depression (PPD) compared to those with private insurance. The recent extension of Medicaid coverage in North Dakota to 12 months postpartum presents a key opportunity to provide more continuous and coordinated care for mothers and infants. This expanded coverage also allows for closer monitoring of health service use during a period when care gaps are common.

However, increased coverage and visit attendance alone do not ensure high-quality care. ACOG recommends comprehensive follow-up to address breastfeeding plans, depression screening, follow-up for gestational diabetes or hypertension, reproductive life planning, and substance use screening. These services are especially important for women on Medicaid, who tend to have more complex health needs. Compared to their uninsured or privately insured peers, Medicaid-enrolled pregnant women are more likely to be overweight or obese, smoke before or during pregnancy, and have chronic illnesses such as diabetes or hypertension. According to 2022 PRAMS data, only 75.4% of Medicaid-insured women in North Dakota reported receiving key recommended care components during their postpartum visit, specifically, being asked about symptoms of depression or anxiety and receiving contraceptive counseling. Again, PRAMS self-report data appears to far over-estimate rates of receiving these recommended care components, as claims data in 2023 reveals very few women received postpartum depression screening. In fact, only 35 women (6.5%) of the 535 who had a postpartum follow-up visit 90 days after delivery had screening, which occurred in only five of the 53 counties in ND. Based on Medicaid Claims data, contraceptive counseling occurred for more women, in part because it happened outside of the postpartum visit. Two hundred fifty-

four women (12.2%) of the 2,083 who delivered received contraceptive counseling. Contraceptive counseling was slightly higher than postpartum depression screening, based on Medicaid claims data, and occurred outside of the postpartum visit, which included counseling as well as contraceptive procedures or medication done/prescribed. This data highlights persistent gaps in the quality of care provided during this critical period.

This National Performance Measure, developed by the Maternal and Child Health Bureau (MCHB), focuses on improving maternal health by encouraging timely and comprehensive postpartum care. It measures two key areas:
**A)** The percentage of women who attend a postpartum checkup within 12 weeks of giving birth, and
**B)** The percentage of those women who receive recommended services such as depression screening, contraceptive counseling, chronic condition follow-up, and infant care guidance.

To support this goal, North Dakota has adopted an Evidence-Based Strategy Measure (ESM) that specifically tracks postpartum care among Medicaid-enrolled women.

Over the next five years, ESM 1.1 will track the postpartum visit for all Medicaid-enrolled women, using the Z392 Medicaid code, which is an encounter for routine postpartum follow up visit. The goal will be to raise the percentage of women who received their visit from 25.7% in 2023 to 35% by 2030.

Additionally, ESM 1.2 will track the postpartum depression screenings for Medicaid-enrolled women administered at the postpartum visit. The goal will be to increase the number of postpartum depression screenings from 6.5% in 2023 to 20% by 2030, using Medicaid claims data. Contraceptive counseling and use will be monitored regularly, but due to its widespread access outside of the postpartum visit, it will not be captured in an ESM.

The first strategy is to identify and remove barriers to care. In the first year, North Dakota will focus on identifying the root causes behind low rates of timely postpartum care among Medicaid-enrolled mothers, especially those living in tribal and rural communities. This initial work is foundational to developing future strategies that are responsive, driven by data, and will ensure every mother and child achieves their full health potential.

To assess both access to and quality of postpartum services (that is the A and B components of the NPM), the state will analyze a mix of quantitative data sources, including Medicaid claims and PRAMS survey results. These efforts will align with national quality measures, particularly those included in the Healthcare Effectiveness Data and Information Set (HEDIS) and the Centers for Medicare & Medicaid Services (CMS) Adult Core Set. One key benchmark is the Prenatal and Postpartum Care (PPC) measure, which tracks the percentage of women who receive a postpartum visit within 90 days after delivery. This widely used quality indicator is part of both the HEDIS set and the CMS Adult Core Set for women. By aligning its analyses with the PPC measure, North Dakota will be able to compare performance against national standards and better understand disparities, especially among rural and tribal populations.

In addition, the state will monitor postpartum depression screening using PRAMS data and the Postpartum Depression Screening and Follow-Up (PDS-AD) measure, which was provisionally added to the CMS 2025 Adult Core Set. This measure assesses whether women were screened for clinical depression during the postpartum period and, for those who screened positive, whether appropriate follow-up care was received. Incorporating this measure allows the state to evaluate how well postpartum mental health needs are being addressed among the Medicaid population.

It is worth noting that while both components of postpartum care are emphasized, North Dakota will prioritize measuring the receipt of postpartum depression screening among Medicaid-enrolled women in the five-year plan. While contraceptive counseling and provision saw relatively higher rates in 2023, partly because services were accessed not only during postpartum visits but also through other entry points, family planning programs' postpartum depression screening was severely lacking across all Medicaid-enrolled postpartum women. Given the state's goal to maintain multiple access points to reconnect women who may have missed their postpartum visits, tracking such distributed service delivery, such as contraceptive counseling and usage, makes data collection challenging. As a result, contraceptive counseling and usage will not be included as an ESM, but will instead be reviewed and considered annually outside of the ESM measurements.

Together, these nationally endorsed measures of the postpartum visit and postpartum depression screening will guide the state's barrier assessment, helping to identify where gaps exist in postpartum visit attendance and mental health screening. By evaluating claims and survey data through the lens of these standardized metrics, North Dakota can develop more targeted and informed strategies to improve outcomes for Medicaid-enrolled mothers.

All data will be disaggregated across multiple barriers, and attention will also be paid to potential gaps in claims data and discrepancies between administrative data and self-reported care. For instance, while 93.2% of mothers in North Dakota reported having a postpartum visit, Medicaid claims data show significantly lower visit rates among enrollees.

To complement this quantitative analysis, the state will conduct qualitative data collection through discussions and community engagement. Participants will include Medicaid beneficiaries, community leaders, obstetric and pediatric providers, and community health workers. Already, some communities and health systems have expressed interest in having these discussions. These conversations will explore personal experiences and perceived barriers to accessing postpartum care.

To help guide and interpret findings, the state will engage stakeholders and partners, such as Title V program staff, Medicaid Managed Care Organizations (MCOs), tribal health authorities, healthcare providers, and members of the North Dakota MMRC, for feedback and input. This collaborative process will support data review, elevate key themes, and inform the direction of future strategies.

As part of the grant preparation process, the team has already held an initial meeting with partners, including Postpartum Support International and MyAlly, to share ideas and discuss priorities for the MCH Title V Grant program plan. Follow-up meetings are planned to continue shaping the strategy collaboratively. In addition, North Dakota will participate in national learning opportunities through CMS-supported postpartum care collaboratives and affinity groups.

At the same time, the state will map existing postpartum care infrastructure and resources across North Dakota. This includes identifying and cataloging home visiting programs, Medicaid case management services, and available telehealth systems. Mapping these services will help highlight under-resourced areas and support alignment with related initiatives.

The next key strategy is to promote family-centered postpartum care. Title V recognizes the critical role that fathers play in supporting maternal recovery, infant bonding, and overall family well-being during the postpartum period. By encouraging father involvement in postpartum visits and care planning, Title V aims to create a supportive environment that acknowledges the unique challenges fathers face, including stress and the risk of postpartum depression, which often goes unrecognized. In addition to addressing these challenges, Title V is committed to fostering a family-centered approach that not only aids in maternal recovery and strengthens the emotional connection between fathers and their infants, but also enhances the well-being of the entire family unit. Engaging fathers in these processes fosters a more comprehensive approach to maternal health, aligning with the NPM goals by emphasizing the importance of family-centered care that includes fathers as active participants in their children's health and well-being.

To achieve these objectives, Title V will collaborate with community partners to develop a family-centered postpartum care program that addresses the critical need for educational resources for fathers and coordinated interventions. This comprehensive program will focus on building supportive environments that empower fathers to engage meaningfully in their families' health journeys, ensuring that all families receive the essential postpartum care necessary for promoting healthier outcomes for mothers, infants, and families as a whole.

The final strategy is to leverage Title V clinics to reach missed postpartum women. North Dakota will collaborate with Title X providers and clinic staff, including MyAlly Health, to reach women who miss the opportunity for postpartum visits. Clinics will incorporate postpartum components, particularly depression screening, into family planning visits and preventive care. By modifying intake forms to identify recent births, electronic medical records (EMRs), and educating staff, Title X nursing staff will screen for postpartum depression and provide abridged assessments with appropriate referrals if needed. This expands postpartum care into non-traditional access points, helping reconnect

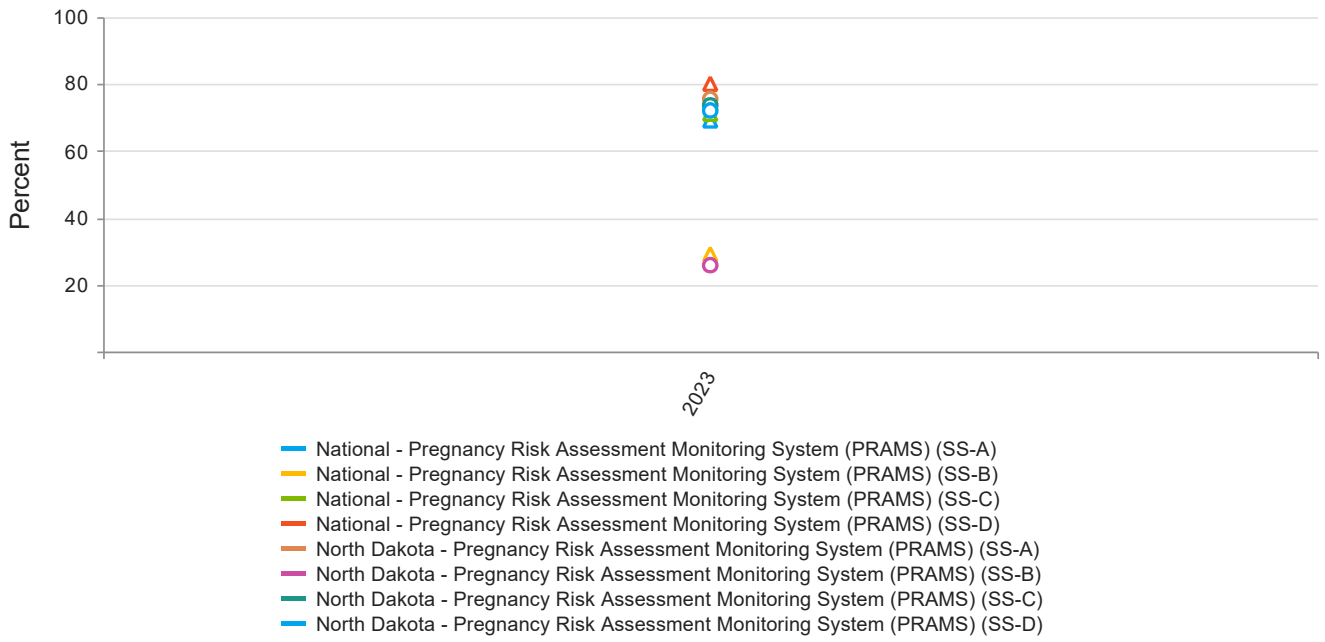
women to healthcare. Training, referral systems, and outreach campaigns will support implementation. This strategy strengthens the safety net and addresses Title V's NPM objectives by ensuring more mothers receive timely and comprehensive follow-ups even outside of OB/GYN settings.

In conclusion, North Dakota’s postpartum care approach is rooted in the belief that every birthing person, deserves timely, high-quality, and compassionate care. By beginning with a comprehensive, people-centered assessment, the state is prioritizing listening, learning, and building trust. The insights gained through this process will lay a strong foundation for future evidence-based strategies that ensure every Medicaid-enrolled mother in North Dakota can access the postpartum care they need to thrive. By developing a family-centered program for postpartum support, North Dakota will strengthen the family-based culture that is so important to the state’s residents. Finally, by continuing to build on partnerships with Family Planning (Title X) developed during the previous five-year cycle, the team will strengthen collaboration and continue the quality improvement efforts that have led to significant changes in depression screening over the last five years.

## Perinatal/Infant Health

### National Performance Measures

**NPM - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult during sleep - SS**
**Indicators and Annual Objectives**




**NPM - A) Percent of infants placed to sleep on their backs - SS**

| Federally Available Data | |
|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 75.4 |
| Numerator | 6,568 |
| Denominator | 8,714 |
| Data Source | PRAMS |
| Data Source Year | 2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**NPM - B) Percent of infants placed to sleep on a separate approved sleep surface - SS**

| Federally Available Data | |
|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 25.7 |
| Numerator | 2,245 |
| Denominator | 8,747 |
| Data Source | PRAMS |
| Data Source Year | 2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**NPM - C) Percent of infants placed to sleep without soft objects or loose bedding - SS**

| Federally Available Data | |
|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 73.7 |
| Numerator | 6,512 |
| Denominator | 8,834 |
| Data Source | PRAMS |
| Data Source Year | 2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**NPM - D) Percent of infants room-sharing with an adult during sleep - SS**

| Federally Available Data | |
|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 71.8 |
| Numerator | 6,403 |
| Denominator | 8,916 |
| Data Source | PRAMS |
| Data Source Year | 2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Evidence-Based or –Informed Strategy Measures**

None

**State Action Plan Table**

| State Action Plan Table (North Dakota) - Perinatal/Infant Health - Entry 1 | |
|---|---|
| Priority Need | |
| Safe Sleep: Infants placed to sleep: A) on their backs B) on a separate sleep surface C) without soft objects D) in the same room as an adult | |
| NPM | |
| NPM - Safe Sleep | |
| Five-Year Objectives | |
| By September 30, 2030, Decrease the Sudden Unexplained Infant Death (SUID) rate in North Dakota from 86.6 to 77.9 (10% reduction) per 100,000 live births by promoting safe sleep practices to increase: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult; and encouraging protective factors such as breastfeeding. | |
| By September 30, 2030, increase the percentage of North Dakota infants who are breastfed exclusively at 6 months from 31% to 35% to support safe sleep practices and reduce sleep-related infant deaths, according to the CDC National Immunization Survey (2021). | |
| Strategies | |
| Fund and/or collaborate with Local Public Health Units across the state to educate birthing families/infant caregivers on evidence-based safe sleep practices. | |
| Promote the NDDHHS Infant Safe Sleep Data Dashboard as a technical assistance resource to support stakeholders in tracking and examining trends related to: sleep-related infant mortality, safe sleep behaviors, and safe sleep education. | |
| Continue partnerships with Cribs for Kids Distribution locations to increase and promote safe sleep statewide. | |
| Provide high-risk communities with SIDS/SUIDS prevention that builds on community strengths and values. | |
| Utilize the SUID cohort to share educational resources (e.g., Digital Storytelling, media campaigns, etc.). | |
| Increase access to professional lactation support during the postpartum period or up to one year after childbirth. | |
| By September 30, 2030, increase the number of businesses designated as Infant Friendly Workplaces from 220 to 270. | |
| ESMs | Status |
| No ESMs were created by the State. | |

## NOMs

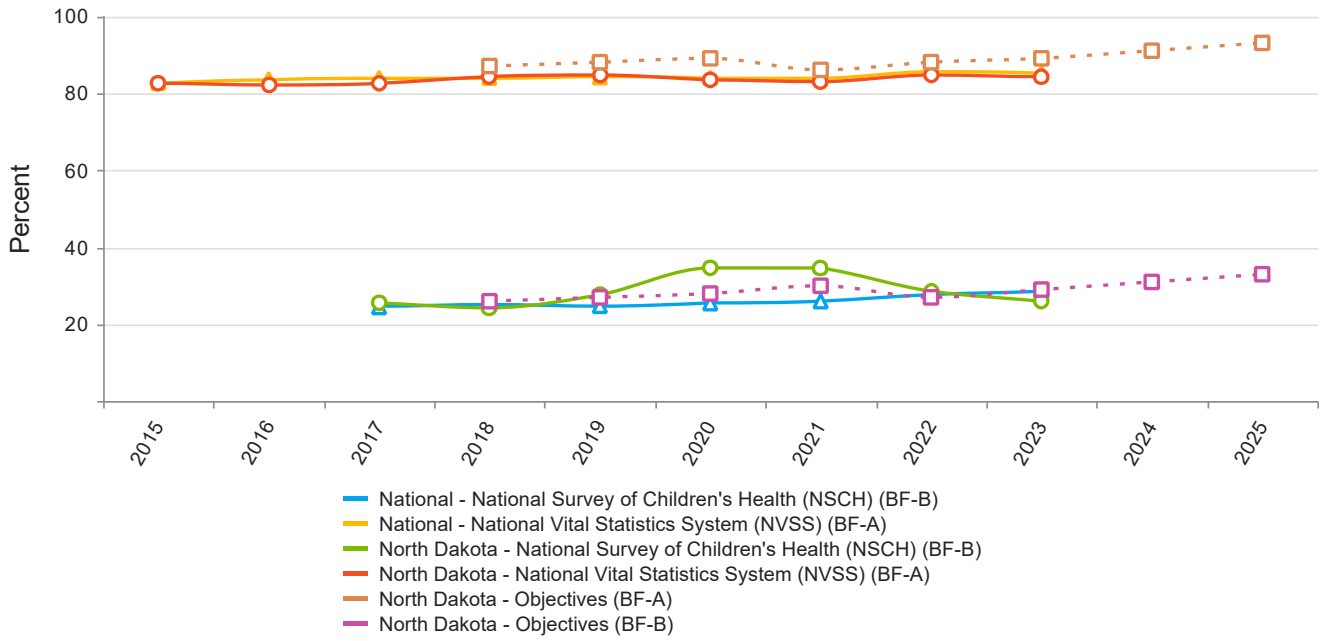
Infant Mortality

Postneonatal Mortality

SUID Mortality

### 2021-2025: National Performance Measures

**2021-2025: NPM - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF**
**Indicators**




### 2021-2025: NPM - A) Percent of infants who are ever breastfed - BF

| Federally Available Data | | |
|---|---|---|
| **Data Source: National Vital Statistics System (NVSS)** | | |
| | **2023** | **2024** |
| Annual Objective | 89 | 91 |
| Annual Indicator | 84.8 | 84.1 |
| Numerator | 7,558 | 7,697 |
| Denominator | 8,911 | 9,154 |
| Data Source | NVSS | NVSS |
| Data Source Year | 2022 | 2023 |

**2021-2025: NPM - B) Percent of infants breastfed exclusively through 6 months - BF**

| Federally Available Data | | |
|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | |
| | **2023** | **2024** |
| Annual Objective | 29 | 31 |
| Annual Indicator | 28.6 | 26.2 |
| Numerator | 6,736 | 6,173 |
| Denominator | 23,569 | 23,550 |
| Data Source | NSCH | NSCH |
| Data Source Year | 2021_2022 | 2022_2023 |

**2021-2025: Evidence-Based or –Informed Strategy Measures**

**2021-2025: ESM BF.2 - Number of businesses designated Infant Friendly Workplaces.**

| **Measure Status:** | **Active** | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 150 | 155 | 165 | 175 |
| Annual Indicator | 136 | 145 | 155 | 190 | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | North Dakota Department of Health. Family Health a | North Dakota Department of Health. Family Health a | The North Dakota Department of Health and Human Se | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | North Dak | |
| Provisional or Final ? | Final | Final | Final | Final | |

**MCH Population Domain: Perinatal/Infant**

**NPM: Breastfeeding: A) Percent of infants who are ever breastfed, and B) Percent of infants breastfed exclusively through 6 months**

**North Dakota Priority Goal: To increase the percentage of infants who are breastfed and who are breastfed exclusively through six months.**

**FY2024 Annual Report Narrative (October 1, 2023-September 30, 2024)**

The numerous benefits of breastfeeding are clear and well-understood. The American Academy of Pediatrics recommends all infants exclusively breastfeed for the first six months, as human milk supports optimal growth and development. The bond of a nursing mother and child is stronger than any other human contact. Additionally, a woman's ability to meet her child's nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and postnatal depression. Therefore, Title V staff continue to work to improve North Dakota's breastfeeding rates.

According to the 2021 National Immunization Survey (NIS), 83.5% of North Dakota mothers initiated breastfeeding, and 31.4% exclusively breastfed their infants at six months of age. Breastfeeding initiation and exclusivity have held steady with little change since 2017, when rates were 84% and 29%, respectively. However, a recent report titled Racial and Ethnic Disparities in Breastfeeding Initiation – United States, 2019 found North Dakota to have the highest differences in breastfeeding rates by racial/ethnic groups at 37.6%. This aligns with 2018-2019 National Vital Statistics System (NVSS) data, which notes "ever breastfed" rates were lowest in Sioux (39.5%), Benson (41.9%), and Rolette (59.8%) counties and the 2022 North Dakota Pregnancy Risk Assessment Monitoring System (PRAMS) noting, American Indian (AI) mothers are less likely to initiate breastfeeding (74.7%), than mothers of other races (white mothers; 92.7% and other mothers; 93.3%).

Also, in the PRAMS survey under the section “Things that may have happened at the hospital where your new baby was born”, 93% of mothers reported breastfeeding their baby in the hospital (82% AI mothers, 88.2% other mothers, 94.5% white mothers); although only 65.3% reported their baby was fed only breastmilk at the hospital, (49.9% AI mothers, 46.6% other mothers, 69.5% white mothers). The top barriers reported by women across all races who stopped breastfeeding were, I thought I was not producing enough milk, or my milk dried up (59%), Breast milk alone did not satisfy my baby (30%), My baby had difficulty latching or nursing (28.8%), and Other Reasons (34.9%). This highlights key opportunities to focus future strategies on the maternity care setting, continuity of care, and access to professional support in the community.

The National Outcome Measures (NOM) for the Infant Domain are NOM 9.1 Infant Mortality, NOM 9.3 Postneonatal Mortality, and NOM 9.5 Sleep-related Sudden Unexpected Infant Death (SUID). In North Dakota in 2020, according to the NVSS, the infant mortality rate was 5.5 per 1,000 live births (down from 2019 at a rate of 7.5). This is slightly higher than the United States (US) rate of 5.4 per 1,000 live births. The 2020 postneonatal mortality rate in North Dakota was 1.9 per 1,000 live births, which was a decrease from 2019 (2.9). The SUID rate from 2020 was 129.2 per 100,000 live births, an increase from 2019 (124.4) and was higher than the US average (92.5). In North Dakota, higher rates of infant mortality, postneonatal mortality, and SUID are among infants born with low birth weight (<1,500 grams), low gestational weeks (<34 weeks), and infants born to women with lower socioeconomic factors. In addition, differences are observed among AI infants, having approximately two to three times higher risk of infant mortality, postneonatal mortality, and SUID.

The Evidence-Based or Informed Strategy Measures (ESM) are defined as:
ESM 4.2 Number of businesses who receive information and technical assistance on workplace breastfeeding policies.
ESM 4.3 Number of businesses designated Infant Friendly Workplaces.
ESM 4.4 Percent of maternity care staff trained with the EMPower curriculum.

See the ESM Detail Sheets for further information.

Objective 1: By September 30, 2025, increase the percentage of North Dakota infants ever breastfed from 84.8% to 89%.

In 2020, a partnership was established with the Family Birthplace Manager at Jamestown Regional Medical Center to provide *EMPower Breastfeeding Training* (https://www.empowerbestpractices.org/training/) to other birthing hospitals in North Dakota. The goal is to train six birthing hospitals by 2025. The training aims to improve evidence-based maternity practices by providing hospitals with training to increase staff capacity and knowledge. During the 2021-2022 grant year, two birthing hospitals, Altru Health System and CHI St. Alexius Health – Bismarck, completed the training and trained over 90% of their maternity care staff. Support was provided to both hospitals via monthly coaching calls. During the 2022-2023 grant year, one birthing hospital, CHI St. Alexius Health – Williston, was trained and developed a training plan for training 90% of their maternity care staff. In May of 2024, 90% of their maternity staff were trained, and additional training with doctors who provide care of newborns was being scheduled to help encourage consistent communication for breastfeeding. Two staff also were trained as Certified Lactation Consultants, with funding support from the MCH grant. The next step will be reviewing their exclusive breastfeeding data to determine the impact of training and identify areas for improvement.

Objective 2: By September 30, 2025, increase the percentage of North Dakota infants breastfed exclusively at six months from 27.9% to 35%.

To address increasing breastfeeding exclusivity at six months, the North Dakota Department of Health and Human Services supports the Infant Friendly Workplace Designation (https://www.hhs.nd.gov/health/children/breastfeeding/breastfeeding-support-workplace) with an overall goal to increase the number of workplaces designated from 133 to 200 by 2025. The designation is a voluntary program for employers with a workplace breastfeeding policy that includes a dedicated, private space (not a restroom) for pumping breastmilk, flexible break/work scheduling for pumping breast milk, and access to a nearby sink and refrigerator. Activities to support workplaces included: provided nineteen workplaces with grants of up to $500 to create a private space for employees, provided support to five Local Public Health Unit partners who conducted outreach and support to workplaces in their communities, and partnered with a local Science Museum to contribute towards the purchase of a Mamava Pod. As a result of these activities, 17 new workplaces were designated from October 1, 2023, through September 30, 2024.

In addition to the strategy above, eight local public health units (Central Valley Health District (CVHD), Emmons County Public Health (ECPH), Fargo Cass Public Health (FCPH), Grand Forks Public Health (GFPH), Richland County Health Department (RCHD), and Walsh County Public Health (WCPH)), Wells County District Health Unit (WCDHU) and Western Plains Public Health (WPPH)), one health system (Altru Health System) and two organizations serving Indigenous families (Indigenous Association and Spirit Lake Health Center) were funded to increase breastfeeding rates at six months in their communities. Each grantee determined their community needs and completed an action plan with objectives, strategies, and activities linked to evidence-based, evidence-informed, and/or promising practices. During the 2023-2024 program year, each grantee had the following successes:

- CVHD: Assisted one workplace with becoming Infant Friendly. Launched an in-office lactation support clinic and provided support to 64 mothers. Hosted two support groups with attendance from nine mothers. Hosted the 2024 Biennial Breastfeeding Conference. The event had 95 people attend in person, and 60 attended virtually.
- ECPH: Provided lactation support / newborn home visits to three mothers.
- FCPH: Assisted six workplaces with becoming Infant Friendly. Reached 36 mothers with the Back 2 Work Mom class and enrolled 12 mothers in the Back 2 Work Mom text messaging program.
- GFPH: Assisted two workplaces with becoming Infant Friendly. Trained 216 nursing, nutrition, and dietetic students and 40 Medical students at the University of North Dakota with the Breastfeeding Skills Training. Opened a Milk Depot to support breast milk donation: Greater Grand Forks Milk Depot | City of Grand Forks, ND.
- RCHD: Provided support to 13 mothers through in-office lactation support and a Baby Café in partnership with their local health system.

- WCPH: Trained one additional Certified Lactation Counselor from their local health system. Assisted two workplaces with becoming Infant Friendly.
- WCDHU: Began training two staff to become Certified Lactation Counselors and pivoted to partnering with a larger LPHU in their area that provides lactation support to offer virtual appointments. Provided one mother with a breast pump.
- WPPH: Assisted four workplaces with becoming Infant Friendly.
- Altru Health System: Served 212 mothers with its walk-in breastfeeding clinic. Developed kits for the prenatal clinic for early collection of breastmilk/colostrum to assist mothers with diabetes in having a successful start to breastfeeding.
- Indigenous Association: Contracted with an RN, IBCLC, who served six mothers with breastfeeding support. Applied and was selected to host an Indigenous Lactation Training. The training was held June 24-28, 2024, with eight participants completing the training.
- Spirit Lake Health Center: Trained one staff member as a certified lactation counselor. Developed prenatal and postnatal breastfeeding education packets.

Additional critical partnerships/initiatives to support this priority include:

- The Women, Infants, and Children (WIC) program promoted the breastfeeding initiation bag project (implemented in two tribal, local agencies and six rural local agencies), breastfeeding peer counseling (implemented in seven agencies), provided training to local agency WIC staff using the new USDA/FNS WIC Breastfeeding Curriculum, supported local agency staff attaining advanced breastfeeding credentials (International Board-Certified Lactation Consultant) and provided local agency staff with resources for breastfeeding promotion and support as identified by the WIC Breastfeeding Committee (local agency IBCLCs). In addition, the WIC program is housed in the same unit as the MCH Nutritionist and the North Dakota WIC Breastfeeding Coordinator was the immediate supervisor of the MCH Nutritionist. This relationship encouraged strong partnership and awareness of activities between state and local WIC agencies and MCH programs and grantees.

- North Dakota Breastfeeding Coalition (NDBC) –Both entities share the vision of increasing breastfeeding initiation and duration across the state. The NDBC disseminates consistent information to professionals across the state via bi-monthly member conference calls.

- Association of State Public Health Nutritionists (ASPHN) – The MCH Nutritionist serves on the Steering Committee for the MCH Nutrition Council with ASPHN. ASPHN has strong connections with the Maternal and Child Health Bureau and works with three states, North Dakota included, to implement the State Capacity Building program. This program aims to build the capacity of participating states' Title V programs to integrate nutrition by increasing MCH nutrition competency and optimizing nutrition-related data sources for effective programs.

In summary, Title V staff recognize the importance of breastfeeding and its significant impact on children and families across the state. Collaborating with existing partners and developing new working relationships is essential to improving breastfeeding rates and enhancing infants' overall health and well-being.

**MCH Population Domain: Perinatal/Infant**

**NPM: Safe Sleep: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult**

**North Dakota Priority Goal: Support services, programs, and activities that encourage safe sleep.**

**FY2026 Annual Plan Narrative (October 1, 2025-September 30, 2026)**

In the United States in 2022, there were approximately 3,700 Sudden Unexplained Infant Death (SUID) cases due to sleep-related causes, including sudden infant death syndrome (SIDS), unknown causes, and accidental suffocation/strangulation in bed. SUID rates declined in the 1990s but have remained relatively stagnant since 2000. In North Dakota between 2019 and 2023, there were *53* infant deaths identified by the Child Fatality Review Panel as SUID. This number also includes those accidental sleep-related asphyxia deaths by overlay/wedging. Eighteen of these cases were bed sharing on an adult bed and fourteen did not have a crib. The American Academy of Pediatrics (AAP) recommends the following to reduce the risk of SUID: supine positioning, firm, non-inclined sleep surface, room-sharing without bed-sharing, avoiding soft bedding, and human milk feeding. Breastfeeding is associated with lower SUID risk.

Breastfeeding helps reduce the risk of SUID because it provides multiple protective health benefits for infants. It assists in strengthening the immune system because breastmilk contains antibodies and essential nutrients that protect infants from infections, which can contribute to SUID risks. Breastfeeding improves infant arousal response because breastfed babies tend to have enhanced arousal mechanisms during sleep, reducing the likelihood of deep sleep episodes associated with SUID. Exclusive breastfeeding reduces the chances of respiratory infections, including upper respiratory tract infections, which have been linked to higher SUID risk. Breastfeeding promotes optimal development of neurological functions, leading to more stable breathing patterns and cardiovascular regulation during sleep. Breastfeeding encourages safe sleep practices because breastfeeding mothers are more likely to follow safe sleep guidelines, such as room-sharing without bed-sharing, which further decreases SUID risk. The AAP recommends exclusive breastfeeding for at least 6 months to maximize its protective effects.

The National Performance Measure under the Perinatal/Infant Health Domain is Safe Sleep. The National Outcome Measures (NOM) for the Infant Domain are Infant Mortality, post neonatal, and Sudden Unexpected Infant Death (SUID).

According to the Centers for Disease Control and Prevention (CDC), North Dakota’s infant mortality rate in 2022 was 4.39 per 1,000 live births, a decrease from 5.5 per 1,000 live births in 2020. Despite this improvement, the rate remains slightly higher than the national average of 5.6 per 1,000 live births in 2022, which saw a slight increase from 5.44 per 1,000 in 2021.

The Sudden Unexplained Infant Death (SUID) rate in North Dakota in 2020 was 129.2 per 100,000 live births, exceeding the U.S. average of 100.9 per 100,000.
Certain populations in North Dakota experience higher rates of infant mortality, post-neonatal mortality, and SUID, particularly:

- Infants born with low birth weight (<1,500 grams)
- Infants born at low gestational age (<34 weeks)
- Infants born to mothers with lower socioeconomic status

Additionally, differences are notably observed among American Indian (AI) infants, who face a two to three times higher risk of infant mortality, post-neonatal mortality, and SUID compared to other racial groups. Using this data, eight Evidence-Based or Informed Strategy Measures (ESMs) were developed to guide efforts in promoting safe sleep and breastfeeding, with four measures focused on safe sleep and four dedicated to breastfeeding initiatives.

| ESM Metric | Description |
|---|---|
| Safe Sleep | Safe Sleep A: Percent of women who reported that they placed their infant to sleep only on their backs (not stomach or side). |
| Safe Sleep | Safe Sleep B: Percent of women who reported that their infant always slept alone in their own crib or bed while they themselves were sleeping. |
| Safe Sleep | Safe Sleep C: Percent of women who reported that their infant was not placed to sleep with comforters, quilts, blankets, non-fitted sheets, soft toys, cushions, pillows, or crib bumper pads. |
| Safe Sleep | Safe Sleep D: Percent of women who reported that their infant's crib or bed was in the same room where they or another adult slept. |

In North Dakota, safe sleep practices among infants show notable trends compared to national averages. Currently, 88.8% of women report placing their infants only on their backs to sleep, exceeding the U.S. average of 82.8%. The target is to increase this to 90% by 2030.

Regarding separate, approved sleep surfaces, 60.8% of North Dakota infants follow this practice, slightly above the national average of 59.2%, with a goal of reaching 62% by 2030. When considering sleep environments free from soft objects or loose bedding, 57.3% of North Dakota infants adhere to safe practices, though this remains lower than the U.S. rate of 59.6%. The target is to increase compliance to 60% by 2030. Finally, room-sharing without bed-sharing is reported by 72.2% of North Dakota mothers, significantly below the national rate of 82.1%. The goal is to raise this to 75% by 2030.

By September 30, 2030, North Dakota aims to reduce the SUID rate from 86.6 to 77.9 per 100,000 live births (a 10% reduction) by promoting safe sleep practices, particularly separate sleep surfaces and protective factors like breastfeeding. The baseline SUID Rate (2018-2022, CDC Data): 86.6 per 100,000 live births. NDDHHS will offer funding, up to $14,500, to all 28 Local Public Health Units (LPHU) to implement strategies on Safe Sleep.

The first strategy is to strengthen LPHU Partnerships. These partnerships will focus on funding and collaborating with the LPHUs across North Dakota to educate birthing families and infant caregivers on evidence-based safe sleep practices. A few of the key activities include educating LPHU staff on Safe Sleep by having them complete the Safe Sleep Ambassador Training that is offered on the National Cribs for Kids site. State Title V will also focus on educating LPHU's clients on safe sleep, especially placing infants to sleep on their backs, placing infants to sleep on a separate, approved sleep surface, placing infants to sleep without soft objects or loose bedding, and the importance of infant's room-sharing with an adult. The NDDHHS will provide funding to LPHU partners to reach workplaces in their community with the designation and will offer up to $500 in funding to workplaces across North Dakota to assist with educating on safe sleep. Applications will be accepted on a first-come, first-served basis through August 1, 2025.

The next strategy is to expand data tracking and technical assistance by promoting the NDDHHS Infant Safe Sleep Data Dashboard. State Title V will also support stakeholders in tracking sleep-related infant mortality trends, safe sleep behaviors, and education efforts by linking Qualtrics data into the Safe Sleep Dashboard and partnering with Title V staff to complete Cribs for Kids data entry for accurate reporting.

Title V staff will also strengthen partnerships with Cribs for Kids (C4K's) Distribution Locations by providing materials to C4K's distribution sites to expand outreach. Title V staff will host bi-annual calls with all participating Cribs for Kids distribution locations to improve safe sleep education statewide.

Finally, Title V will expand SIDS/SUID Prevention in AI populations by providing targeted prevention efforts that incorporate community cultural values and strengths. Staff will distribute bedside sleepers in specific regional areas, emphasizing safe sleep education tailored to community needs. The statewide SUID Cohort will be used for educational outreach to distribute and promote digital storytelling projects, media campaigns, and educational materials.

Because breastfeeding plays such a significant role in preventing sleep-related deaths in infants, Title V will continue to work towards increasing exclusive breastfeeding rates as an overarching objective. By September 30, 2030,

North Dakota aims to increase the percentage of infants exclusively breastfed at six months from 31% to 35% to support safe sleep practices and reduce sleep-related infant deaths, as reported in the CDC National Immunization Survey (2021).

The first strategy is to expand lactation support and workplace initiatives. To achieve this, North Dakota is focusing on enhancing postpartum lactation support, increasing the number of lactation professionals, and expanding workplace accommodations for breastfeeding parents. NDDHHS will offer funding, up to $14,500, to all 28 LPHUs to implement strategies from the Continuity of Care in Breastfeeding Support: A Blueprint for Communities (https://www.naccho.org/blog/articles/continuity-of-care-in-breastfeeding-support-a-blueprint-for-communities). The Blueprint aims to increase local capacity to implement community-driven approaches and ensure breastfeeding services are continuous, accessible, and coordinated throughout community partners. In North Dakota, strategies 1.5, 2.7, 3.2, 3.3, 5.3, 5.4, 5.5, 7.1, and 7.2 were selected for LPHUs to focus on, with the intent to increase access to professional lactation support during the postpartum period. A request for proposal (RFP) will be distributed to all 28 LPHUs. The applications include work plan and budget templates as well as summary and narrative proposals. Contracts will start on October 1, 2025.

The NDDHHS will continue to partner with North Dakota State College of Science (NDSCS) and a professor offering a new course, Human Lactation 1 and 2. The course is intended to be a Pathway 2 option for students and professionals wanting to obtain their IBCLC credentials. The program also plans to become a short-term provider for L-CERPS and provide continuing education for current Certified Lactation Consultants (CLC) to maintain their credentials. The partnership will focus on providing funding support for professionals to attend either the Human Lactation 1 or 2 course and to provide continuing education opportunities for CLC's in North Dakota. This will help strengthen the lactation landscape in North Dakota, especially in rural areas, which have the greatest gaps in lactation care.

One additional strategy that will continue in 2025-2026 to address increasing breastfeeding exclusivity at six months is the Infant Friendly Workplace Designation (https://www.hhs.nd.gov/health/children/breastfeeding/breastfeeding-support-workplace). The goal is to increase the number of workplaces designated from 220 to 270. The NDDHHS will continue to provide funding to LPHU partners to reach workplaces in their community with the designation and will offer up to $500 in funding to workplaces across North Dakota to assist with creating private space. A grant application will be posted on the North Dakota Breastfeeding website to announce the funding opportunity. Applications will be accepted on a first-come, first-served basis. Resources for implementation include, but are not limited to:

- LPHU staff and matching funds
- NDSCS Human Lactation Course Professor
- MCH Staff and MCH funding
- Workplace staff time and engagement

Partnerships are essential when striving to improve infant/perinatal death rates. Additional critical partnerships/initiatives to support this priority include:

- Child Care Aware® of North Dakota is an information hub for current and prospective childcare providers and offers parents customized referrals to licensed childcare options. We work to build the capacity of childcare in North Dakota and ensure that children have the opportunity to play and learn in a safe and healthy environment. Child Care Aware works diligently to promote safe sleep with their clients.
- Safe Kids Worldwide is a nonprofit organization working to reduce unintentional injuries to children ages 0-19 and build sustainable systems that support injury prevention. They work with strategic partners and an extensive network of more than 400 coalitions in the U.S. to reduce traffic injuries, drownings, sleep-related deaths, falls, burns, poisonings, and more. We achieve this work through a public health approach that includes research, interventions to educate and raise awareness, safety device distribution, and advocacy at the federal, state, and local levels. Safe Kids also supports a worldwide alliance of like-minded organizations in more than 20 countries. Since 1988, Safe Kids and its partners have contributed to a more than 60 percent reduction in the rate of fatal childhood unintentional injury in the U.S. There are 3 coalitions in North Dakota and are working on becoming a Safe Kids State office with the NDDHHS as the lead agency.
- Families Flourish empowers families to thrive by providing community-driven resources that foster safe and

nurturing environments for children.

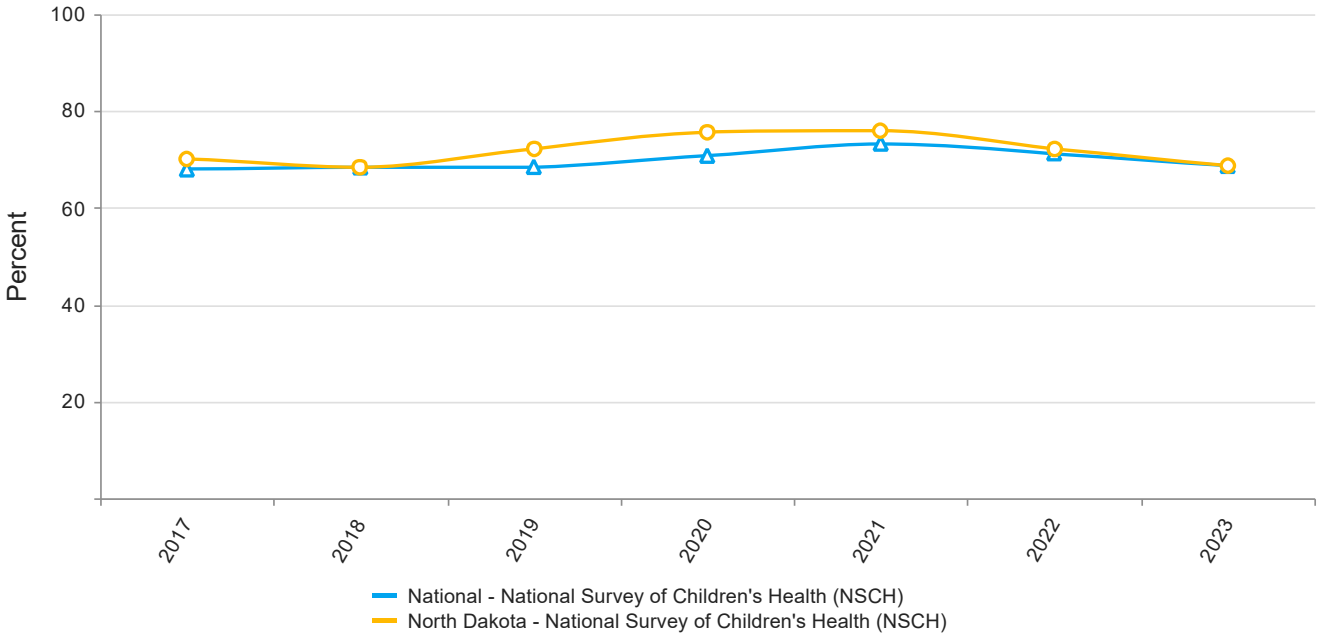
- United Tribes Technical College Wellness Center promotes safe sleep with their students and is a distributor of NDDHHS Cribs for Kids program.
- The Women, Infants, and Children (WIC) program promotes the breastfeeding initiation bag project (implemented in two tribal, local agencies and six rural local agencies), breastfeeding peer counseling (implemented in six agencies), provided training to local agency WIC staff using the new USDA/FNS WIC Breastfeeding Curriculum, supported local agency staff attaining advanced breastfeeding credentials (International Board-Certified Lactation Consultant) and provided local agency staff with resources for breastfeeding promotion and support as identified by the WIC Breastfeeding Committee (local agency IBCLCs). In addition, the WIC program is housed in the same unit as the MCH Nutritionist, and the North Dakota WIC Breastfeeding Coordinator is the immediate supervisor of the MCH Nutritionist. This relationship encourages strong partnership and awareness of activities between state and local WIC agencies and MCH programs and grantees.
- North Dakota Breastfeeding Coalition (NDBC) –Both entities share the vision of increasing breastfeeding initiation and duration across the state. The NDBC disseminates consistent information to professionals across the state via bi-monthly member conference calls.
- Association of State Public Health Nutritionists (ASPHN) – The MCH Nutritionist serves on the Steering Committee for the MCH Nutrition Council with ASPHN. ASPHN has strong connections with the Maternal and Child Health Bureau and works with three states, North Dakota included, to implement the State Capacity Building program. This program aims to build the capacity of participating in states' Title V programs to integrate nutrition by increasing MCH nutrition competency and optimizing nutrition-related data sources for effective program planning.

This Title V action plan establishes a systematic approach to educating caregivers, increasing awareness, expanding data-driven decision-making, strengthening partnerships, and tailoring outreach efforts for high-risk communities. Implementing these strategies and evidence-based measures ensures stronger lactation support, workplace accommodations, and improved tracking of breastfeeding trends, ultimately contributing to safe sleep practices and reducing preventable infant deaths. North Dakota aims to reduce preventable infant deaths and improve MCH outcomes statewide.

## Child Health

### National Performance Measures

**NPM - Percent of children, ages 0 through 11, whose households were food sufficient in the past year - FS**
**Indicators and Annual Objectives**



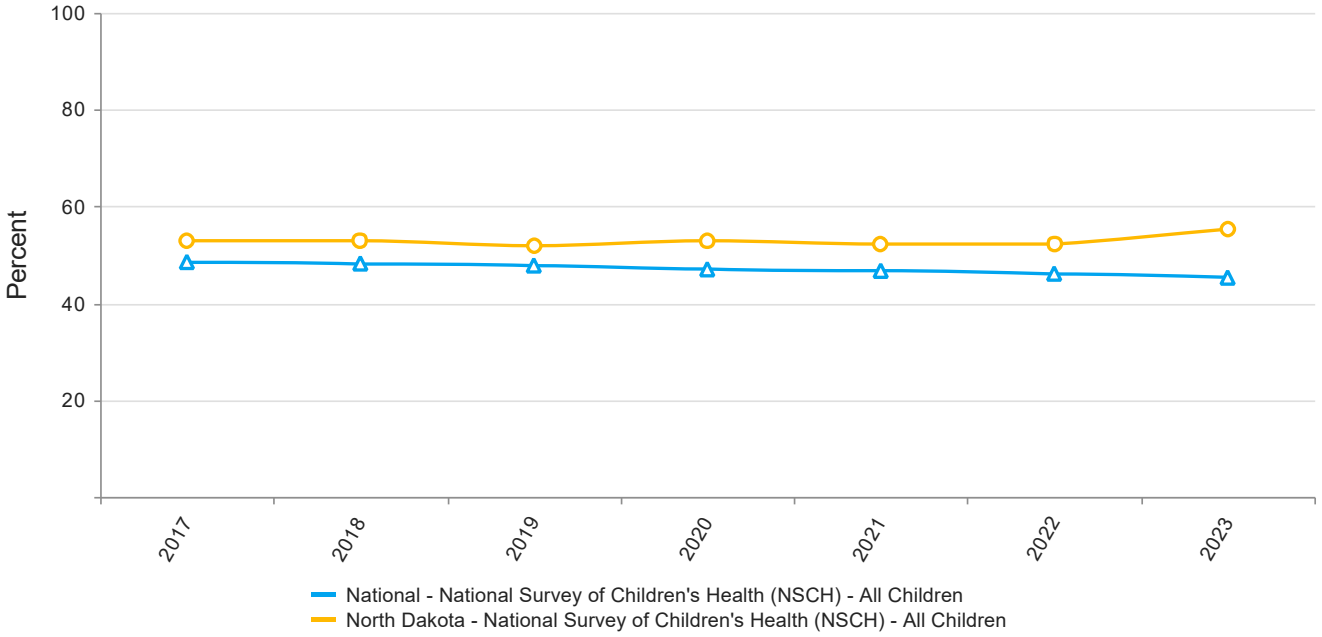

| Federally Available Data | |
|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 68.7 |
| Numerator | 80,878 |
| Denominator | 117,702 |
| Data Source | NSCH |
| Data Source Year | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Evidence-Based or –Informed Strategy Measures**

None

**NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH**
**Indicators and Annual Objectives**




**NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children**

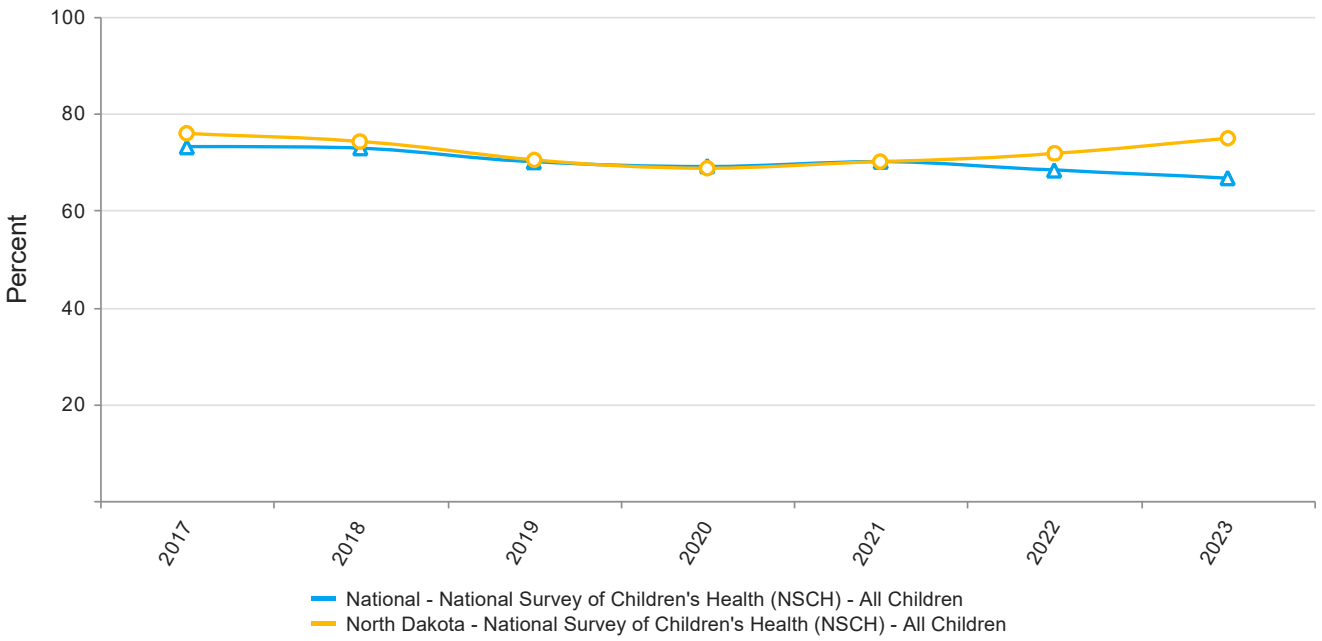
| Federally Available Data | | |
|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - All Children** | | |
| | **2023** | **2024** |
| Annual Objective | | |
| Annual Indicator | 52.3 | 55.2 |
| Numerator | 94,277 | 99,691 |
| Denominator | 180,420 | 180,515 |
| Data Source | NSCH-All Children | NSCH-All Children |
| Data Source Year | 2021_2022 | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Evidence-Based or –Informed Strategy Measures**

None

**NPM - Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination - MH_CC**
**Indicators and Annual Objectives**




**NPM - Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination - MH_CC - Child Health - All Children**

| Federally Available Data | |
|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - All Children** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 74.9 |
| Numerator | 68,642 |
| Denominator | 91,695 |
| Data Source | NSCH-All Children |
| Data Source Year | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Evidence-Based or –Informed Strategy Measures**

None

**State Action Plan Table**

| State Action Plan Table (North Dakota) - Child Health - Entry 1 |
|---|
| Priority Need |
| Food Sufficiency: Percent of children, ages 0 through 11, whose households were food sufficient in the past year |
| NPM |
| NPM - Food Sufficiency |
| Five-Year Objectives |
| By 2030, increase the percentage of children ages 0-11 from 68.7% to 73.5% whose homes were food sufficient, according to the National Survey of Children's Health (NSCH). |
| Strategies |
| By September 30, 2025, increase the number of Local Public Health Units (LPHUs) implementing Farm to School, Farm to Table, and Community Garden initiatives. |
| Participate in the Full-Service Community School (FSCS) advisory committee to identify opportunities to promote food sufficiency in the schools and communities. |

| ESMs | Status |
|---|---|
| No ESMs were created by the State. | |

| NOMs |
|---|
| School Readiness |
| Children's Health Status |
| Behavioral/Conduct Disorders |
| Flourishing - Young Child |
| Flourishing - Child Adolescent - CSHCN |
| Flourishing - Child Adolescent - All |
| Adverse Childhood Experiences |

## State Action Plan Table (North Dakota) - Child Health - Entry 2

### Priority Need

Medical Home-Care Coordination: Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination

### NPM

NPM - Medical Home; Medical Home_Care Coordination

### Five-Year Objectives

By 2030, the percentage of all children, ages 0-17 with medical home care coordination services will increase from 75% to 80% according to the NSCH.

### Strategies

The Title V Child Health Domain will work with the Adolescent and CSHCN Domain to incorporate mental health into medical home/care coordination activities.

Title V staff will work with the NDDHHS Behavioral Health Division and North Dakota Department of Public Instruction (DPI) on various projects and initiatives around care coordination and adolescent mental health.

Title V Staff will work with Full-Service Community Schools to improve access to care coordination.

Title V Child Health Domain will work with the Title V Adolescent Domain to identify where the needs are for Check and Connect programs.

| ESMs | Status |
|---|---|

No ESMs were created by the State.

### NOMs

Children's Health Status

CSHCN Systems of Care

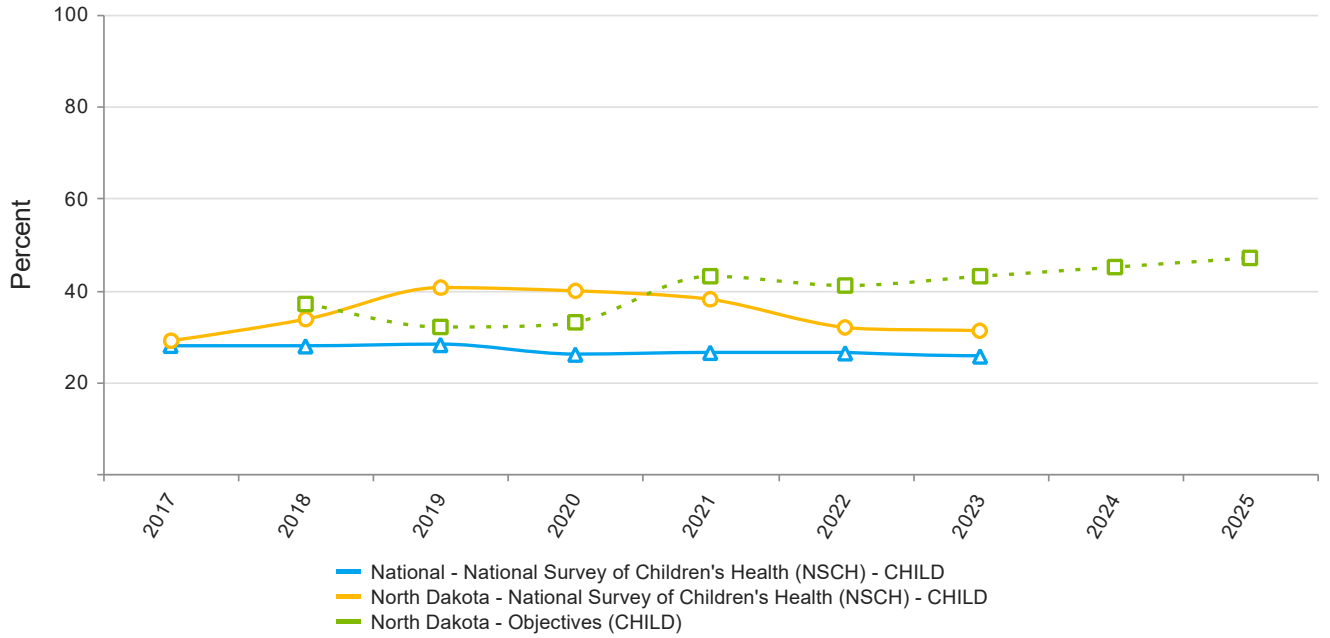
Flourishing - Young Child

Flourishing - Child Adolescent - CSHCN

Flourishing - Child Adolescent - All

**2021-2025: National Performance Measures**

**2021-2025: NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child**
**Indicators**




| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CHILD** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 33 | 43 | 41 | 43 | 45 |
| Annual Indicator | 41.3 | 40.2 | 38.2 | 31.9 | 31.1 |
| Numerator | 25,974 | 24,470 | 22,897 | 19,703 | 19,307 |
| Denominator | 62,891 | 60,820 | 59,972 | 61,720 | 62,113 |
| Data Source | NSCH-CHILD | NSCH-CHILD | NSCH-CHILD | NSCH-CHILD | NSCH-CHILD |
| Data Source Year | 2018_2019 | 2019_2020 | 2020_2021 | 2021_2022 | 2022_2023 |

**2021-2025: Evidence-Based or –Informed Strategy Measures**

**2021-2025: ESM PA-Child.1 - Number of communities actively involved with the physical activity / nutrition strategies.**

| **Measure Status:** | **Active** | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | | 30 | 24 | 28 |
| Annual Indicator | 0 | 0 | 20 | 61 | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | North Dakota Department of Health. Family Health a | North Dakota Department of Health. Family Health a | The North Dakota Department of Health and Human S | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

## MCH Population Domain: Child

### NPM: Physical Activity

### North Dakota Priority Goal: To increase the percentage of children and adolescents who are physically active. (overall obesity prevention, including nutrition)

### FY2024 Annual Report Narrative (October 1, 2023-September 30, 2024)

A balanced diet and regular physical activity benefit all ages' health and quality of life. Obesity in children in the United States is on the rise. North Dakota recognizes that a poor diet and physical inactivity contribute to many serious and costly health conditions at a younger age and increase the risk into adulthood, including overweight and obesity, cardiovascular disease, hypertension, Type II diabetes, some types of cancer, and osteoporosis. The North Dakota Department of Health and Human Services (NDDHHS) maternal and child health (MCH) program recognizes that promoting and increasing the capacity for policy, system, and environmental changes will provide the essential building blocks to fight childhood obesity in North Dakota.

According to the 2023 Youth Risk Behavior Survey (YRBS), the prevalence of obesity among North Dakota students in grades 9 through 12 is 16.3%, defined as a Body Mass Index (BMI) at or above the 95th percentile. This figure reflects a concerning upward trend over the years: 11% in 2009, 11.1% in 2011, 13.5% in 2013, 13.9% in 2015, and 14.9% in 2017. Although there was a slight decrease noted in 2019, with rates at 14%, rates increased in 2021 at 16.3% and remained consistent at 16.3% in 2023.

Additionally, the 2022 National Survey of Children’s Health (NSCH) indicates that 15.2% of North Dakota children aged 10 to 17 are classified as obese, marking a 2.6% increase from 2020 to 2021. This rate is slightly below the national average of 16.6%.

The amount of time a student must spend in physical education (PE) courses varies across grade levels. In North Dakota, elementary students in grades 1 through 5 must receive a minimum of 90 minutes of PE each week. Students in grades 9 through 12 must have at least one credit of PE, of which half can be health education. According to the 2023 YRBS, 29.2% of North Dakota students in grades 9 through 12 reported being physically active for at least 60 minutes a day on all seven days of the week, representing a slight decrease of 1.1% from 2021. In contrast, 32.6% of students in grades 6 through 8 met this standard, which reflects a decrease of 41.9% from the previous year

Furthermore, the 2022 NSCH, indicates that 27.9% of North Dakota children ages 6-11 are physically active for at least 60 minutes a day, seven days a week, surpassing the national average of 25.2%. Additionally, 19.3% of North Dakota children ages 12 through17 are physically active for 60 minutes a day, seven days a week, which is higher than the national average of 12.9%. Therefore, the YRBS and NSCH indicate that as North Dakota children get older and standards for PE requirements decrease, the percentage of inactivity in grades 9 through12 significantly increases, and the prevalence of obesity rises.

The overarching goal established for the Child Health domain is by 2025, the percentage of North Dakota children, ages 6 through 11, who are physically active at least 60 minutes per day will increase from 34% to 49%. In addition, the percentage of North Dakota adolescents, ages 12 through 17, who are physically active at least 60 minutes per day will increase from 18% to 28%, according to the NSCH.

To assist in achieving this goal, an Evidence-Based or Informed Strategy Measures (ESM 8.1.1) was established, which focused on the number of communities actively involved with the physical activity/nutrition strategies. The Child Health domain convened a stakeholder group from multi-sector agencies (state and local partners) that shared the same objective of increasing physical activity and improving nutrition in North Dakota children. In North Dakota, there are four Regional Public Health Networks (RPHN). Each RPHN was required to submit an annual plan by October 1st for approval regarding how they will be sharing services with the North Dakota Department of Health and Human Services (NDDHHS). The plan also included their set outcomes and measures. Their plans aimed to address a community health priority more efficiently and effectively through a network of shared services, expertise, and opportunities to build capacity. However, after meeting with the four RPHNs, the MCH Child Health staff concluded that NDDHHS would need to move in a different direction. The MCH Child Health staff convened all 28 North Dakota Local Public Health Units (LPHUs) for feedback on how to gain more traction on state-wide childhood obesity prevention. Feedback regarding barriers being faced by those LPHUs that do not accept MCH funding was also sought after. The two major challenges identified from the meeting were the capacity to do the work, and a lack of funding to match.

The NDDHHS MCH School Health Specialist (MSHS) continued to serve on the Full-Service Community Schools

(FSCS) Advisory team. A FSCS coordinates comprehensive support for students and families through partnerships in the following pipeline service areas: Early Childhood Development, Family Engagement, Remedial & Academic Enrichment Activities, Wellness, Juvenile Justice & Delinquency Prevention, and Workforce Readiness. To further enhance the FSCS initiatives, MCH allocated $90,000 in funding to support the North Dakota FSCS program through September 30, 2024.

MCH staff prepared a request for proposal (RFP) and distributed it to all 28 LPHUs on May 31, 2024, for the 2024-2025 grant year. The applications included a work plan and budget templates, as well as summary and narrative proposals. Applications were due August 4, 2024, with contracts starting October 1, 2024. Currently funded LPHUs were encouraged to continue their work, and assistance was provided to additional LPHUs interested in applying. MCH staff reviewed and awarded communities' funding to work on the Centers for Disease Control and Prevention (CDC) Comprehensive School Activity programs (CSCP) or other evidence-based strategies developed by North Dakota entities to prevent overweight and obesity.

In addition, over the past three years NDDHHS supported and will continue to support North Dakota schools to attend the North Dakota Roughrider Health Promotion Conference. This conference has been held for 38 years, and its mission is: To promote healthy lifestyle concepts to North Dakota students, school personnel, and community members to share, learn, and develop plans of action for healthy schools and communities. The objectives are: (1) Develop a realistic and attainable Healthy School and Community Action Plan. (2) Expand knowledge of research-based prevention curriculum, enhancement through after-school programming, and classroom behavior management strategies. (3) Expand prevention efforts specific to environmental strategies, and evidence-based programs. (4) Share successful teaching techniques, prevention strategies, and programs. (5) Expand knowledge of North Dakota health initiatives, resources, and community programs for healthy students, schools, and communities. The outcomes are: (1) Provide data-driven decision-making choices. (2) Understand Coordinated School Health approaches. (3) Realize healthy students make better learners. (4) Facilitate a sustained collaboration between schools and community. (5) Prevent substance abuse in all communities of North Dakota. (6) Understand how your Regional Education Association (REA) can help your school.

The second overarching goal for the Child Health domain is that by September 30, 2025, there will be an increased number of opportunities to access fresh fruits, vegetables, and healthy environments by implementing Farm to School, Farm to Table, and/or Healthy Concessions initiatives in communities.

In addition to physical activity strategies for children, NDDHHS was selected for an opportunity to develop a state model in MCH for nutrition integration, the Children's Healthy Weight State Capacity Building program (SCBP). This opportunity began on September 1, 2020, and continues through September 1, 2025. The Association of State Public Health Nutritionists (ASPHN), a nonprofit that provides state and national leadership on food and nutrition policy, programs, and services, is leading the efforts. Further information can be found on their website: https://asphn.org/chw-state-capacity-building-program/

North Dakota's program has three focuses: (1) Strengthen the workforce (2) Integrate nutrition strategies into Title V programs, and (3) Optimize MCH nutrition data sources. To strengthen the workforce, a workforce development plan was developed based on results from a survey sent to all 28 LPHUs in North Dakota. The MSHS partnered internally with the Public Health Training Plan by sitting on their committee to provide feedback on trainings and promote trainings to partners, as many of the training goals intersect with the workforce development plan developed. The NDDHHS MCH Nutritionist and MSHS are also partnered with the University of Minnesota to provide the *Systems Approaches to Healthy Communities Course* (https://extension.umn.edu/nutrition-education/systems-approaches-healthy-communities) to four LPHUs and six FSCS from the end of January to mid-March 2024. The course provides an opportunity to increase the integration of Policy, Systems, and Environmental (PSE) approaches into their MCH grant work. The course lasts three months, including five online modules and three coaching calls.

Integration of nutrition strategies into the Title V program occurs in partnership with MCH funding offered to all 28 LPHUs for the child health priority. In addition to CDC CSCP strategies, evidence-based strategies for nutrition are provided to LPHUs, including NDSU Extensions *On the Move to Better Health* program and Fargo Cass Public Health's Fast Fuel Toolkit (https://fargond.gov/city-government/departments/fargo-cass-public-health/health-promotion/fast-fuel), Cavalier County Health District Farm to Table toolkit: Maternal and Child Health | Cavalier County Health District, Langdon, ND, and Bismarck Burleigh Public Health's videos highlighting Farm to School: https://vimeo.com/dncinematics/review/867342358/4d59895b9d. To support the adoption of nutrition strategies, SCBP funds, up to $3,250, were made available to LPHUs to either start or expand Farm to School, Farm to Table work in their community. Seven LPHUs submitted applications and completed projects from February 1, 2024, to August 31, 2024. Successes from those projects include: one community garden box created, nine schools implemented tower gardens impacting 249 students and nine teachers, nine childcare centers were provided with tower gardens impacting 46 providers and 132 children, six Head Start classrooms were provided with gardening education and garden boxes impacting 84 students and 13 teachers.

To optimize MCH nutrition data sources, beginning June 1, 2023, three questions related to maternal nutrition were added to the Pregnancy Risk Assessment Monitoring Survey (PRAMS). In addition, the NSCH data is reviewed annually for the Weight Status of children based on BMI for ages 10 through 17, and new data is released to describe how frequently, according to parent report, children aged 1 through5 years consumed fruits, vegetables, and sugar-sweetened beverages.

In addition to the strategies above, 13 LPHUs, Bismarck Burleigh County Public Health (BBPH), Cavalier County Health District (CCHD), City County Health District (CCHD), Dickey County Health District (DCHD), Fargo Cass Public Health (FCPH), First District Health Unit (FDHU), LaMoure County Public Health Department (LCPHD), McIntosh District Health Unit, (MDHU), Nelson-Griggs District Health Unit (NGDHU), Richland County Health Department (RCHD), Rolette County Public Health District (RCPHD), Walsh County Public Health (WCPH), and Western Plains Public Health (WPPH), one Regional Education Association ((REA) Central Regional Education Association), and one University (North Dakota State University (NDSU)) Each grantee determined their community needs and completed an action plan with objectives, strategies, and activities linked to evidence-based, evidence-informed, and/or promising practices. During the 2023-2024 program year, each grantee had the following successes:

- BBPH- Pickleball checkout at a local library, Family Day River Walk, Bike/Walk to school events, Farm to School field trips, multiple PA/Nutrition resources distributed to rural communities.
- CCHD- Garden bed project continued in 2023-2024. In 2022-2023, 22 garden beds were constructed in collaboration with local high school. In 2023-2024, 16 additional beds were constructed. Local radio ads, newspaper advertisements, and social media.
- CCHD- Provided the "*On the Move*" curriculum in schools. Conducted a 30-day PA challenge in six schools.
- DCHD- PA/Nutrition resources were provided to 10 childcare centers. Ten garden boxes, with supplies distributed to nine centers, and education was provided on gardening.
- FCPH- 68 PA evaluations were done at all licensed centers. Online and face-to-face trainings were provided for all licensed childcare staff, 2,143.
- FDHU- The "*On the Move*" curriculum implemented in two schools. Four garden beds were distributed to four childcare centers, along with education. Placemaking in one community park was evaluated and continued.
- LCPHD- Provided the "*On the Move*" curriculum in three schools. Raised garden beds were distributed to seven childcare centers and education was implemented by County Extension Agent.
- MDHU- PA policy/recommendations in place at 6 childcare centers in the county. Produce for community garden beds were utilized at the centers.
- NGDHU- After-school wellness classes provided monthly, with multiple PA and nutrition lessons. Wellness newsletters are sent home monthly with resources for families to be PA and improve nutrition at home. Eighteen garden beds and supplies were distributed to childcare centers, Extension provided education.
- RCHD- Healthy concessions implemented at a community pool and continued at a community hockey arena.
- RCPHD- SPARKS curriculum was provided to three elementary schools. Held a Bike Rodeo event for 25 children and family members. The "*On the Move*" curriculum was provided to one school.
- WCPH- Held a "Fitness Frenzy" for youth of all ages. Provided three rural city parks with PA supplies.
- WPPH- Provided PA/Nutrition education to Head Start programs in six locations. Farm to Table project was implemented in the summer to a summer activity center. Walk for Wellness events.
- CREA- Funding was provided to help support the school site coordinators and provide professional development opportunities to enhance the "Wellness" pipeline.
- NDSU- Funding was provided to support Extension agents across the state to support and implement the "*On the Move*" curricula. Facebook pages, newsletters, and multiple materials and resources provided to the state at large.

Furthermore, the NDDHHS MSHS served on the Community Engagement Committee. The North Dakota Community Engagement Committee is a statewide leadership committee to address health barriers that include social, economic, and environmental challenges. Members are dedicated to increasing access to quality health care concerning affordability, availability, accessibility, accommodation, and acceptability. The committee will promote cultural strengthening and safety while implementing strategies founded on collaboration, data, advocacy, policy, and resource alignment for all North Dakotans. Members will serve to educate, inform, and advise the NDDHHS agency, ensuring that factors that influence health outcomes are adequately addressed.

When it comes to obesity prevention, breastfeeding has been proven to help reduce obesity. Breastfeeding promotion and support are also an integral component of the state MCH Nutritionist's work. MCH staff partner with the Women, Infants, and Children (WIC) program and their work to reduce obesity and increase physical activity. Over the past 40 years, WIC has improved at-risk children's health, growth, and development and prevented health problems. Since WIC reaches so many infants and children, it has a vital role in helping children maintain a healthy weight. North Dakota WIC promotes breastfeeding as the standard way to feed infants and young children because

it reduces the likelihood of childhood obesity; offers breastfeeding classes, support groups, peer counselors, and breast pump supplies to WIC moms to support them in their decision to breastfeed; and provides nutritious foods to participants such as fresh fruits and vegetables and whole grains. To reduce the amount of fat in the WIC food package, only fat-free or 1% milk is allowed, along with less cheese. All WIC juices are 100% juice and provide the appropriate amount of juice to be consumed each day. WIC cereals are low in sugar and provide a good source of iron, and many are high in whole grains. WIC also offers participant-centered nutrition education on proper nutrition across the life cycle, healthy meal planning and family meals, and ways to be physically active as a family. Healthy eating habits are essential for even our youngest participants. Parents are taught how to understand their baby's behavior and feeding cues and the proper guidelines for feeding infants (how often to feed, when to introduce complementary foods, etc.). WIC frequently collects height and weight measurements, including BMI, on participating children and provides counseling and referrals to their healthcare providers as appropriate.

MCH staff will continue to work with new and existing critical partners, including but not limited to:

- North Dakota Department of Public Instruction (NDDPI)--NDDHHS and the NDDPI collaborate in sharing resources on physical activity (PA) and nutrition. The NDDPI sends out quarterly newsletters to schools on safe and healthy-related topics and wellness professional development opportunities happening in the state. NDDHHS supports this newsletter by providing any resources that are made available to the department. Partnership is being strengthened through the development of a state-level workgroup to create consistent wellness messaging.
- Regional Education Associations (REA)-NDDHHS will continue to partner and collaborate on health-related activities that are happening in each of the seven REA's.
- Full-Service Community Schools (FSCS)--NDDHHS will collaborate with FSCS to expand their current physical activity and nutrition program.
- NDSU, Extension program--to increase the number of schools that can implement the “On the Move” curriculum. The curriculum encompasses lessons on healthy lifestyles, such as increasing physical activity and making healthy food choices.
- North Dakota Department of Transportation--to promote Safe Routes to School funding to new and existing partners.
- NDDHHS, Community Engagement Unit--serve on various committees to address state-wide health barriers that include social, economic, and environmental challenges.
- NDDHHS, Early Education Unit--to collaborate with the childcare educational modules for licensed childcare providers.
- Association of State Public Health Nutritionists (ASPHN)--collaboration to support state and national leadership on food and nutrition policy, programs, and services, is leading the efforts.
- University of Minnesota Extension program--collaborate to offer the *Systems for Healthy Communities* course.

**MCH Population Domain: Child**

**NPM: Food Sufficiency: Percent of children, ages 0 through 11, whose households were food sufficient in the past year**

**North Dakota Priority Goal: Improve accessibility to healthy food options through community resources (schools, food banks, health units, etc.).**

**FY2026 Annual Plan Narrative (October 1, 2025-September 30, 2026)**

As part of North Dakota's Maternal and Child Health (MCH) priorities, addressing household food sufficiency and improving access to nutritious foods remains a critical focus. The 2025 Needs Assessment identified food sufficiency as a top child health performance measure, with widespread concern among stakeholders regarding limited access to healthy, affordable foods, especially in low-income and rural communities. These barriers contribute to poor nutrition, lack of dietary variety, and higher rates of chronic conditions such as obesity, diabetes, and hypertension. Beyond physical health, food insecurity is linked to mental health challenges, including chronic stress, anxiety, and depression, particularly among families with children. Individuals facing food insecurity often rely on inexpensive, highly processed foods, which further exacerbate long-term health outcomes and reduce overall quality of life. These effects can span generations, underscoring the need for sustainable, systemic solutions.

In response, the North Dakota Department of Health and Human Services (NDDHHS) MCH program prioritizes policy, systems, and environmental (PSE) change strategies to build capacity at the community level and improve access to healthy, whole foods. These upstream efforts are central to the MCH mission of creating a more universal system of care that supports the health and well-being of all children and families, particularly those at highest risk.

By 2030, the North Dakota MCH program will collaborate with Local Public Health Units (LPHUs) and other community partners to increase the percentage of children ages 0–11 living in food-sufficient households from the current baseline of 68.7% to 73.5%, as measured by the National Survey of Children's Health (NSCH). This targeted improvement reflects the state's commitment to addressing factors that influence health outcomes and promoting impartial access to nutritious food for all children.

According to the 2022-2023 NSCH (two-years combined), 68.7% of North Dakota children ages 0-11, can always afford to eat good, nutritious meals, while nationally the rate is 68.6%. In 2021-2022, 72.1% of North Dakota children ages 0-11 could always afford to eat good, nutritious meals, while nationally the rate was 71.2%. Although North Dakota has not had a significant change, the decrease in food sufficiency is still an ongoing issue that needs to be addressed.

According to Feeding America's "Map the Meal Gap," the food insecurity rates in North Dakota were 4.8% in 2020, 5.5% in 2021, and 8.5% in 2022. As indicated, the percentage of food insecurity in North Dakota households is increasing.
The National Outcome Measure (NOM) for the Child Health domain is: Percent of children, ages 0 through 17, who have experienced 2 or more adverse childhood experiences (ACES), according to the NSCH survey.

According to the 2022-2023 NSCH (two-years combined), 19.6% of North Dakota children ages 0-17 experienced 2 or more ACES, while 17.2% nationally. In 2021-2022 (two-combined years), 17.8% of North Dakota children ages 0-17 experienced 2 or more ACES, while 17.2% nationally. Based on the identified data and stakeholder input, one Evidence-Based or Informed Strategy Measure (ESM) will be implemented to address food insufficiency and improve health outcomes for children and families in North Dakota. This ESM will track the number of schools, Early Childhood Education Centers (ECEs), and community events that implement Farm to School, Farm to ECE, Farm to Table, or community garden initiatives.

These strategies are grounded in evidence supporting the effectiveness of local food systems in increasing access to nutritious foods, promoting healthy eating habits, and enhancing community engagement. By embedding these initiatives in educational and community settings, the North Dakota MCH program aims to improve food sufficiency

and support lifelong healthy behaviors among children and their families.

The NDDHHS will provide funding of up to $14,500 to each of the 28 LPHUs to support the implementation of strategies aimed at increasing access to fresh fruits and vegetables and creating healthier environments for children and families. This funding will be used to implement evidence-based strategies and utilize tools that promote nutrition and healthy eating behaviors.

LPHUs will be encouraged to select from a set of evidence-informed resources, including but not limited to:

- Farm to School, guided by the *Bismarck Burleigh Public Health Farm to School Toolkit* (farmtoschool.org),
- Farm to Table, supported by the *Cavalier County Health District Farm to Table Toolkit*,
- Strategies from The Community Guide (focusing on gardening interventions to increase fruit and vegetable intake among children), and
- Guidance from the Centers for Disease Control and Prevention's (CDC's) Healthy Kids/Nutrition findings.

These resources were intentionally selected to help LPHUs expand the reach of Farm to School, Farm to ECE, Farm to Table, and community garden initiatives statewide. The goal is to not only increase access to fresh, nutritious foods but, also to foster sustainable, community-based environments that support healthier outcomes for North Dakota's children.

To support the expansion of food sufficiency initiatives, the School Health Specialist (SHS) and MCH Nutritionist will develop a Request for Proposal (RFP) to be released to LPHUs. The RFP will require applicants to submit an action plan, budget template, and both summary and narrative proposals outlining their strategies to enhance access to healthy food through evidence-based approaches. Contracts are scheduled to begin on October 1, 2025.

As the North Dakota Child Health domain transitions its focus from physical activity to food sufficiency, it is important to note that 95% of current grantees already included a nutrition component in their physical activity programming. This existing foundation positions grantees well to pivot and expand their efforts to directly address food insecurity through sustainable, community-based interventions.

In addition to LPHU funding, MCH will extend support to the Central Regional Education Association (CREA), one of the seven Regional Education Associations (REAs) in North Dakota. CREA is home to the North Dakota Full-Service Community Schools Consortium (NDFSCS), which currently includes nine schools across the state. The SHS will continue to serve on the NDFSCS advisory team, contributing to the strategic vision and implementation of school-based initiatives.

The NDFSCS provides comprehensive support services for students and families through a series of coordinated pipeline service areas, including:

- Early Childhood Development
- Family Engagement
- Remedial & Academic Enrichment Activities
- Wellness
- Juvenile Justice & Delinquency Prevention
- Workforce Readiness
- Community-Based Support
- Mentoring & Other Youth Development Programs

MCH funding will specifically target the Wellness pipeline, with a focus on nutrition, physical activity, and behavioral health. Many participating schools have already implemented innovative food access and health promotion strategies such as school food pantries, Meal Repack programs, hydroponics, and school gardens.
To sustain and scale these efforts, NDFSCS will be encouraged to continue its structured support system, including:

- Monthly site coordinator network meetings
- Regular one-on-one check-in meetings with each school
- Ongoing school site action planning to enhance wellness strategies and outcomes

This partnership reflects MCH's commitment to supporting school-based, community-driven models that promote

holistic student well-being and advance food sufficiency and positive developmental outcomes. Furthermore, as funding allows, MCH will allocate and promote financial resources to support tribal partners in implementing nutrition-focused strategies within their communities. Recognizing the importance of cultural relevance and trust in public health efforts, MCH will collaborate closely with the NDDHHS Community Engagement Unit (CEU), Tribal Liaisons, and MCH staff to initiate and strengthen relationship-building efforts. These partnerships will be essential for identifying tailored approaches that honor tribal sovereignty and community priorities, while promoting sustainable, evidence-informed nutrition strategies to improve food access and health outcomes in tribal communities across North Dakota.

If additional funding is available, North Dakota State University (NDSU) Extension will be encouraged to continue developing and disseminating resources that support nutrition strategies aligned with the efforts of LPHUs and schools. These resources will enhance the capacity of implementing partners to deliver effective, evidence-based interventions. In addition, NDSU Extension will be encouraged to maintain and expand its social media outreach and electronic newsletters aimed at educating families on the benefits of healthy eating, mindfulness, and positive lifestyle behaviors. These communication strategies play a critical role in reinforcing community-level work and fostering long-term behavior change among children and families across North Dakota.
To strengthen and expand Farm to School, Farm to ECE, Farm to Table, and community garden efforts across North Dakota, the SHS and MCH Nutritionist will collaborate with the North Dakota Department of Public Instruction (NDDPI), Farm to School Specialist and the North Dakota Department of Agriculture (NDDA), Local Food Marketing Specialist, to pursue grant opportunities aimed at funding garden initiatives in ECE settings.

Although North Dakota was not selected for funding through the FARMWISE initiative supported by the Association of State and Public Health Nutritionists (ASPHN), the state was invited to participate in ongoing technical assistance (TA) opportunities offered through the grant. As a result of this opportunity, North Dakota established the North Dakota Farm to Early Care and Education Coalition—a collaborative body that includes representatives from:

- North Dakota Department of Health and Human Services (NDDHHS), including the SHS, MCH Nutritionist, and Community Health Specialist
- North Dakota Department of Public Instruction (NDDPI)
- North Dakota Department of Agriculture (NDDA)
- North Dakota State University (NDSU) Extension
- A representative from a Local Public Health Unit (LPHU)

The coalition meets monthly to share resources, align strategies, and advance efforts to improve nutrition education, local food sourcing, and gardening initiatives for young children. This cross-sector partnership reflects a shared commitment to building sustainable, locally driven solutions to improve child health and food access across the state.

In 2020, the NDDHHS MCH program was selected to participate in the Children's Healthy Weight State Capacity Building Program (SCBP) to develop a state-level model for integrating nutrition into MCH initiatives. This five-year initiative began on September 1, 2020, and will conclude on September 1, 2025. In 2023, the North Dakota SCBP team partnered with Dr. Mary Larson with the NDSU to conduct a Public Health Nutrition Workforce Assessment targeting staff at LPHUs. The assessment identified key challenges that limit the ability of LPHUs to implement PSE strategies in nutrition. Notably, most respondents reported limited experience or training in nutrition-related intervention planning and often worked across multiple program areas rather than specializing in one. Only 10% (3 of 29) of respondents were Registered Dietitians, and the majority (19 of 29) had fewer than five years of experience in their current roles.

These findings informed the development of the state's Workforce Development Plan, which is being implemented during Year 5 of the SCBP. A central strategy includes facilitating the Systems Approaches for Healthy Communities (SAHC) course, designed to build LPHU capacity for PSE nutrition interventions. The SAHC course consists of five online modules (completed independently) and three facilitated coaching calls, where participants reflect on and apply the course content. Two course sessions will be offered—Fall 2025 and Spring 2026. Additional workforce development strategies will be aligned with the NDDHHS Public Health Training Series, coordinated by the NDDHHS CEU, to ensure integration and sustainability of training efforts across public health domains.

To optimize and enhance nutrition surveillance within the MCH program, the NDDHHS began expanding its data

collection tools in 2023. Starting June 1, 2023, three maternal nutrition-related questions were added to the Pregnancy Risk Assessment Monitoring System (PRAMS) to better capture dietary behaviors during pregnancy. Additionally, the NSCH continues to serve as a key data source, offering insights into dietary patterns of young children in the state. The NSCH data, based on parent-reported information, tracks the frequency with which children ages 1–5 years consume fruits, vegetables, and sugar-sweetened beverages. These enhanced data sources will support strategic planning, program development, and evaluation of nutrition-related interventions within the MCH population.

Community collaboration and partnerships remain essential pillars of MCH work and are critical in ensuring MCH populations achieve their full health potential. The NDDHHS MCH program continues to foster strong partnerships, including with the Women, Infants, and Children (WIC) program, to improve nutrition access and outcomes for at-risk families. WIC plays a significant role in supporting optimal health and nutrition for pregnant women, infants, and young children. Over the past 40 years, WIC has contributed to improved health, growth, and developmental outcomes, while preventing nutrition-related health issues. Given WIC's extensive reach, the program is uniquely positioned to help children maintain a healthy weight and foster lifelong healthy habits.

North Dakota WIC actively promotes breastfeeding as the standard for infant feeding, offering breastfeeding classes, support groups, peer counselors, and breast pump supplies to help participants succeed. WIC provides nutritious food packages that include fresh fruits, vegetables, whole grains, and low-fat dairy, and limits foods high in fat and sugar to promote healthier diets. All WIC juices are 100% juice and provided in age-appropriate amounts; cereals are low in sugar, high in iron, and often high in whole grains. WIC also delivers participant-centered nutrition education, focusing on age-appropriate feeding, healthy meal planning, physical activity, and responsive parenting. Parents are educated on understanding infant feeding cues, appropriate timing for introducing complementary foods, and general nutrition practices across the lifespan. Additionally, WIC collects anthropometric data, including height, weight, and BMI, and provides counseling and referrals to healthcare providers when needed.

This collaboration strengthens the overall system of care and ensures families are connected to resources that support their nutritional well-being. It aligns with the broader goals of the MCH program to promote accessibility and improve outcomes across the life course.

MCH staff will continue to work with new and existing critical partners, including but not limited to:

- North Dakota Department of Public Instruction--The NDDHHS and the NDDPI Farm to School/ECE collaboration.
- Regional Education Associations (REA)--the NDDHHS will continue to partner and collaborate on health-related activities that are happening in each of the seven REA's.
- North Dakota Full-Service Community Schools (NDFSCS)--the NDDHHS will collaborate with FSCS to expand their current wellness pipeline.
- North Dakota Department of Agriculture (NDDA)-- the NDDHHS will continue to partner with the NDDA to seek out grant opportunities.

**MCH Population Domain: Child**

**NPM: Medical Home-Care Coordination: Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination**

**North Dakota Priority Goal: Improve care coordination to link the MCH population to essential services and resources.**

**FY2026 Annual Plan Narrative (October 1, 2025-September 30, 2026)**

The establishment of a medical home is critical to ensuring all children receive the care and support they need to thrive. Medical home care coordination is a proven model for delivering comprehensive, high-quality primary care that emphasizes collaborative partnerships among patients, families, clinicians, and care teams. This approach moves beyond traditional clinical practice to address the whole child, delivering care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.

By integrating these core principles, the medical home model supports not only physical health but also the broader developmental, emotional, and social needs of children and families. As North Dakota works to strengthen its system of care, embedding medical home strategies across the child health domain will ensure a more well-rounded and responsive healthcare infrastructure that meets the various needs of all children, including those who are underserved or at higher risk.

By 2030, North Dakota Maternal and Child (MCH) staff will work with the North Dakota Full-Service Community Schools Consortium (NDFSCS) to improve access to care coordination to increase the percentage of all children, ages 0-17 from 75% to 80% with medical care coordination services, according to the National Survey for Children's Health (NSCH). According to the 2022-2023 NSCH (two-years combined), 74.9% of North Dakota children 0-17, have received needed care coordination, while nationally 66.6%. In 2021-2022 (two years combined), 71.6% of North Dakota children 0-17, have received needed care coordination, while nationally 68.2%. While the state is performing above the national average, there remains an opportunity for improvement in this area.

The National Outcome Measure is the percentage of children ages 0 through 17 who are in excellent or very good health, as reported in the NSCH. In 2022-2023, 92.6% of North Dakota children ages 0-17 were in excellent or very good health, while nationally, 90%. In 2021-2022 (two years combined), 92.1% of North Dakota children ages 0-17 were in excellent or very good health, while nationally, 89.9% (according to NSCH).

The 2025 North Dakota MCH Needs Assessment identified key service gaps and priorities for enhancing child health through the medical home model. Stakeholders across the state ranked mental health and substance abuse support, family support and childcare, and nutrition and exercise support as the top three unmet needs for children. Notably, food sufficiency emerged as the leading child health performance priority, selected by 23% of respondents. Additionally, 52% of stakeholders identified care coordination as the most important component of an effective medical home. These findings highlight a clear opportunity to strengthen and integrate support systems within the medical home framework. In response, North Dakota MCH staff will integrate food sufficiency into broader medical home care coordination efforts, ensuring that access to nutritious food is recognized as a core element of child health. By aligning stakeholder-identified priorities with MCH strategies, the state will advance to a more comprehensive and coordinated system of care for children and families.

To address identified gaps and improve health outcomes, North Dakota will implement an Evidence-Based or Informed Strategy Measure (ESM): increasing the number of services offered through the NDFSCS eight pipelines. Site coordinators will track progress by recording the number of new services provided to students and families. The School Health Specialist (SHS) and MCH Nutritionist will develop a Request for Proposal (RFP) to be released to the Central Regional Education Association (CREA). The RFP will include an action plan, budget template, and both a summary and narrative proposal outlining strategies to support medical home care coordination. This contract will tentatively begin on October 1, 2025. This process will enable targeted investment in community school sites, advancing the integration of public health priorities within educational settings and expanding access to comprehensive support services for children and families across North Dakota.

The North Dakota Department of Health and Human Services (NDDHHS) seeks to strengthen student and family support systems by funding the Central Regional Education Association (CREA), one of the seven Regional Education Associations (REAs) in North Dakota. CREA serves as the fiscal and administrative home for the NDFSCS initiative, which currently comprises nine schools across the state. This initiative addresses the diverse needs of students and families through a coordinated, school-based service delivery model.

The School Health Specialist (SHS) will continue to provide leadership and support by serving on the NDFSCS Advisory Team. This team plays a critical role in guiding implementation, ensuring alignment with public health goals, and supporting cross-sector collaboration.

NDFSCS is designed to provide integrated services across eight key pipeline areas:

- Early Childhood Development
- Family Engagement
- Remedial and Academic Enrichment Activities
- Wellness

- Juvenile Justice and Delinquency Prevention
- Workforce Readiness
- Community-Based Support
- Mentoring & Other Youth Development Programs

The MCH program will provide targeted funding to support all pipeline areas, with a focus on implementing a medical home care coordination approach. This model seeks to improve health outcomes by surrounding students and families with comprehensive, accessible, and community-based services.

To sustain and grow this work, NDFSCS will continue to:

- Facilitate monthly Site Coordinator Network meetings to share best practices and ensure consistent implementation
- Conduct one-on-one check-ins between program leadership and individual schools to assess progress and address challenges
- Support ongoing school site action planning, enabling schools to tailor services to local needs and continuously refine strategies

Each participating school has a dedicated Site Coordinator who works closely with students and families to identify needs and connect them with appropriate internal and external services. This proactive coordination ensures that families are linked to a comprehensive support network and that services are responsive to evolving needs. Site Coordinators will also collect data on newly identified services throughout the year to contribute to the state's ESM framework. In addition to supporting the care coordination model, MCH funding will also reinforce the integration of food sufficiency, a priority child health area, into the NDFSCS framework. By braiding and layering the priorities of care coordination and food access, the partnership with CREA is expected to deepen service delivery and improve outcomes in participating schools and communities statewide. This funding opportunity represents a strategic investment in scalable, community-centered models that promote whole-child, whole-family support across North Dakota.

Incorporating elements of the medical home model is essential to improving the quality, effectiveness, and efficiency of care provided to children. A medical home ensures care is comprehensive, coordinated, family-centered, and responsive to the unique needs of each child. While the universal medical home performance measure is housed within the Children with Special Health Care Needs (CSHCN) domain, North Dakota recognizes that every child should have access to a medical home, not only those with special health needs. To that end, the collaborative leadership of the MCH program, including domain leads for CSHCN, Adolescent Health, and Child Health, will be central to aligning strategies and ensuring medical home initiatives are accessible for all children across the lifespan. These efforts will involve braiding and layering resources, sharing data, and coordinating program implementation to create a stronger, more integrated system of care. Through this collaboration, North Dakota aims to advance medical home practices that are sustainable, scalable, and impartial for children and families across the state.

As part of its ongoing commitment to strengthening systems of care for school-aged children and adolescents, the MCH program in North Dakota is expanding collaboration efforts within the Child Health domain. These efforts are grounded in a braided and layered service approach that aligns multiple programs and funding streams to improve population health outcomes.

The Child Health domain will work in close partnership with the CSHCN and Adolescent Health domains to create a unified approach to child well-being. In addition, the program will strategically collaborate with key external partners:

- NDDHHS Behavioral Health Division (BHD)
- North Dakota Department of Public Instruction (NDDPI)

These partnerships leverage existing structures, including established monthly interagency meetings, which now include participation from MCH domain staff. The primary goal of this collaboration is to coordinate and align efforts across public health and education sectors, with a specific focus on identifying and supporting school-based initiatives already active in North Dakota communities.

One such initiative is the Check & Connect (C&C) program—an evidence-based intervention for at-risk students in grades 5–10, implemented by the CREA with funding from NDDHHS BHD. The program is designed to improve student attendance, academic performance, and behavior through structured mentorship and consistent monitoring.

Under the MCH framework, the MCH Child Health domain will support the integration of the C&C program within one of the NDFSCS, which are also housed under CREA and currently serve nine schools. This integration directly supports the MCH goal of creating a medical home care coordination model that extends into educational environments.
C&C Key Components:

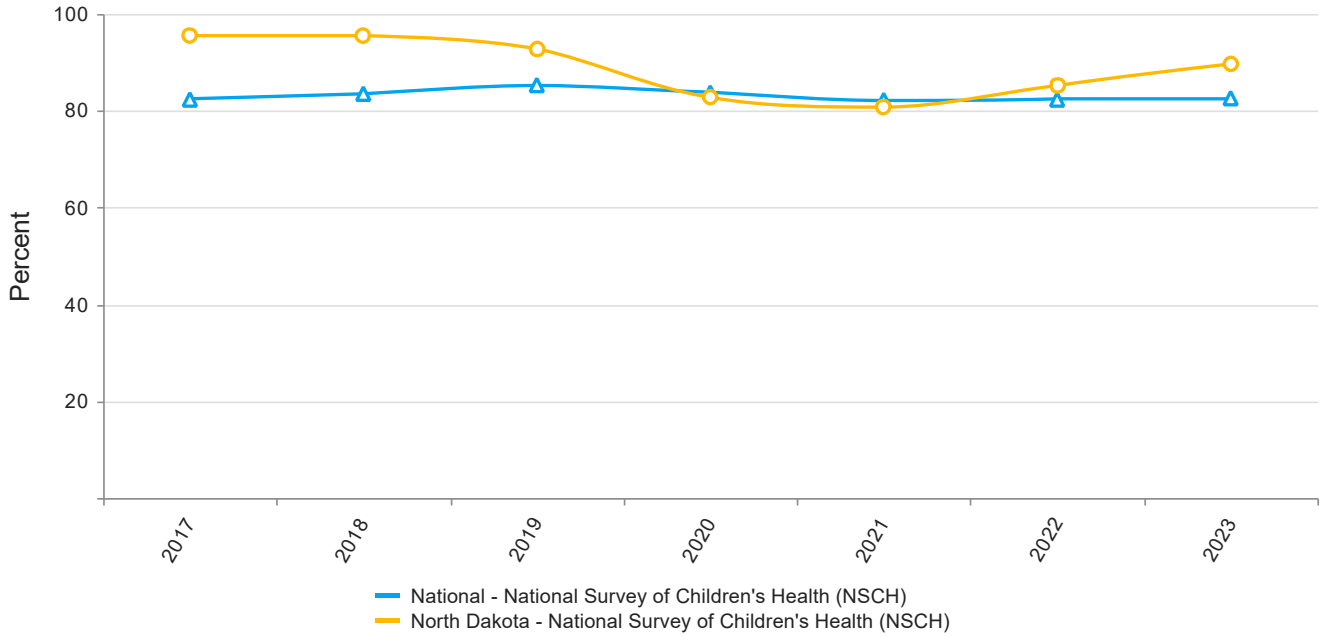
- Weekly student check-ins with trained, caring adult mentors
- Review of personal academic and behavioral data (e.g., GPA, absences, referrals)
- Goal setting and skill-building activities promoting healthy decision-making
- Real-time data collection via the C&C web-based App for tracking progress and fidelity
- Engagement of families in celebrating milestones and navigating challenges

By layering C&C within the broader NDFSCS pipeline services, MCH is ensuring that students and families receive comprehensive, wraparound support. This strategic alignment exemplifies the MCH principles of systems integration, and prevention, ensuring that services meet children where they are both developmentally and geographically. Furthermore, research supports that early intervention in grades 5 through 10 significantly increases a student's chances of academic success and healthy decision-making as they approach graduation. Through these partnerships, the MCH Child Health domain is building a stronger, more responsive network of support for North Dakota's youth, advancing both state and national MCH priorities while leveraging collective impact across systems.

North Dakota is committed to strengthening and expanding its system of care to support the health and well-being of all children and their families. Through a coordinated approach that prioritizes education, access to resources, and medical home care coordination, the state aims to create an environment where every child is surrounded by the support necessary to thrive. By fostering collaboration among healthcare providers, state agencies, schools, youth, and families, North Dakota is building a more integrated and family-centered system. The ultimate goal is to ensure that all children, regardless of background or circumstance, have the opportunity to grow up healthy, supported, and prepared for a successful evolution into adulthood.

**National Performance Measures**

**NPM - Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling - MHT**
**Indicators and Annual Objectives**




| Federally Available Data | |
|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 89.5 |
| Numerator | 11,931 |
| Denominator | 13,324 |
| Data Source | NSCH |
| Data Source Year | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Evidence-Based or –Informed Strategy Measures**

None

**State Action Plan Table**

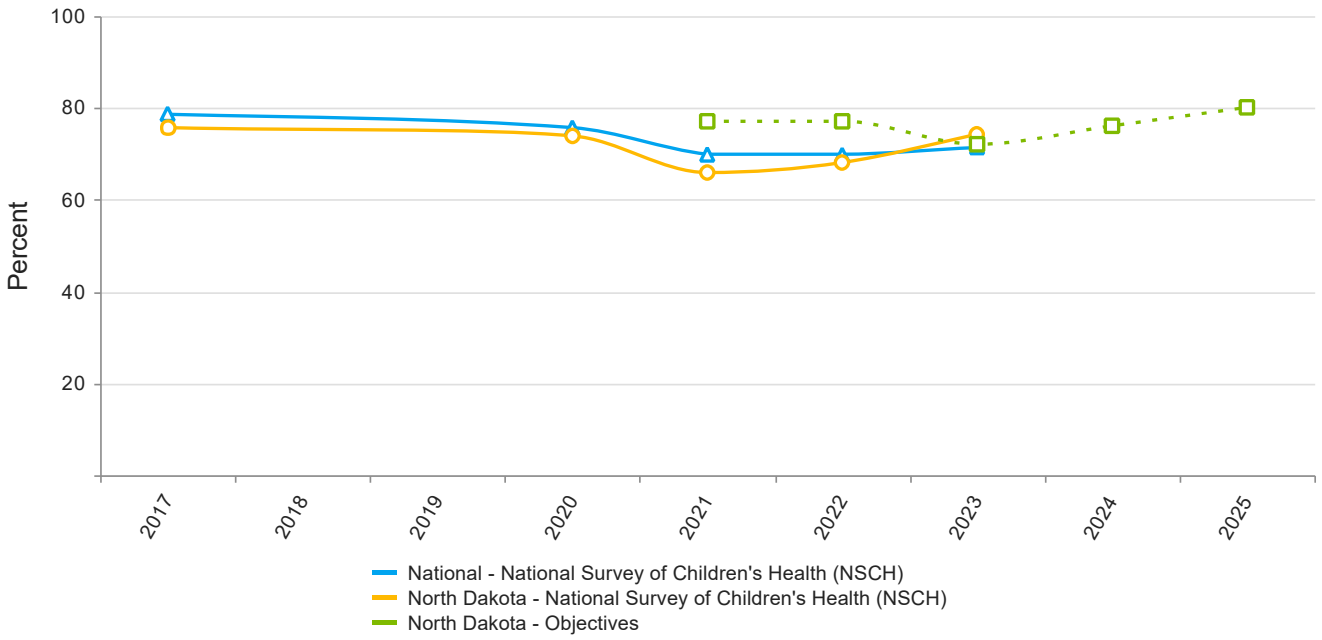
| State Action Plan Table (North Dakota) - Adolescent Health - Entry 1 |
|---|
| Priority Need |
| Mental Health Treatment: Percent of adolescents, ages 12 through 17, who receive needed mental health treatment and counseling |
| NPM |
| NPM - Mental Health Treatment |
| Five-Year Objectives |
| By September 30, 2030, Title V will increase and expand partnerships with other programs that work on adolescent mental and behavioral health projects. |
| By September 30, 2030, Title V will aim to increase the number of schools implementing data-driven programs for promoting student engagement for students at risk (poor attendance, behavioral/mental health issues, low grades, etc.). |
| Strategies |
| Title V staff will work with the NDDHHS Behavioral Health Division on various projects and initiatives around adolescent mental health. |
| Title V staff will partner with other organizations regarding mental health and suicide prevention efforts for adolescents. |
| The Title V Adolescent Domain will work with the Child and CSHCN Domain to incorporate mental health into medical home/care coordination activities. |
| Title V Staff will work with school-based entities to improve access to adolescent mental health resources. |
| ESMs Status |
| No ESMs were created by the State. |

## NOMs

- Adolescent Mortality
- Adolescent Suicide
- Adolescent Firearm Death
- Adolescent Injury Hospitalization
- Children's Health Status
- Adolescent Depression/Anxiety
- CSHCN Systems of Care
- Flourishing - Child Adolescent - CSHCN
- Flourishing - Child Adolescent - All

### 2021-2025: National Performance Measures

**2021-2025: NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV**
**Indicators**



| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 77 | 77 | 72 | 76 |
| Annual Indicator | 75.5 | 75.0 | 67.6 | 68.0 | 74.0 |
| Numerator | 37,391 | 39,331 | 37,880 | 37,986 | 42,723 |
| Denominator | 49,536 | 52,409 | 56,000 | 55,881 | 57,763 |
| Data Source | NSCH | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | 2019 | 2019_2020 | 2020_2021 | 2021_2022 | 2022_2023 |

**2021-2025: Evidence-Based or –Informed Strategy Measures**

**2021-2025: ESM AWV.1 - Percent of Medicaid EPSDT eligible adolescents, ages 15 through 18, who received at least one initial or periodic screen.**

| **Measure Status:** | **Active** | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | | 26 | 28 | 30 |
| Annual Indicator | 24.9 | 29.8 | 29.8 | 29.7 | |
| Numerator | 1,961 | 2,721 | 2,721 | 3,142 | |
| Denominator | 7,863 | 9,117 | 9,117 | 10,563 | |
| Data Source | North Dakota Department of Human Services, Early a | North Dakota Department of Human Services, Early a | Data Source-The North Dakota Department of Health | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2021 | 2022 | |
| Provisional or Final ? | Final | Final | Provisional | Final | |

**2021-2025: ESM AWV.2 - Number of adolescents, ages 12 through 17, with a reported visit to an emergency department (ED) involving depression within the last year.**

| **Measure Status:** | **Active** | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | | 330 | 310 | 290 |
| Annual Indicator | 293 | 358 | 272 | 259 | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | North Dakota's Electronic Surveillance System for | North Dakota's Electronic Surveillance System for | The North Dakota Department of Health and Human S | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

## MCH Population Domain: Adolescent

### NPM: Adolescent Well Visit: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

### North Dakota Priority Goal: To increase the percentage of adolescents who have a preventive medical visit.

### FY2024 Annual Report Narrative (October 1, 2023-September 30, 2024)

Adolescence is a pivotal period characterized by significant physical, psychological, and social development. It is essential to equip adolescents with strategies that promote healthy habits, mitigate risky behaviors, and prevent disease during this critical stage, as these factors can have lasting impacts on their lifelong health. As adolescents grow into adulthood, they begin to assume individual responsibility for maintaining healthy practices, particularly those with chronic health conditions who must take an even more proactive role in managing their health and overall well-being. Both physical and mental health are integral to adolescents' overall wellness and are significantly influenced by lifestyle choices. It is crucial to address and prevent the initiation of risky behaviors, such as unsafe sexual practices, reckless driving, and substance use, as adolescents navigate adult roles and responsibilities. To enhance the health and well-being of adolescents and young adults, it is vital to ensure that they have access to appropriate healthcare services, regardless of their geographical location. These essential services encompass annual preventive medical visits, which play a key role in educating adolescents and young adults about maintaining their health, addressing behavioral health concerns, providing immunizations, and managing chronic conditions. According to the 2022-2023 National Survey of Children's Health (NSCH), 86.9% of children aged 12 to 17 reported their health as excellent or very good nationwide, with North Dakota surpassing the national average at 91.2%.

Additionally, the Bright Futures guidelines advocate for annual health checkups for adolescents from ages 11 to 21. These visits should encompass a comprehensive array of preventive services, including physical examinations, immunizations, and discussions surrounding health-related behaviors such as nutrition, physical activity, substance use, sexual behavior, violence, and motor vehicle safety. According to the 2022-2023 NSCH, 74% of adolescents aged 12 to 17 in North Dakota reported having a preventive health visit in the past year, surpassing the national average of 71.4%. This marks an increase from the 2021-2022 data, where only 68% of North Dakota adolescents had an annual health visit.

Furthermore, the 2023 Youth Risk Behavior Survey (YRBS) revealed that 35% of adolescents reported experiencing depressive symptoms, reflecting a slight decrease from the 36% reported in the 2021 YRBS. The same survey indicated that 7.4% of North Dakota adolescents reported attempting suicide in 2023. Additionally, the 2023 YRBS confirmed that 16.3% of adolescents in North Dakota are classified as obese. This data is accessible through the North Dakota Department of Health and Human Services (NDDHHS) website (https://www.hhs.nd.gov/health/YRBS), providing easy access for various stakeholders. The North Dakota YRBS is scheduled for administration again in March 2025 to further evaluate and compare data trends among middle school and high school students.

The first Evidence-Based Strategy Measure (ESM) selected evaluated the percentage of Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) adolescents aged 15 to 18 who received at least one initial or periodic screening. Title V staff collaborated with Medical Services staff to discuss and explore potential partnerships related to the North Dakota Health Tracks (EPSDT) program. According to data obtained from Medical Services for the Federal Fiscal Year 2024, only 34% of EPSDT adolescents received at least one initial or periodic screening.

Title V staff collaborated with the University of North Dakota Family Medicine Clinic (UND FMC) to enhance adolescent well visits among high-risk populations on the Standing Rock Reservation, including those covered by North Dakota Medicaid. A pediatrician and staff from UND FMC conducted visits to local schools, completing a total of 135 well-child visits and sports physicals. In addition to these well checks and sports physicals, mental health screenings were performed, and the team partnered with Indian Health Services (IHS) to provide screening labs for diabetes, hyperlipidemia, and sexually transmitted infections (STIs). If a student's mental health screening indicated the need for further services, an immediate telehealth consultation with a mental health professional was arranged.

Furthermore, the team collaborated with the Sioux County Local Public Health Unit to administer necessary immunizations.

Recognizing oral health as a critical component of preventive healthcare, Title V staff also partnered with the NDDHHS Oral Health program and IHS to ensure that adolescents had access to preventive oral health services. IHS dental staff accompanied UND FMC during the well-child visits to provide dental and orthodontic screenings. Moreover, the importance of educating adolescents about the transition from pediatric to adult healthcare was emphasized by the staff. Title V will continue to promote well-child visits and encourage adolescents to take an active role in managing their health.

In addition to promoting optimal physical health among adolescents, addressing mental and behavioral health remained a key priority, particularly as these issues continue to emerge. A second ESM was developed to assess the number of adolescents aged 12 to 17 who visited an emergency department (ED) due to depression within the past year. According to the 2023 data from the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE), 253 adolescents were seen in the ED for depression within this timeframe. Title V is dedicated to improving access to mental and behavioral health services for adolescents.

The World Health Organization identifies multiple factors that influence mental health outcomes, indicating that the greater the exposure to risk factors, the more significant the potential impact on mental health. Given that 35% of adolescents reported experiencing depressive symptoms in the 2023 YRBS, Title V staff have expanded their collaboration with behavioral health partners to evaluate the referral process for mental health and behavioral health services. Many adolescents face increased risks for mental health conditions due to various barriers when accessing services, including challenging living conditions, stigma, discrimination or exclusion, and a lack of access to quality support and services. These challenges are prevalent at both state and national levels. To address these issues, Title V staff partnered with the UND FMC and the Northern Plains Special Education Unit (NPSEU) to provide mental health telehealth services in schools.

The NPSEU facilitated access to telehealth therapeutic mental health counseling for students, collaborating with five rural school districts to ensure counseling services were available regardless of students' insurance status. Additionally, the NPSEU initiated the Check and Connect program, which mentors at-risk youth through weekly on-site sessions with a dedicated 'champion' to support their academic and behavioral goals. By building relationships with families, the mentors effectively bridged the gap between home and school to promote student success. Through these collaborative efforts, nine uninsured adolescents accessed therapeutic counseling sessions, while a total of 60 students benefited from direct services facilitated by coordinated efforts among NDDHHS behavioral health teams, schools, and families. The Check and Connect program was implemented in four of the five participating schools, with six administrators and nine mentors trained. Furthermore, 47 students received support through weekly Check and Connect sessions with mentors. Data indicates an 81% decrease in absences and a 100% decrease in suspensions among participating students. Mentors also convened virtually via ZOOM at least quarterly to collaborate on program development and address ongoing needs.

In addition to the NPSEU's provision of mental health telehealth visits, the State School Nurse Consultant continued to distribute various resources and training addressing adolescent mental health to school professionals through the School Nurse listserv. These resources encompassed a range of mental health topics, including bullying.

Furthermore, youth engagement is a fundamental building block for enhancing the system of care and infrastructure for comprehensive adolescent health care. Title V staff and partners recognized the importance of collaborating with the NDDHHS Youth Advisory Board (YAB). The mission of the YAB was to foster a safe and consistent environment for youth aged 15 to 21, enabling them to make a positive impact in North Dakota communities through peer influence. The board focused on planning, implementing, and advising on meaningful projects and topics aimed at improving the health of North Dakota youth. The YAB was actively engaged with Title V staff, with tribal representation included on the board. This collaboration provided an alternative strategy for soliciting feedback from this population group. Participants of the YAB contributed valuable insights into adolescent-focused projects covering various topics, including well visits, immunizations, safe behaviors, mental health, sexual health, physical health, and resource development. Given the success of this collaboration, these partners are expected to remain engaged in future Title V initiatives. The Injury Prevention Program Director and the State School Nurse Consultant attended all

three scheduled YAB meetings and will continue to participate in future gatherings to maintain strong partnerships and ensure that maternal and child health needs are discussed and addressed collaboratively. Additionally, staff have continued to work with Tribal Health Liaisons employed by NDDHHS, collaborating with each tribe in North Dakota. An ongoing goal in this domain is to partner with the YAB and other stakeholders within NDDHHS to develop a comprehensive and dynamic social media campaign focused on adolescent health. The YAB has identified financial health as a significant concern for themselves and their peers. To address this topic, methods to engage youth were explored, resulting in the development of short video clips that will be shared across various social media platforms.

An event was organized by the NDDHHS, Bismarck State College, and North Dakota's Gateway to Science to promote the health and well-being of children, youth, and the Bismarck-Mandan community. Planning sessions took place to ensure specific topics were addressed at the event. The topics included at the event were financial health, physical health (nutrition and exercise), behavioral health, and more. Title V staff aided in the planning of this event and set up booths to disseminate various resources and educational materials. There were food trucks, games, prizes, a sudden cardiac arrest simulation with the American Heart Association (AHA) and Metro Ambulance, and interaction from community partners. Approximately 700 community members of all ages attended the event, so this was a great event to reach adolescents. NDDHHS intends to expand Gateway to Health events in 2025 due to meaningful community interaction and feedback given.

Lastly, staff continued to foster partnerships across Title V domains (e.g., CSHCN, state priorities, child health, women's health, etc.) as well as continued to collaborate and enhance work efforts to achieve the core goal to improve adolescent health. Title V already had close working relationships with several programs that serve adolescents and youth (e.g., North Dakota Family Planning Clinics, North Dakota Women's Way, North Dakota State University Extension Services, North Dakota Immunization program, the North Dakota Pediatric Mental Health Assess Grant, local public health tobacco prevention programs, etc.), these have been strengthened even further. Staff also played an active role on the Oral Health Coalition and attended all scheduled meetings. The NDDHHS has continued evaluating potential opportunities to braid and layer funding or other potential resources.

Adolescence is an important time in one's life. This developmental period is characterized by physical, emotional, and intellectual changes, as well as changes in social roles, relationships, and expectations. It is essential to promote healthy development, safety, and the well-being of adolescents in North Dakota and ensure they are receiving all necessary services required for optimal health.

## MCH Population Domain: Adolescents

**NPM: Mental Health Treatment: Percent of adolescents, ages 12 through 17, who receive needed mental health treatment and counseling**

**North Dakota Priority Goal: Identify, reduce, or eliminate barriers preventing adolescents from receiving mental health treatment and counseling.**

### FY2026 Annual Plan Narrative (October 1, 2025-September 30, 2026)

Adolescence is a time of incredible growth and serves as a crucial period for physical, psychological, and social development. The habits formed and the support received during this stage can have lasting effects on lifelong health. As adolescents move from childhood to adulthood, they begin to take personal responsibility for their health and, for those with chronic conditions, a greater role in managing their care. While physical health remains essential, mental and behavioral health have emerged as equally critical components of overall well-being, especially in North Dakota, where youth mental health challenges are becoming increasingly prevalent. Depression, anxiety, and behavioral health conditions can interfere with academic performance, social relationships, and long-term stability if left unaddressed. To improve the health and well-being of adolescents and young adults, it is essential that they have access to timely, developmentally appropriate physical and mental health services, no matter where they live in the state.

The 2022 National Survey of Children's Health (NSCH) indicated that 92.7% of North Dakota children, ages 12 through 17, reported having excellent or very good health. North Dakota strives to reach 90.0% of children and adolescents who report excellent health, which they met as North Dakota is currently trending above the national average at 89.9% in this area for physical health. However, according to the 2022-2023 NSCH, 29.2% of North Dakota children aged 3-17 years have one or more reported mental, emotional, developmental, or behavioral problems. This is above the national average of 25.8%.

North Dakota's 2023 Youth Risk Behavior Survey (YRBS) indicated that 35% of adolescents reported experiencing depressive symptoms, which is a slight decrease from the 2021 YRBS of 36%. The YRBS also indicated that 7.4% of North Dakota adolescents reported attempting suicide in 2023. This data is housed through the website for the North Dakota Department of Health and Human Services (NDDHHS) (https://www.hhs.nd.gov/health/YRBS) for easy access by various partners. The North Dakota YRBS will be administered once again in March 2025 to North Dakota middle school and high school students to further assess and compare data trends.

The Evidence-Based Strategy Measure (ESM) selected for Year 1 will be the number of adolescents, age 12 through 17, with a reported visit to an emergency department (ED) involving depression within the last year. According to the 2024 Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) data, 173 adolescents were seen in the ED for depression within the last year. Title V has a mission to improve access to mental/behavioral health services for adolescents.

According to the World Health Organization (WHO), multiple factors determine mental health outcomes. The more risk factors adolescents are exposed to, the greater the potential impact on their mental health. Since 35% of adolescents reported depressive symptoms in the 2023 YRBS, Title V staff will partner with other organizations regarding mental health and suicide prevention efforts for adolescents and continue to expand collaboration with other behavioral health partners to address challenges and provide education around healthy adolescent behavioral health. Staff plan to identify obstacles and challenges that adolescents face when accessing mental and behavioral health services. Title V staff will partner with the NDDHHS Behavioral Health Division on various projects and initiatives around adolescent mental health. For example, the Title V Director will continue to take part in meetings for the Pediatric Mental Health Care Access Grant and work towards expanding the utilization of these services. Title V team members will also attend meetings with the Behavioral Health Unit to explore opportunities for collaboration on projects that are applicable to adolescent mental health. The State School Nurse Consultant has begun attending meetings for the unit's B-Hero Advisory group and will continue to use this as an opportunity to collaborate for behavioral health initiatives in North Dakota schools and communities.

Title V has contributed to the annual suicide prevention conference held in North Dakota through the North Dakota Suicide Prevention Coalition. A Title V team member currently sits on the planning committee for this conference. In the upcoming year, it is hoped that Title V will increase its participation even further and ensure that adolescent mental health is a topic being explored in the planning process.

Title V staff will also partner with school-based entities to enhance adolescents' access to mental health resources. State Title V will organize and lead quarterly meetings with school nurses to inform them about available mental health resources for students. Partners from various entities will be asked to attend and present at these meetings to share resources, discuss the services they offer, and answer questions from the school nurses from around the state who are working directly with adolescents in schools. Additionally, training sessions addressing adolescent mental health will be disseminated through a School Nursing listserv as they become available.

Next, youth engagement is a basic building block to improve infrastructure for comprehensive adolescent health care. Title V staff will continue to seek opportunities to collaborate and partner with adolescents directly. The North Dakota Youth Advisory Board (YAB) has been actively engaged with Title V staff. Therefore, feedback will continue to be solicited through this avenue as an alternative strategy to reach the adolescent population. The board will provide valuable input into adolescent-focused projects around topics such as well-visits, immunizations, safer behaviors, mental health, sexual health, diet/obesity prevention, and resource development. The Injury Prevention Program Director and State School Nurse Consultant will continue to participate in future meetings to ensure that partnerships remain intact and MCH needs are brought forward for discussion and collaboration.

Additionally, although Title V already has close working relationships with several programs that serve adolescents (e.g., Title V partners, North Dakota Family Planning Clinics, North Dakota Women's Way, North Dakota State University Extension Services, North Dakota Immunization program, the North Dakota Pediatric Mental Health Assess Grant, local public health tobacco prevention programs, etc.), these will continue to be strengthened even further. The NDDHHS will continue evaluating potential opportunities to braid and layer funding as the Title V adolescent health domain begins to incorporate behavioral health components into its work efforts.

Title V will also be working towards increasing the number of schools implementing data-driven programs to promote student engagement for students at risk (poor attendance, behavioral/mental health issues, low grades, etc.). This will be accomplished through releasing a Request for Proposals (RFP) to facilitate the implementation of such a program. One example is the Check and Connect program (C&C), a mentoring program that is targeted for at-risk youth in need of support to improve attendance, grades, and behavior. Using caring adults as mentors, the students will have weekly check-ins to review their personal data, set positive goals, and build healthy decision-making skills with a trusted adult. Using the web-based C&C App, mentors will document, monitor, and report on student progress using their tablets or laptops to collect and interpret "Check" data, look for patterns of student engagement, track "Connect" data, and monitor progress. For administrators, the C&C App automates the processes of assessing fidelity of implementation and determining program impact. Student attendance, GPA, Failing Classes grades, and behavior incident reports/referrals will be monitored. Using the data, students can identify, alongside the support of their mentor, areas to focus on for improvement. Setting healthy goals together, the student and mentor will engage with the family to celebrate the positives. If needs come up, the mentor will guide the student and the family in accessing resources to meet the need. The goal is to ensure all students make progress and are on track for a healthy life and positive school outcomes. The targeted age group for this intervention is grades 5 through 10. Research shows early intervention at these grade levels will increase the success and overall healthy decision-making skills of students near graduation.

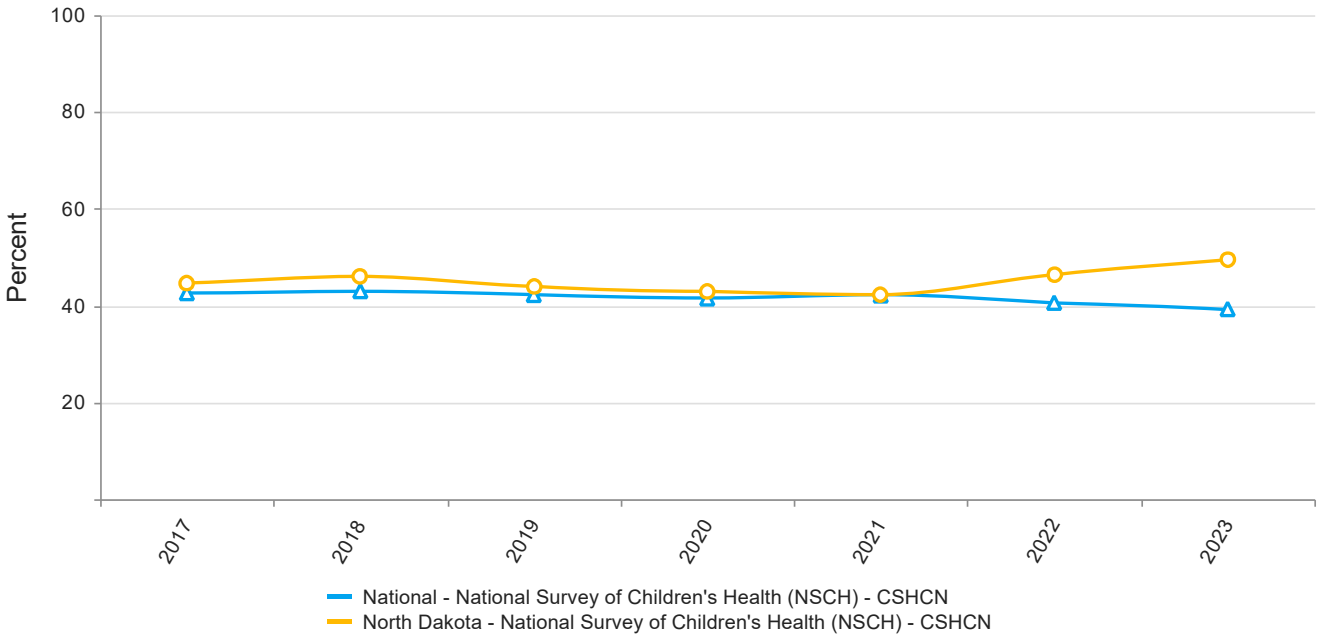
Lastly, the importance of collaboration is acknowledged as a vital component in the development of innovative initiatives aimed at ensuring adolescents receive adequate preventive health care. Integrating elements of the medical home model is essential for enhancing the quality, effectiveness, and efficiency of care provided, while also addressing the unique needs of each patient. It is crucial that every individual, including children and adolescents, has access to a designated medical home. While the universal measure for the medical home will be incorporated within the CSHCN domain, the collaborative efforts of Title V staff overseeing the CSHCN, Adolescent Health, and Child Health domains will be instrumental in ensuring that all future medical home projects encompass every child, including those with special health care needs. To advance these medical home initiatives, domain leaders will

integrate resources and collaborate effectively to enhance the overall system of care for all children.

**Children with Special Health Care Needs**

**National Performance Measures**

**NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH**
**Indicators and Annual Objectives**




**NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs**

| Federally Available Data | | |
|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | |
| | **2023** | **2024** |
| Annual Objective | | |
| Annual Indicator | 41.2 | 49.6 |
| Numerator | 15,526 | 24,324 |
| Denominator | 37,687 | 48,993 |
| Data Source | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | 2021_2022 | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Evidence-Based or –Informed Strategy Measures**

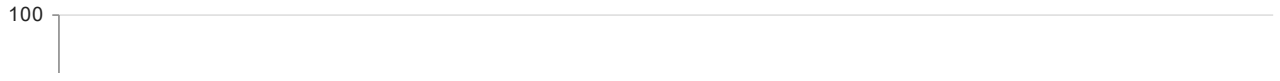
None

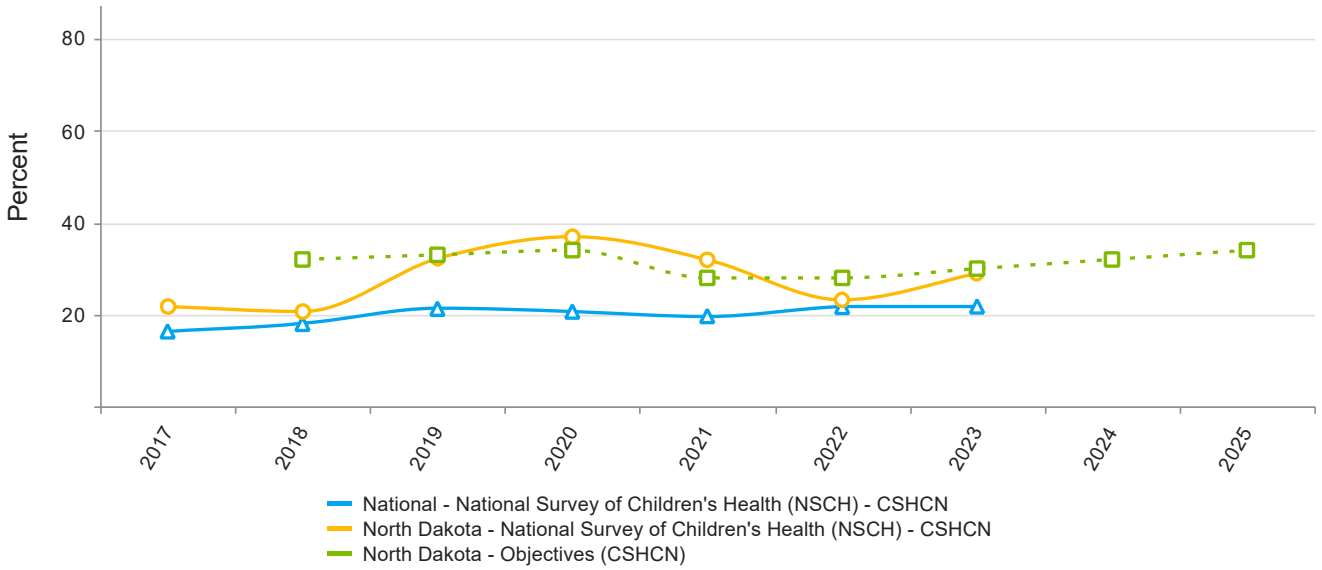
**State Action Plan Table**

| State Action Plan Table (North Dakota) - Children with Special Health Care Needs - Entry 1 | |
|---|---|
| Priority Need | |
| Medical Home-Overall: Increase the number of children with special health care needs engaged in medical home | |
| NPM | |
| NPM - Medical Home | |
| Five-Year Objectives | |
| By September 30, 2030, the percentage of all children with a medical home will increase from 55.2% to 60.2% according to the National Survey of Children's Health (NSCH). | |
| Strategies | |
| Provide education and outreach to families to increase awareness and improve utilization of available services. | |
| Provide education and outreach to providers to implement and/or enhance medical home activities within their practice. | |
| ESMs | Status |
| No ESMs were created by the State. | |
| NOMs | |
| Children's Health Status | |
| CSHCN Systems of Care | |
| Flourishing - Young Child | |
| Flourishing - Child Adolescent - CSHCN | |
| Flourishing - Child Adolescent - All | |

**2021-2025: National Performance Measures**

**2021-2025: NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC Indicators**






**2021-2025: 2021-2025: NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC - Children with Special Health Care Needs**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 34 | 28 | 28 | 30 | 32 |
| Annual Indicator | 26.1 | 27.5 | 27.7 | 25.0 | 28.9 |
| Numerator | 3,271 | 3,339 | 3,707 | 4,265 | 6,427 |
| Denominator | 12,512 | 12,121 | 13,390 | 17,081 | 22,226 |
| Data Source | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | 2018_2019 | 2019_2020 | 2020_2021 | 2021_2022 | 2022_2023 |

**2021-2025: Evidence-Based or –Informed Strategy Measures**

**2021-2025: ESM TAHC.1 - Percentage of individuals ages 14 through 21 served in SHS multidisciplinary clinics that received a transition assessment.**

| **Measure Status:** | **Active** | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 80 | 80 | 85 | 90 | 95 |
| Annual Indicator | 74.4 | 81.2 | 70.6 | 73.2 | |
| Numerator | 99 | 125 | 96 | 101 | |
| Denominator | 133 | 154 | 136 | 138 | |
| Data Source | The North Dakota Department of Health. Division of | The North Dakota Department of Health. Division of | The North Dakota Department of Health | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

**2021-2025: ESM TAHC.2 - Number of educational opportunities provided to health care professionals/providers from Title V regarding health care transition.**

| Measure Status: | Active | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 10 | 10 | 8 | 10 |
| Annual Indicator | 8 | 8 | 6 | 5 | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | The North Dakota Department of Health. Division of | The North Dakota Department of Health. Division of | The North Dakota Department of Health and Human S | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

**2021-2025: ESM TAHC.3 - Number of educational opportunities provided to school personnel from Title V regarding health care transition.**

| Measure Status: | Active | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 2 | 3 | 4 | 5 |
| Annual Indicator | 1 | 0 | 0 | 1 | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | The North Dakota Department of Health. Division of | The North Dakota Department of Health. Division of | The North Dakota Department of Health and Human Se | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

**2021-2025: ESM TAHC.4 - Percentage of families served by family support contracts who received education and / or training on healthcare transition.**

| Measure Status: | Active | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | | 13 | 16 | 19 |
| Annual Indicator | 3.6 | 10.6 | 16.1 | 8.7 | |
| Numerator | 286 | 763 | 919 | 979 | |
| Denominator | 7,902 | 7,170 | 5,709 | 11,315 | |
| Data Source | The North Dakota Department of Health. Division of | The North Dakota Department of Health. Division of | The North Dakota Department of Health and Human S | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

**MCH Population Domain: Children with Special Health Care Needs (CSHCN)**

**NPM: Transition: Percent of individuals with and without special health care needs, ages 12 through 17, who received services necessary to make transitions from pediatric to adult health care**

**North Dakota Priority Goal: To increase the percentage of individuals with and without special health care needs who have received the services necessary to make transitions from pediatric to adult health care.**

**FY2024 Annual Report Narrative (October 1, 2023-September 30, 2024)**

Transition is defined as the movement, passage, or change from one position or state to another. Moving from pediatric to adult health care occurs for all children, but may be more difficult for children and youth who have special health care needs. This is of importance as youth and young adults begin to transition from a pediatric health system to an adult health care provider. Often, this requires leaving a pediatric provider who has cared for the child and family with a strategic and hands-on approach for managing their medical needs and a substantial amount of care coordination. As the child ages, it becomes very important for the family and child to start planning for this change early so that their needs can be met prior to the youth turning 18 years of age, when many leave home for college, work, or other out-of-home living situations. Pediatric health care transition readiness is important for all youth and young adults to receive. The preparation time required for this process is unique to the child and their needs. In many situations, a portion of the planning occurs in the clinic to promote a seamless conversion into adult health care.

Data from the 2022 National Survey of Children's Health (NSCH) indicates that 21.1% of children through age 17 are children with a special health care need in North Dakota. In addition, according to the 2022-2023 NSCH, 24.7% of adolescents, ages 12 through 17, received services to prepare for the transition from pediatric to adult health care. This is slightly higher than what the percentage was in North Dakota in 2021-2022 (24%) and is also higher than the national average of 18.1%. The data goes on to state that 31.8% of children with special health care needs (CSHCN), ages 12 through 17, received services to prepare for the change to adult health care, which again is above what the percentage was in 2021-2022 (25%) and above the national average at 22.3%. While transition services that aid in the transition from pediatric to adult health care are essential for all children, CSHCN undergo extra stress and are particularly vulnerable, especially during this time period. It is imperative that these families receive the extra support needed.

Lastly, medical homes have been shown to be effective in ensuring children are receiving all necessary services, including support when moving from pediatric to adult health care. Fortunately, according to the 2022-2023 NSCH, 55.2% of children through the age of 17 have a medical home. This is above the national average at 45.3% and is higher compared to North Dakota's percentage in 2021-2022 at 52.3%. Furthermore, the 2022-2023 NSCH indicates that the number of CSHCN ages 0 through 17 who received needed care coordination was 62.7%, which is higher than the national average at 53.3% and is also higher than North Dakota's percentage in 2021-2022 at 55.1%.

Mental health is a critical component of a child's quality of life, including CSHCN. Unfortunately, the 2022-2023 NSCH indicates that 63.3% of adolescents with special health care needs, ages 12 through 17, are bullied. This is higher than the national average of 51.3%. Therefore, North Dakota has some work to do in this area. It is important to note that this data statistic should be interpreted with caution due to the low sample size.

The strategies for helping youth switch from pediatric to adult health care can be categorized by various focus areas (e.g., systems building, families, health care providers, education, etc.); therefore, several Evidence-Based or Informed Strategy Measures (ESMs) were selected specifically to examine the impact within each category. First, a systems-focused ESM was implemented to evaluate the percentage of youth receiving readiness assessments at contracted multidisciplinary clinics. Contracts with various health care organizations were initiated to support a variety of pediatric multidisciplinary clinics across the state, including but not limited to asthma clinics, metabolic clinics, and autism clinics. Grantees were expected to provide readiness assessments as necessary to all adolescent clients who were being served in a multidisciplinary clinic. In addition, grantees incorporated data in their required reports that included the number of adolescents who received an assessment and details on the education

that was provided to the child and family. The goal of this data collection was to better gauge the level of transition activities occurring amongst patients and families. In State Fiscal Year (SFY) 2024, multidisciplinary clinics reported 83% of transition-aged attendees received a transition assessment in addition to transition-focused education; this was an increase from SFY 2023 at 73.2%. Additionally, the multidisciplinary clinics offered services to all individuals at no cost, regardless of residence, insurance coverage, income, and socioeconomic status. Several clinics also offered travel reimbursement for families traveling long distances to ensure their child could attend the clinic. This helped mitigate potential barriers for disparate populations that may have difficulty accessing care. Non-English-speaking individuals were offered interpretive services to ensure understanding of the child's condition and plan of care.

Furthermore, Title V staff partnered and collaborated on an adolescent health project to increase the number of adolescents who received a well-child check. A pediatrician and a team of other health care professionals traveled to the Standing Rock Reservation to provide well-child checks to their students; readiness assessments were given to all 135 adolescent students. Lastly, having a medical home for youth and young adults not only assists in readiness to change from pediatric to adult health care, but also enhances the partnership between the provider, family, and patient and ensures necessary care is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. Therefore, a contract was initiated with Sanford Health in Fargo to support the Children's Medical Home program by providing children who have a special health care need with care coordination, coordinated care specific to the child's health needs, support from outside agencies, and an individualized care plan to highlight the child's goals, medical history, and community services. In SFY 2024, the program served 227 (unduplicated number) children with special health care needs.

Next, health care professionals and providers play a critical role in initiating the conversation regarding changing from pediatric to adult health care. Thus, additional efforts geared towards improving the level of education and training to health care providers/professionals on strategies to better facilitate these discussions with youth and their families were implemented. A second ESM was incorporated to measure the number of health care providers/professionals who have received education and/or training specific to CSHCN changing from pediatric to adult health care. In year four of the grant, 10 educational opportunities were provided to health care professionals regarding the switch from pediatric to adult health care. Special Health Services (SHS) staff directly led six of these educational opportunities, which educated 127 professionals. These opportunities included hosting a three-part webinar Lunch and Learn series with GotTransition, an online education session with the Transition Community of Practice group, a presentation on the Minot State University Transition Project ECHO Series, and one-on-one education to a provider regarding transition resources. Education to health care professionals was also provided by Family Voices of North Dakota who offered various educational trainings regarding transitioning from pediatric to adult health care to a total of 1,511 professionals.

Likewise, it is also realized that youth spend an exponential amount of time at school. Educational professionals and school nurses play a role in better preparing students for addressing health transition-related challenges and help students be better prepared. A third ESM was initiated to measure the number of educational and training efforts that SHS provided to school professionals to expand knowledge and skills around successful health transitions. While it is challenging to get into the schools, information and resources related to transition were shared to the school nurses via the listserv. One education opportunity was offered as SHS staff shared the Student Transition Toolkit with the school nurses on the listserv which includes 172 nurses.

Finally, family engagement and the expansion of family-professional partnerships is imperative in implementing successful health transitions. Support and assistance to family support organizations to train or assist families in expanding knowledge and leadership capacity around health transition was provided. To measure the impact this had on North Dakota families, a fourth ESM was developed to measure the percentage of families served by family support contracts who received education and/or training on health care transition. Funding and support provided to Family Voices of North Dakota allowed their staff to provide education to families across the state through various opportunities, including one-on-one support, Leadership Institutes, Caregiver Cafes, and Youth Transition Cafes. The Youth Transition Cafes are hosted by Family Voices staff for families and their youth that review self-advocacy, transition preparation, and provider transfer. Topics discussed at these trainings include Readiness Assessments, transition timelines, decision-making, health insurance, budgeting, IEPs/504s, guardianship, etc. Out of all 9,567 families that received services, training, or education by Family Voices, 1,084 (11.3%) received health care transition-specific education. While this may seem like a low percentage, it is recognized that Family Voices provides an extraordinary amount of education to families who do not have transition-aged children. In addition, Title

V and other family support organization staff participated on the planning committee for the annual Power-Up for Health conference, geared towards providing education to individuals with physical and intellectual disabilities and their families. Additionally, staff provided resources and technical assistance necessary to implement evidence-based or evidence-informed practices to advance the switch from pediatric to adult health care in North Dakota. This was achieved through collaboration with both new and previously existing partnerships that worked to enhance the CSHCN system of care.

Staff from SHS remained actively engaged in various workgroups to bolster collaboration, including the North Dakota Department of Public Instruction (NDDPI)'s Transition Community of Practice, which includes a diverse group of stakeholders (e.g., representatives from special education, independent living centers, vocational rehabilitation, family organizations). This committee provided opportunities for partnership with school personnel, vocational rehabilitation, developmental disabilities program managers, the State Council on Developmental Disabilities, and many others who are working with adolescents.

In an effort to expand partnerships even further, SHS staff continued to participate on the North Dakota Interagency Task Force on Transition. Key members of this committee included staff from the North Dakota Federation of Families for Children's Mental Health, North Dakota Independent Living Centers, Job Service North Dakota, Vocational Rehabilitation, and the North Dakota Department of Health and Human Services (NDDHHS). Updates were shared from each agency regarding opportunities to collaborate or provide education to stakeholders. Engaging youth with transition-related activities remained a key priority for Title V staff. Therefore, SHS continued partnering with the NDDHHS Community Engagement Unit who leads the Youth Advisory Board (YAB). SHS staff attended and participated in YAB meetings to seek input and feedback as needed to drive adolescent work efforts and partnerships across North Dakota. Lastly, a new partnership was fostered with the North Dakota Emergency Medical Systems for Children (EMSC) Coordinator. SHS staff attended EMSC meetings to discuss a variety of topics, including hospital pediatric emergency care coordinator roles, prehospital pediatric readiness projects, hospital recognition programs, and sickle cell.

Next, cross-cutting implementation strategies remained at the heart of all SHS activities and led to continuous quality improvement within programs. These strategies included care coordination, collaboration, information/education, and data-informed decisions. SHS staff sought out feedback from Medical Advisory Council (MAC) members at the annual MAC meeting regarding how they would like to see funding utilized for CSHCN and strategies to improve data-driven decisions around existing priority efforts. In addition, a workgroup with interdisciplinary key partners and stakeholders that was previously formed to assist with transition-related strategic planning and work activities continued to be utilized as necessary.

Technical assistance was provided to existing grantees of SHS multidisciplinary clinic contracts regarding the transition-focused assessment and education that is to be provided to all adolescent clients. An overview of available resources was provided to grantees to ensure they were aware of the various resources that could assist with education and assessment. To ensure quality care was delivered and needs were addressed, SHS staff conducted several site visits to funded multidisciplinary clinics and provided recommendations for quality improvement strategies. Additional site visits will be completed moving forward to ensure that work efforts towards moving from pediatric to adult health care are incorporated into the visit.

Finally, numerous methods for dissemination of information pertaining to transition were implemented. Resource materials relating to transitioning from pediatric to adult health care have a dedicated location on the SHS website for all families and providers to easily access. These materials include resources from GotTransition for both parents and youth, local resources including Launch my Life North Dakota, and educational resources regarding medical home. Along with these materials, SHS has linked the national centers of excellence to the website so that partners utilize evidence-based materials and strategies in their current and future transition projects or contract workplans. Materials were also disseminated at various conferences and stakeholder meetings to ensure partners had up-to-date resources. For example, a SHS staff member attended and had a booth at the Standing Rock Community Health Fair where they disseminated information to approximately 300 students and school staff. Likewise, Title V staff also participated and had a booth at the Gateway to Health event, coordinated by the NDDHHS YAB, which is a free even for community members of all ages to access the Gateway to Science exhibits, interactive health booth and exhibits, and an opportunity for parents, guardians, grandparents, etc., to participate in discussion rooms on topics relevant to their youth's overall health. Participants were also given tools to aid in the discussion of these topics with their youth. Materials regarding the switch from pediatric to adult health care were also disseminated at

the booth.

In conclusion, preparing CSHCN for the switch from pediatric to adult health care has and will continue to be a priority as SHS recognizes the importance of enhancing and expanding services and education to youth, young adults, and their families across the state. Moreover, SHS will continue its work efforts to provide transition-related education to health care providers and school professionals to meet the needs of adolescent children and continue to grow and strengthen partnerships with the goal of improving the CSHCN system of care.

**MCH Population Domain: Children with Special Health Care Needs (CSHCN)**

**NPM: Medical Home-Overall: Increase the number of children with special health care needs engaged in medical home**

**North Dakota Priority Goal: Improve the system of care for children with special health care needs.**

**FY2026 Annual Plan Narrative (October 1, 2025-September 30, 2026)**

Children with Special Health Care Needs (CSHCN) are defined as those who have, or are at an increased risk for, chronic physical, developmental, behavioral, or emotional conditions. Despite these challenges, it is imperative that children and youth with special health care needs are provided the opportunity to lead fulfilling lives and thrive within a supportive system that addresses their social, health, and emotional requirements. This approach ensures their dignity, autonomy, independence, and active engagement in their communities. According to data from the 2022 National Survey of Children's Health (NSCH), approximately 21.1% of children aged 0 to 17 in North Dakota are identified as having a special health care need.

The establishment of a medical home is crucial for all children, including those with special health care needs. A medical home is characterized as a model for delivering comprehensive, high-quality primary care that fosters collaborative partnerships among patients, clinicians, medical staff, and families. This model transcends the traditional confines of clinical practice, encompassing care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.

Federally available data indicates that North Dakota is exceeding the national average of 45.3% for CSHCN aged 0 to 17 who have a medical home, achieving a rate of 55.2% in the 2022-2023 period. This marks an increase from the previous year's rate of 52.3%. It is crucial to continue promoting and facilitating the integration of the medical home model throughout the health care system, as it appears to significantly contribute to the overall health and well-being of CSHCN. Key components of the medical home model include providing families with care coordination, a seamless referral process, family-centered care, and having a usual source of sick care.

Data from the 2022-2023 NSCH reveals that 62.7% of CSHCN in North Dakota received needed care coordination, exceeding the national average of 53.3%. However, there remains an opportunity for improvement in this area. Furthermore, 74.4% of these CSHCN did not have difficulty getting referrals when needed, compared to the national average of 70.0%. Additionally, 91.4% of CSHCN in North Dakota have family-centered care, which is above the national average of 81.6%. Next, the 2022-2023 NSCH indicates that 88.6% of North Dakota CSHCN have a usual source of sick care, versus the national average at 82.4%. Lastly, according to the NSCH, the percentage of CSHCN, ages 0 through 17, who are receiving care in a well-functioning system in North Dakota increased from 13.4% in 2020-2021 to 19.2% in 2022-2023, significantly above the national average at 13.1%. While North Dakota is trending above the national average in many of these metrics, there remains ongoing potential for enhancement.

Data gathered from the 2025 Needs Assessment identified the necessity for enhanced services related to the medical home model. First, when survey stakeholders were asked to rank the top three unmet needs in order of priority for CSHCN in their community, the results were as follows: (1) Family Support and Child Care; (2) Health Care and Insurance; and (3) Mental Health and Substance Abuse Support. Furthermore, when stakeholders were asked to identify the single performance measure they believed should be prioritized for the CSHCN population, medical home emerged as the predominant choice, gathering 60% of the responses. An expansion of this survey question was asked, inquiring which medical home component should be the priority. Care coordination was the top component selected by stakeholders at 52%.

Based on this data, the priority for the CSHCN domain is to improve the system of care for children with special health care needs. The established goal is to increase the percentage of children, including CSHCN, who have a medical home from 52.3% to 57.3% according to the NSCH by September 30, 2030. As previously mentioned, a medical home is comprised of several key components. Because the Needs Assessment survey stakeholders identified care coordination as their top priority, Title V staff will specifically monitor the percentage of children,

including CSHCN, who receive necessary care coordination through their medical home, thereby enhancing continuity of care through an Evidence-Based or Informed Strategy Measure (ESM) that has been developed. This ESM will be implemented through various strategies aimed at achieving the outlined goals.

First, Title V staff acknowledge the critical role of education and outreach in raising awareness and enhancing the utilization of available services for families and their children. The team will leverage existing programs and services supported by the Special Health Services Unit within the NDDHHS, such as pediatric multidisciplinary clinics, the Financial Coverage program that works and partners directly with families, and the Newborn Screening Long-Term Follow-Up program, to emphasize the importance of a medical home. Efforts will include the exploration and promotion of existing resources (e.g., fact sheets, checklists, family care planners, etc.) from the National Resource Center for Patient/Family-Centered Medical Home (https://www.aap.org/en/practice-management/medical-home), alongside other evidence-based materials. These resources will be disseminated to families, showcased at conferences, and integrated into staff presentations as appropriate.

Next, Title V staff intend to collaborate with other MCH domain workgroups and various state-level partners to encourage the utilization of existing supports and services available to children, ensuring families are well-informed about these resources and are equal partners in their child's care. Title V not only works closely with the Adolescent and Child Health domain leads, but they also participate in several councils, committees, and workgroups (e.g., Interagency Coordinating Council, Developmental Disabilities Council, Medical Advisory Council, Newborn Screening Advisory Council, meetings with North Dakota Medicaid around Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) which is known as North Dakota Health Tracks). These groups work closely with children, including CSHCN. In these collaborative efforts, Title V staff will advocate for and encourage the integration of the medical home model components in the group's work efforts, focusing on verifying adequate outreach to families to ensure they are aware of the available program or service, and discussing strategies to enhance care coordination efforts.

Lastly, Title V staff will attend and provide educational opportunities for families regarding the importance and functions of a medical home. These opportunities include (1) participating on planning committees and/or presenting at various conferences that families frequently attend. One example includes the Power Up Your Voice Conference, which is a conference for individuals with disabilities and advocates filled with inspiring talks, interactive workshops, and networking opportunities; (2) partnering with Family Voices of North Dakota (FVND) to present at one of their Extended Learning calls regarding medical home. These educational calls are available to any interested family or provider and are highly promoted by FVND, and (3) provide education on the medical home model to the Family Advisory Council (FAC) for feedback and strategies on how to improve the system of care for children and CSHCN.

Title V staff also recognize the importance of providing education and outreach to providers to implement and enhance medical home activities within their practice and across the system of care. Title V staff will provide funding specifically for medical home-related projects or initiatives. Requests for Proposals (RFPs) will be created that will include new requirements for grantees to incorporate medical home components into their projects. Additionally, staff will identify and promote evidence-based tools and resources that enhance family-centered care, such as shared decision-making and care that is comprehensive, coordinated, and accessible. These resources include vetted tools from the National Resource Center for Patient/Family-Centered Medical Home (https://www.aap.org/en/practice-management/medical-home) that will be housed on the NDDHHS website and promoted through various mechanisms (e.g., social media posts, press releases, listservs, training networks, etc.).

Finally, Title V staff will attend and provide educational opportunities specifically geared towards providers that will encourage the implementation of medical home functions within their practices. These opportunities include (1) presenting at various conferences that providers attend for continuing education. One example includes the annual Dakota Conference on Rural and Public Health, which is a conference that provides opportunities to share strategies for building and sustaining healthy communities in North Dakota, (2) partnering with the University of North Dakota Medical School, to educate and advocate for medical home utilization by new physicians, and (3) facilitate dialogue on the components of the medical home model with the Medical Advisory Council (MAC) for feedback and strategies on how to increase buy-in by providers for medical home expansion.

Engaging family and community partners is essential when working towards improving the system of care for CSHCN. First, it is recognized that family-led support organizations play a key role in providing information to

families and partners regarding important topics such as medical home. SHS has a strong partnership with several family-led organizations that provide leadership, support, and advocacy for families. Four prominent organizations include FVND, Pathfinder Services of North Dakota, the Federation of Families, and Designer Genes. Other organizations in the state also actively provide support to target populations such as families in the early intervention system and individuals with down syndrome, autism, or hearing loss. In addition, SHS plans to ensure continued engagement and representation of families and family support organizations on various workgroups and advisory boards, including the Newborn Screening Advisory Council, the SHS FAC, and the SHS MAC. Members of the FAC were actively engaged and participated in the development of the CSHCN Action Plan, where they provided valuable input and feedback.

The upcoming North Dakota priorities and activities align with family and child well-being and quality of life, access to services, and financing of services.

First, providing families with the opportunity to live their healthiest lives will be highlighted in various programs and services by promoting health care access for all children, including CSHCN. Translation services will be available to all children participating in a SHS service or program to mitigate language barriers. Furthermore, travel assistance for families traveling long distances to certain multidisciplinary clinics may be provided through a contract with a health care organization. Various multidisciplinary clinics, such as clinics for asthma, autism, metabolic disorders, cleft lip and palate, and neurodevelopmental concerns, will be offered to children free of charge. The multidisciplinary format is beneficial as it reduces the number of individual appointments a child needs to attend and improves care coordination and communication among the team and family. In addition, to better engage families and verify that the work being done around CSHCN is valuable, family participation on the FAC is expected to continue. The application for interested families that want to join the Council is available online on the SHS website to ensure all families have the opportunity to join.

Next, family and child well-being and quality of life activities will be addressed through various strategies. First, as mentioned above, SHS coordinates the FAC, where families of CSHCN are equal partners and aid in decision-making and strategic planning for Title V work efforts. Next, strong partnerships with family support organizations will continue. SHS supports and helps to promote various FVND events, including the Leadership Institute for families, Extended Learning calls, and their Family-to-Family support network.

Ensuring CSHCN and their families have access to services is essential for optimal health and well-being. Key medical home efforts, such as care coordination, play a significant role in the work being done in Title V. Staff foster strong working relationships with numerous state and local programs to ensure access to services is not a barrier for families with CSHCN. Referral systems are in place to verify that children are accessing all programs and services they qualify for. Common referrals for CSHCN include Early Intervention, Right Track, North Dakota Medicaid, FVND, North Dakota Association for the Disabled, and the Newborn Screening Long-Term Follow-Up program. Furthermore, Title V will continue funding multidisciplinary clinics across the state to fill gaps in care and ensure CSHCN are being closely monitored and receiving all necessary treatments.

Lastly, financing of services will be incorporated into North Dakota’s strategies. SHS has a Financial Coverage program for CSHCN that acts as a payer of last resort for eligible children across the state to help pay for medical expenses. This program will continue to be offered and routinely evaluated for effectiveness. Furthermore, Title V staff and the SHS Medical Director, a local pediatrician, will attend North Dakota Medicaid Medical Advisory meetings to discuss potential changes to North Dakota Medicaid based on the current needs of CSHCN. As previously stated, care coordination by Title V staff will also continue, including dual-eligible children to ensure they have adequate insurance coverage. Lastly, providing resources and making referrals to families regarding insurance coverage will continue, such as through the SHS Health Care Coverage Options Resource Booklet that is available on the SHS website (https://www.hhs.nd.gov/health/children/special-health-services), as well as referrals to Early Intervention and North Dakota Medicaid.

In summary, North Dakota plans to continue advancing the system of care for CSHCN and their families. SHS acknowledges the importance of medical homes and will strive to expand the education, knowledge, and resources offered in North Dakota to improve access to medical homes and the CSHCN care delivery system. It will be essential to initiate and promote collaboration among stakeholders, including, but not limited to, health care providers, state professionals, and youth and their families. North Dakota strives to ensure all residents have what

they need for their child, so they can enjoy a full life, thrive in their community, and grow to become healthy adults.

**Cross-Cutting/Systems Building**

**State Performance Measures**

**SPM 1 - Vision Zero--Eliminate fatalities and serious injuries caused by motor vehicle crashes**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | | | | | |

**Evidence-Based or –Informed Strategy Measures**

None

**SPM 2 - North Dakota State Mandates--Implement North Dakota state mandates delegated to North Dakota Department of Health and Human Services' Title V / Maternal and Child Health Program.**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | Yes | Yes | Yes | Yes | Yes |
| Annual Indicator | Yes | Yes | Yes | Yes | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | ND Century Code, ND Administrative Rules | ND Century Code, ND Administrative Rules | The North Dakota Century Code, North Dakota Admini | The North Dakota Century Code | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | | | | | |

**Evidence-Based or –Informed Strategy Measures**

None

**State Action Plan Table**

| State Action Plan Table (North Dakota) - Cross-Cutting/Systems Building - Entry 1 | |
|---|---|
| **Priority Need** | |
| Vision Zero: Eliminate fatalities and serious injuries caused by motor vehicle crashes | |
| **SPM** | |
| SPM 1 - Vision Zero--Eliminate fatalities and serious injuries caused by motor vehicle crashes | |
| **Five-Year Objectives** | |
| By September 30, 2030, Title V staff will increase partnerships with other programs to develop and implement a plan focused on teen drivers and vehicle occupant safety to support Vision Zero in achieving its goal of reducing fatalities to 75 or less by 2030. | |
| By September 30, 2030, Title V staff, in collaboration with partners, will implement at least 80% of the recommendations identified from the North Dakota Occupant Protection Program Assessment created in 2025. | |
| **Strategies** | |
| Staff will partner with the North Dakota Department of Transportation (ND DOT) and Vision Zero Coordinators on various projects and initiatives focused on young drivers/occupants. | |
| Title V Staff will identify a project to supplement through committee member networking. | |
| Title V staff will work to develop and implement strategies to enhance child passenger safety programming focusing on: childcare providers, foster care providers, and grandparents. | |
| Adopt statewide use of the National Digital Car Seat Check Form (NDCF) for all certified Child Passenger Safety Technicians to improve data collection and analysis to be used to drive outreach and messaging. | |
| Increase law enforcement officer's confidence and better prepare them for the identification of proper use of child restraints during enforcement stops. | |
| Implement the use of standardized child passenger safety materials to train all new and current law enforcement officers. | |
| Enhance the child passenger safety website. | |
| **ESMs** | **Status** |
| No ESMs were created by the State. ESMs are optional for this measure. | |

## State Action Plan Table (North Dakota) - Cross-Cutting/Systems Building - Entry 2

### Priority Need

State Mandates: Implement North Dakota State Mandates for the Maternal and Child Health Population

### SPM

SPM 2 - North Dakota State Mandates--Implement North Dakota state mandates delegated to North Dakota Department of Health and Human Services' Title V / Maternal and Child Health Program.

### Five-Year Objectives

Implementation of state mandates relating to Title V/Maternal and Child Health.

### Strategies

| |
|---|
| Implement North Dakota State Mandate regarding Title 23 Health and Safety – Chapter 23-01 Health Division. |
| Implement North Dakota State Mandate N.D.C.C. Chapter 50-25.1-15 Abandoned Infant. |
| Implement North Dakota State Mandates regarding Abortion: 1. Abortion Control Act: N.D.C.C. Chapter 14-02.1-02.1 and Chapter 14-01-03.4 2. Limitation of Abortion: N.D.C.C. Chapter 14-02.3-01 and N.D.C.C. Chapter 14-02.3-02 3. Abortion Referrals: N.D.C.C. Chapter 15.1-19-06 – Students and Safety |
| Implement North Dakota State Mandate regarding Umbilical Cord Blood: 1. N.D.C.C Chapter 23-45 Umbilical Cord Blood Disposition 2. N.D.C.C Chapter 23-16-15 Umbilical Cord Blood Donation |
| Implement North Dakota State Mandates relating to Children with Special Health Care Needs: 1. N.D.C.C Chapter 23-01-34 Children with Special Health Care Needs 2. N.D.C.C Chapter 23-41-01 through 23-41-07 – Children with Special Health Care Needs |
| Implement North Dakota State Mandates relating to Newborn Screening: 1. N.D.C.C Chapter 23-01-03.1 – Newborn metabolic and genetic disease screening tests 2. N.D.C.C Chapter 25-17 Testing and Treatment of Newborns 3. N.D.C.C Chapter 33-06-16 Newborn Screening program |

| ESMs | Status |
|---|---|

No ESMs were created by the State. ESMs are optional for this measure.

## State Action Plan Table (North Dakota) - Cross-Cutting/Systems Building - Entry 3

### Priority Need

Access to Services: Improve access to health-related services to improve the health and well-being of the MCH population

### SPM

SPM 3 - Access to Services--Improve access to health-related services to improve the health and well-being of the MCH population

### Five-Year Objectives

By September 30, 2030, Title V will improve collaboration with North Dakota Medicaid to increase access to services for high-risk populations.

By September 30, 2030, Title V will expand access to essential healthcare services through partnerships.

### Strategies

Identify ways to increase access to Medicaid-eligible health services for infants in the first 15 months of life.

Title V staff will participate on various collaboratives, coalitions, and boards that work towards addressing priorities within the State Health Implementation Plan (SHIP).

Work with Tribal populations to address healthcare access issues.

| ESMs | Status |
|---|---|

No ESMs were created by the State. ESMs are optional for this measure.

**2021-2025: State Performance Measures**

**2021-2025: SPM 1 - Vision Zero – Eliminate fatalities and serious injuries caused by motor vehicle crashes.- By 2025, Increase the number of car seat checkups offered by the NDDoH for North Dakotans from 69 to 100.**

| **Measure Status:** | **Active** | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | | 70 | 72 | 76 |
| Annual Indicator | 50 | 63 | 68 | 85 | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | The North Dakota Department of Health (NDDOH) and | The North Dakota Department of Health (NDDOH) and | The North Dakota Department of Health and Human S | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

**2021-2025: SPM 3 - Maternal and Child Health (MCH) Workforce Development-The number of individuals enrolled in the Maternal and Child Health (MCH) Certificate Program.**

| Measure Status: | Active | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 45 | 10 | 15 | 20 |
| Annual Indicator | 35 | 4 | 4 | 14 | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | The North Dakota Department of Health. | The North Dakota Department of Health. | The North Dakota Department | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

**MCH Population Domain: Crosscutting**

**SPM: Vision Zero: Eliminate fatalities and serious injuries caused by motor vehicle crashes**

**North Dakota Priority Goal: To reduce annual motor vehicle crash fatalities to fewer than 75 by 2025.**

**FY2024 Annual Report Narrative (October 1, 2023-September 30, 2024)**

Motor vehicle crashes represent a significant public health concern across the United States, particularly in North Dakota, where they rank among the leading causes of childhood fatalities. Importantly, these incidents are largely preventable, and the implementation of effective strategies can significantly reduce both fatalities and severe injuries.

According to the North Dakota Department of Transportation (NDDOT), the fatality rate for children under 18 years of age was 3.6 per 100,000 (slightly higher than the 3.5 rate recorded from 2018 to 2022). Additionally, 254 per 100,000 children were injured in vehicle crashes between 2019 and 2023, a decrease from 268 in the previous period. The severity of injuries sustained, as categorized by law enforcement crash reports, is as follows:

- Suspected serious injuries: 17 per 100,000 population (consistent with the rate of 17 from 2018-2022).
- Suspected minor injuries: 137 per 100,000 population (an increase from 126 in 2018-2022).
- Possible injuries: 100 per 100,000 population (a decrease from 125 in 2018-2022).

When analyzing the death and injury statistics by age group for the years 2019-2023, the data reveals:

- Children aged 0-13 experienced a death rate of 1.4 per 100,000 (down from 1.5 in 2018-2022) and an injury rate of 101 per 100,000 (down from 113 in 2018-2022).
- Adolescents aged 14-17 had a death rate of 2.2 per 100,000 (up from 2 in 2018-2022) and an injury rate of 153 per 100,000 (down from 155 in 2018-2022).

In response to these alarming statistics, the NDDOT, in collaboration with the North Dakota Department of Health and Human Services (NDDHHS) and the North Dakota Highway Patrol (NDHP), has launched Vision Zero as the state's primary traffic safety initiative. This comprehensive, multi-agency effort aims to eliminate motor vehicle fatalities and serious injuries on North Dakota roads. The Child Passenger Safety (CPS) program within the Public Health Division of NDDHHS plays a crucial role in this initiative and is integrated into the Vision Zero strategic plan.

The CPS program is tasked with coordinating statewide passenger safety initiatives designed to reduce injuries and fatalities among children involved in motor vehicle crashes. A significant aspect of this program includes offering the *National Child Passenger Safety Technician Certification Training*, which certifies professionals in child passenger safety for a two-year period. These certified professionals are essential for delivering high-quality child passenger safety outreach, conducting best practice presentations for local professionals and caregivers, and providing car seat checkups to assorted populations across the state. In 2024, the CPS program successfully supported and conducted five certification trainings, resulting in the certification of 62 professionals. Currently, North Dakota has 263 certified CPS Technicians, 12 CPS instructors, and 21 CPS proxies. One of the program's activity goals for this period was to certify at least 10 law enforcement personnel. The program successfully certified 9 law enforcement officers this year.

To maintain their certification, CPS Technicians must be observed by a qualified CPS instructor or a proxy during car seat checkups. A proxy can recertify CPS Technicians, but they do not teach the certification curriculum. However, the rural landscape of North Dakota presents challenges in accessing the limited number of CPS instructors and proxies available for recertification. A key goal of the program has been to enhance the retention of CPS Technicians by increasing the number of CPS proxies and instructors within the state. Over this period, the number of proxies has risen from 15 to 21, while the number of instructors has decreased from 18 to 12.

To support CPS Technicians in maintaining their certification and to enhance their knowledge of CPS technologies, a state CPS Workshop was conducted in July. This workshop achieved a record attendance of 80 CPS Technicians,

all of whom received Continuing Education Units (CEUs) for recertification. The workshop sessions covered a variety of relevant topics, including:

- Child Restraint Manufacturers Panel and Hands-On Demonstrations
- LATCH Learning with Peachy, the 2023 LATCH Manual
- You Spin Me Right Round Baby, Right Round
- Navigating Car Seat and Vehicle Interactions
- Scenarios from the Field: Applying Good, Better, Best
- Hot Topics in Child Restraint Installations

In addition to the presentation sessions, two car seat manufacturers attended the training to provide product exhibits, allowing CPS Technicians to explore new products and engage in discussions with company representatives. Furthermore, CPS enrichment courses were offered, including the *National CPS Bus Safety Training*, which consisted of three sessions—one specifically for CPS Technicians and two tailored for school transportation personnel.

Efforts are underway to integrate the *CPS Bus* training within the North Dakota Department of Public Instruction (DPI). However, there has been low interest from local school transportation personnel in participating in these trainings. To address this challenge, staff are seeking DPI's guidance and support to incorporate this training into transportation infrastructure of the department.

While the goal of establishing a CPS-certified position within the department's Emergency Medical Services for Children has not yet been achieved, work is ongoing in this area. The objective is to train personnel who can subsequently provide CPS emergency transport training to EMS personnel in the field. In the interim, Safe Kids Grand Forks is filling this training gap by offering a one-hour virtual training session for EMS personnel, which provides essential training on CPS. In addition, a *Special Needs Car Seat* training occurred in the fall of 2024 in Jamestown, North Dakota.

CPS training sessions aimed at law enforcement personnel continue to be offered through law enforcement academies across North Dakota. Six training sessions have been conducted at academies in Bismarck, Devils Lake, West Fargo, and Grand Forks. Additionally, arrangements have been made with the North Dakota Peace Officer Standards and Training (POST) Board to provide 90-minute interactive virtual training sessions (facilitated via the National CPS Board) for current law enforcement professionals. Participants who complete this training will also receive POST credits.

Next, efforts are underway to enhance CPS communications with birthing hospitals, leading to the establishment of new partnerships with facilities in communities where the CPS class *Baby's First Ride* (BFR) is taught. Collaborations with St. Alexius in Bismarck, Dickinson, Williston, and Devils Lake to develop a standardized flyer template that each location will utilize to promote the *BFR* program to expecting parents in these communities. The Williston site took the initiative to create this fillable template for all four locations, which is expected to facilitate greater promotion of this vital training by the hospitals.

During the COVID-19 pandemic, hospitals requested that *BFR* classes be conducted outside their facilities, resulting in the classes being held at various alternative locations. This year, state Title V staff sought the hospitals' support to reinstate *BFR* classes within their premises, and are pleased to report that they have approved this request. Consequently, all classes conducted by St. Alexius are now supported in the hospital training rooms, with the goal of increasing attendance at these trainings.

In addition to expanding *BFR* classes, staff aimed to enhance CPS resources for hospital staff to enable them to receive and disseminate CPS best practices while working with patients. To achieve this, the program collaborated with the North Dakota instructor who specializes in special needs from Sanford Health to offer a webinar focused on the car seat challenge test for premature infants, as well as general CPS practices. The webinar was well-received, attracting 67 healthcare providers. Furthermore, the session was recorded and made available to those who were unable to attend.

In 2023-2024, the program leveraged funding from the NDDOT to support seven individuals and organizations in conducting car seat checkups, recertifying CPS Technicians, entering checkup data, and providing CPS outreach to the public within their designated regions. With instructors and proxies on staff, these agencies established a robust infrastructure to assist in maintaining certifications for all CPS Technicians within their counties.

Outreach activities included the distribution of CPS best practices, CPS law flyers, and other CPS educational materials, all of which are available through the CPS program's online order form (https://www.hhs.nd.gov/health/prevention-healthy-living/child-passenger-safety/materials). In addition to the seven regional organizations operating throughout North Dakota, CPS educational materials have been made available year-round to organizations that work with caregivers responsible for transporting young children.

As part of the five-year action plan, the program set a goal to conduct an average of 100 car seat checkups over five years, with a baseline of 69 checkups established. The five-year average for 2023-2024 was 70 (up from 69 previously). To promote public awareness of car seat checkups and fitting stations across the state, the program continues to utilize an online CPS resource featuring geographic information system (GIS) maps. To view the resource, visit https://www.hhs.nd.gov/health/prevention-healthy-living/child-passenger-safety/assistance/events. These maps are regularly updated and promoted through social media channels and local stakeholders. Additional GIS maps detailing car seat distribution programs and hospital car seat classes can also be accessed through this link as well.

To enhance public attendance and awareness of car seat checkups, as well as to drive traffic to the CPS program website, the program partnered with Odney Advertising to develop a targeted social media campaign. Odney designed the campaign artwork and managed social media postings from May through September, coinciding with the peak car seat checkup season. The campaign's messaging encouraged caregivers to seek assistance with their car seats, emphasizing the importance of proper usage. Additionally, caregivers were directed to the CPS website to locate community resources for assistance and to learn about CPS best practices.

While the campaign successfully increased traffic to the CPS program website, it did not result in a significant rise in attendance at rural car seat checkups. During the car seat checkups sponsored by the NDDHHS this year, a total of 715 car seats were checked for safety, compared to 722 in the previous year. Furthermore, approximately 220 CPS Technicians received mentorship and recertification opportunities through collaborations with contractors and stakeholders during these NDDHHS-sponsored checkups.

A major program goal is to increase the five-year average of car seats checked during NDDHHS-sponsored checkups across the state. The established baseline for this goal was 747 (the 5-year average), with a target goal set at 772 (5-year average). Since the onset of the pandemic in 2020, there has been a noticeable upward trend in the number of car seats checked annually through the program. However, the five-year average reflects the following declines:

| Year | Actual Seats Checked | 5-Year Average |
|---|---|---|
| 2016 | 635 | |
| 2017 | 852 | |
| 2018 | 901 | |
| 2019 | 892 | |
| 2020 | 458 | 2016-2020 747 Baseline |
| 2021 | 555 | 2017-2021 731 |
| 2022 | 692 | 2018-2022 699 |
| 2023 | 722 | 2019-2023 663 |
| 2024 | 715 | 2020-2024 628 |

To ensure that all caregivers have access to car seats for their children, the CPS program continued to coordinate car seat distribution initiatives across most counties in North Dakota. Funded by the NDDOT, these programs provided car seats specifically to low-income populations. During this period, approximately 469 child restraints were distributed. Currently, North Dakota has approximately 30 Car Seat Distribution programs statewide. For more information, please refer to the North Dakota Distribution program location map at https://www.hhs.nd.gov/health/prevention-healthy-living/child-passenger-safety/assistance/locations.

Efforts to expand the Tribal Car Seat Distribution programs from three to four locations have faced challenges due to changes in staff positions. Each program is required to have a certified CPS technician on staff; however, only two out of the four programs currently meet this requirement. Plans are being developed to increase the number of trained staff and to reinstate the programs.

To promote National CPS Week in North Dakota, the program utilized MCH funding to contract with Odney Advertising in promoting a public service announcement (PSA) featuring a compelling story. This PSA highlighted a North Dakota family of seven who survived a vehicle rollover in 2023, attributing their survival to the fact that all family members, including five children, were properly buckled at the time of the incident. Given the opportunity to showcase this positive example of seatbelt use, the program opted to allocate funding towards promoting this success story rather than reusing promotional materials from the previous year, as originally planned. For the annual CPS Week promotions, the program did the following to publicize CPS best practices:

First, for the annual CPS Week promotions, the program implemented several initiatives to publicize CPS best practices. A news release was developed and disseminated statewide in collaboration with the NDHP, the North Dakota Safety Council, and the NDDOT. The release detailed the Bitzan family's survival story and invited media representatives to attend a "Saved by the Belt" award ceremony that the family received from the NDHP.

Next, the program further engaged Odney Advertising to produce the Bitzan PSA, which was disseminated through social media, radio, and television for a two-week period in September, coinciding with National CPS Week and the subsequent week. The video is available for viewing on the CPS website at https://www.hhs.nd.gov/health/prevention-healthy-living/child-passenger-safety.

In summary, effective outreach for CPS is crucial, as many fatalities resulting from motor vehicle crashes are preventable. Consistently securing children in age-and size-appropriate car seats, booster seats, and seat belts can reduce the risk of serious injuries and fatalities by up to 80%.

**MCH Population Domain: Crosscutting**

**SPM: State Mandates: Implement North Dakota State Mandates for the Maternal and Child Health Population**

**North Dakota Priority Goal: To implement all North Dakota state mandates delegated to the North Dakota Department of Health Title V/Maternal and Child Health Programs.**

**FY2024 Annual Report Narrative (October 1, 2023-September 30, 2024)**

Responsibilities of the North Dakota Department of Health and Human Services (NDDHHS) are addressed in North Dakota Century Code (N.D.C.C.), Chapter 23-01 Health Division. The State Health Officer (SHO) of the NDDHHS is responsible for the administration of programs carried out with allotments made to the state by Title V. The NDDHHS functions in compliance with Chapter 28-32, Administrative Agencies Practice Act, N.D.C.C.

Priorities are often influenced by state mandates, which in turn, are generally reflective of expressed need within the state over time. Inclusion of these mandates epitomizes the successful federal-state partnership by honoring a state’s unique priorities. Focus areas funded by the federal-state Title V Maternal and Child Health (MCH) Block Grant include: Children with Special Health Care Needs (CSHCN), child/teen passenger safety, injury/violence prevention, newborn screening (NBS), MCH epidemiology, maternal and reproductive health, obesity prevention,

nutrition, breastfeeding, school health/nursing and infant and child death services (sudden infant death syndrome).

North Dakota has several mandates addressing the health of the MCH population that direct Title V work efforts and require use of significant resources for successful implementation. A complete listing of the mandates can be found in Section V., Supporting Documents, Title V-MCH State Mandates and are discussed below.

**Abandoned Infant State Mandate**

N.D.C.C 50-25.1-15 allows a parent or a parent's agent (another person acting with the parent's consent) who feels they are unable to take care of their infant, to surrender the infant without facing prosecution for abandonment. To be protected by the Baby Safe Haven Law, the child must be unharmed, under one year of age, and surrendered to an on-duty staff person working for a Baby Safe Haven approved location. An MCH Public Health Specialist at NDDHHS developed and implemented a public awareness campaign that provided information, public service announcements, and educational materials regarding the state's Safe Haven Law to the public, including medical providers, law enforcement, and social service agencies as outlined in N.D.C.C. 50-25. 1-15. During the public awareness campaign, a video was created to educate viewers about the North Dakota Baby Safe Haven Law which received 882,792 impressions on social media and digital networks. The campaign also utilized a video which received 173,687 impressions and 120,278 online video completions. There have been 2,014 professionals from approved Safe Haven locations that completed the North Dakota Baby Safe training that was created with 648 of those within this reporting timeframe. For additional information visit the resource page at https://www.hhs.nd.gov/cfs/safe-haven and the Baby Safe Haven training at: https://babysafehaven.pcand.org/.

**Abortion State Mandates**

Alternatives to Abortion Program, North Dakota Century Code (N.D.C.C) Chapter 50-06-26. During the 2023 legislative session, funding for the Alternatives to Abortion (A2A) Program was increased from $600,000 to $1,000,000 per biennium and expanded services from assisting pregnant women and women who believe they may be pregnant, to also include parents or other relatives caring for children twelve months of age or younger.

The Human Services Division of the NDDHHS had historically administered the A2A Program. To align services more effectively, NDDHHS executive leadership made the decision to move the A2A Program to the Public Health Division. Funded through state funds and the Title V grant, a Maternal Health Specialist position was hired to transition and manage the program.

Abortion Control Act, N.D.C.C. Chapter 14-02.1, Section 14-02.1-02.1, Printed Information – Referral Service. To meet the requirements of this law, the Public Health Division of the NDDHHS developed the Information About Pregnancy and Abortion booklet. This publication consists of objective information on specific topics to include: information and resources on various agencies and services available to assist a pregnant woman through pregnancy; anatomical information along with colored photos of development of the unborn child at two-week gestational increments; information regarding the obligations of the father; and materials that describe various surgical and drug-induced methods of abortion as well as any risk factors associated with those methods. In addition to the required information, content was also added on the harmful efforts of tobacco use during and after pregnancy. The booklet can be found at:
https://www.hhs.nd.gov/sites/www/files/documents/DOH%20Legacy/Information_About_Pregnancy_and_Abortion.pd

During the 2023 North Dakota legislative session, language was included in the NDDHHS appropriation bill, Senate Bill 2012, that required the development and maintenance of a website that provides information and links to social services, financial assistance, adoption services, pregnancy and parenting information, planning guidance, care centers and agencies, and other available public and private resources for expectant families and new parents. The website was developed and operational by August 1, 2023. Several MCH staff were involved in the content development of the website. In September 2024, a media campaign was launched to enhance promotion and raise awareness of the website and its valuable resources. The website can be found at: https://www.life.nd.gov/.

**Umbilical Cord Blood Mandates**

N.D.C.C. Chapter 23-45, Umbilical Cord Blood Disposition, Section 23-45-02. Umbilical cord blood - Information pamphlet – Distribution, requires the NDDHHS to prepare a pamphlet that includes information on medical processes involved in the collection of umbilical cord blood; any risks of cord blood collection for both mother and baby; the current and potential future uses for the collected cord blood; the cost of cord blood donation; and options for ownership and future use of the donated material. The pamphlet must be available on the NDDHHS website and be distributed upon request at no charge. The NDDHHS elected to use and disseminate the pamphlet from the Cord Blood Registry titled Parent's Guide to Cord Blood Banking. This pamphlet is free to patients, hospitals and other entities that choose to utilize the information. The Title V grant supports the costs associated with these unfunded, state mandates and the Maternal Health Specialist has been assigned responsibility for both activities.

**Children with Special Health Care Needs Mandates**

Several mandates in N.D.C.C. address Title V children with special health care needs (CSHCN)-related responsibilities within the NDDHHS. Chapter 23-01-34 includes program administration for CSHCN, including the provision of services and assistance to CSHCN and their families and the development and operation of clinics for the identification, screening, referral, and treatment of CSHCN. Chapter 23-01-41 requires the establishment and administration of an autism spectrum disorder database. Chapter 23-41 mandates administrative duties of state and county agencies, confidential birth reports for newborns with visible congenital deformities, and services for individuals with Russell Silver Syndrome. Chapter 25-17-03 mandates treatment for individuals with phenylketonuria or maple syrup urine disease through the provision of medical food and low-protein modified food products.

N.D.C.C. Chapters 23-01-03.1 and 25-17 mandates the North Dakota Newborn Screening and Follow-up Program. Newborn screening is performed shortly after birth to identify newborns that may have a potentially life-threatening condition that could cause serious illness, disability or death if not identified and treated early. The national Advisory Committee on Heritable Disorders in Newborn and Children (ACHDNC) provides recommendations to state newborn screening programs which disorders should be included on their state panel. The disorders included in the recommendations supported by ACHDNC are known as the Recommended Uniform Screening Panel (RUSP). Currently, North Dakota screens for 34 of the 38 core conditions that are included on the RUSP, with the most recent conditions Pompe Disease and Mucopolysaccharidosis Type I (MPS I) added effective January 1, 2024. As new conditions are added to the RUSP, the North Dakota Newborn Screening Advisory Committee will review them and determine the feasibility of adding them to the state screening panel. The SHO is the approving authority to add new conditions to the state newborn screening panel. The feasibility of screening is dependent on several factors that may include the program's readiness to:

1) approve the screening
2) conduct laboratory testing
3) conduct short and long-term follow-up
4) provide information technology support
5) access a medical specialist specific to the disorder
6) educate providers and community, and
7) fully implement statewide newborn screening

The screening and follow-up of newborns is performed in collaboration with the University of Iowa State Hygienic Laboratory and the University of Iowa Hospitals and Clinics, as well as Special Health Services (SHS). Intermediate and long-term follow up after NBS has primarily been addressed in SHS by:

- providing follow-up contacts, resource information and care coordination for children with abnormal newborn screening results.
- providing financial support for metabolic disorder clinics that result in coordinated disease management.
- providing no-cost or at-cost medical food and care coordination for newborns and individuals with phenylketonuria (PKU) and maple syrup urine disease (MSUD).
- providing diagnostic and treatment services for children birth to age 21 who meet medical and financial eligibility criteria.

Along with the follow-up calls for babies with abnormal newborn screening results, SHS assists families with referrals for services, care coordination, and support. Information is provided regarding the SHS diagnostic and treatment program as well as other state-wide resources (e.g., WIC, North Dakota Medicaid, Early Intervention) to assist the

family in meeting their needs, and to provide them support and direction during a time that can be very stressful and overwhelming. After a diagnosis is confirmed, the baby enters the Long-Term Follow-Up (LTFU) program through six years of age. Within a few weeks after the diagnosis is made, the family is contacted on a quarterly basis for the first year of their baby's life and annually thereafter to ensure the baby is healthy and to see if the family is having any difficulties with things such as insurance coverage, transportation, and medication. Since the inception of the LTFU program for newborn screening in January of 2019 through September of 2024, 112 of 140 (80%) children identified with a condition through the screening process have been served. Reasons for not receiving services include: 1) out-of-state residents, 2) unable to contact after three attempts, 3) the family is not interested in receiving services, and 4) the family moved out of state after the screening was completed. Financial eligibility for SHS diagnostic and treatment services is legislatively mandated at 185% of the federal poverty level.

North Dakota is a 209(b) state, which means that Supplemental Security Income (SSI) beneficiaries under 16 years of age are not automatically eligible for North Dakota Medicaid. If assets are an issue affecting North Dakota Medicaid eligibility, children eligible for SSI can be covered under the children and family coverage groups where asset testing is not required. The state CSHCN program pays for or provides rehabilitative services for eligible children that are served by Title V to the extent services are not provided by North Dakota Medicaid. State CSHCN program staff conduct outreach, information and referral activities targeted to the SSI population. On a monthly basis, Disability Determination Services provides referrals electronically to the state CSHCN program. In response, state CSHCN staff provide a direct mailing to families notifying them about potential programs that could be of assistance. In State Fiscal Year 2024, state CSHCN staff provided outreach to 144 families that applied for SSI. This assures that children are consistently being referred to the Title V program and that families receive information about program benefits and needed services.

Federally, the MCH Block Grant enables the state to address the following on behalf of children with special health care needs and their families: 1) to provide and promote family-centered, community-based, coordinated care (including care coordination services) for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families, and 2) to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI, to the extent medical assistance for such services is not provided under Title XIX.

The Title V and CSHCN Directors assure compliance with these state mandates and oversee staff assigned to carry out the roles and responsibilities related to the mandates. Title V staff share program accomplishments and challenges at bi-monthly Title V meetings, which serve as an avenue for program updates, sharing, and collaboration.

**MCH Population Domain: Crosscutting**

**SPM: Maternal and Child Health (MCH) Workforce Development**

**North Dakota Priority Goal: To support workforce development for State Title V program leaders and staff to meet current public health MCH policy and programmatic imperatives around health transformation, including ongoing transformation of the Title V Block Grant.**

**FY2024 Annual Report Narrative (October 1, 2023-September 30, 2024)**

The North Dakota Department of Health and Human Services (NDDHHS) recognizes that a well-trained maternal and child health (MCH) workforce is the first line of defense to prevent disease, protect health, and keep the MCH population safe. State Title V staff have always had the ability to avail themselves of various professional development opportunities to build their capacity as part of the MCH workforce. State staff have many strengths, including passion, dedication, and knowledge to ensure families receive high-quality services; strong interpersonal abilities required for partnership building, collaboration, and integration; and the capability to manage multiple priorities. To address specific training needs, state Title V staff have developed career aspirations and professional development goals that identify training opportunities to enhance needed knowledge and skills as part of their annual performance review process.

The MCH Navigator online self-assessment was administered to state Title V staff in December 2019. This self-assessment provided an opportunity for professionals to reflect on competency-based strengths and areas of needed growth to identify learning gaps and reinforce new skills that could improve performance. A North Dakota Workforce Snapshot was provided by MCH Navigator that supplied information regarding North Dakota's MCH workforce composition and learning needs. In line with national data trends, North Dakota MCH staff had cultural competency as the largest gap in knowledge and skills, along with family-professional partnerships. Also consistent with national data trends, policy had the lowest knowledge and skills scores across competencies. In May 2024 the MCH Director re-initiated conversations with the MCH Workforce Development Center, who was working on revising the MCH Navigator's online self-assessment. This assessment will be administered to North Dakota MCH team members by the end of calendar year 2024 to once again provide a snapshot of how the North Dakota team has evolved in their knowledge and skills in the 12 MCH leadership competencies over the last five years.

Since May 2021, collaboration has occurred between the state's MCH program and the North Dakota State University (NDSU) Department of Public Health (DPH) to enhance the knowledge and skills of the current MCH workforce, build workforce capacity, and facilitate collaboration across the academic and practice communities. This partnership has been providing much-needed support to address NDDHHS – and statewide – MCH leadership's key concerns regarding the low percentage of MCH staff with formal public health training, low levels of preparedness to meet local and state MCH needs, limited access to expertise for quality community-based or applied public health research, and the need for MCH innovation among public health professionals in academic and practice environments. In August 2022, NDSU DPH successfully developed and implemented an eight-credit MCH Certification program. This program was geared to build MCH workforce and innovation capacity. Credits from this MCH Certification program could also be applied to a Master of Public Health (MPH) degree. In December 2023, the decision was made to initiate a new contract offering additional learning opportunities for staff to further their learning outside of college-level courses. Examples of such learning would be webinars or in-person training. The MCH curriculum has continued to be offered, and staff are encouraged to participate if able.

In addition to the MCH curriculum, NDDHHS also partnered with NDSU to create a four-part Lunch and Learn Series highlighting content that team members expressed a desire to learn more about. These opportunities were shared with internal and external staff and partners and averaged approximately 40-50 participants per session. Continuing education units (CEUs) were offered by the North Dakota Board of Nursing and the North Dakota Board of Social Work Examiners.

NDDHHS also has a tuition reimbursement policy that may pay up to 80% of tuition and fees, depending upon budget. The college course must be directly job-related and have a stated public health purpose or benefit. This policy makes it more attainable for staff to consider enrolling in the program and advancing their learning and education. In addition to supporting state MCH staff to enroll in the MCH Certificate program, the program has continued to be promoted statewide.

Over the past year, the Title V leadership team expanded collaborative efforts around workforce development to other partners at the state and national levels. A series of meetings throughout the summer of 2024 led to a new contract being drafted with the University of North Dakota's Department of Population Health to explore employing or contracting with a graduate-level student with expertise in minority populations to assist with MCH work efforts. Particular emphasis is being placed on improving access to care for American Indian women.

The Title V Director has been a part of the Public Health Division's workforce development workgroup that has been identifying and implementing processes to better train and educate new or existing public health team members, including MCH staff members. The workgroup met monthly and evaluated previous results of the Public Health Workforce Interests and Needs Survey (PH WINS) as well as other internal surveys taken by Public Health Leadership. These various survey results were utilized to provide quarterly trainings on various topics that also correlated with priorities identified in North Dakota's Public Health Infrastructure Grant (PHIG). This collaboration was an excellent example of braiding and layering of resources amongst the Public Health Division.

Finally, in addition to the previously mentioned professional development opportunities, state MCH staff have always been encouraged to identify and pursue state and national training or individualized opportunities for their programmatic expertise or areas of interest. By providing high-quality education and training, North Dakota has

continued to expand and strengthen a diverse, MCH-informed workforce that understands the unique challenges that North Dakota women, infants, children, children with special health care needs, and families face.

**MCH Population Domain: Crosscutting**

**SPM: Vision Zero: Eliminate fatalities and serious injuries caused by motor vehicle crashes**

**North Dakota Priority Goal: Reduce serious motor vehicle injuries and fatalities to North Dakotans younger than 21 years of age**

**FY2026 Annual Plan Narrative (October 1, 2025-September 30, 2026)**

The North Dakota Department of Health and Human Services (NDDHHS) and the North Dakota Department of Transportation (NDDOT) recognize the significant impact of motor vehicle crashes on children in North Dakota, making the reduction of serious motor vehicle injuries and fatalities to North Dakotans younger than 21 years of age a priority. Both agencies, in collaboration with the North Dakota Highway Patrol, are dedicated to implementing Vision Zero strategies aimed at preventing these incidents. North Dakota is committed to fostering a strong safety culture to reduce traffic fatalities and serious injuries. To meet the goal of this priority, Title V staff developed two overarching objectives: (1) By September 30, 2030, Title V staff will increase partnerships with other programs to develop and implement a plan focused on teen drivers and vehicle occupant safety to support Vision Zero in achieving its goal of reducing fatalities to 75 or less; and (2) By September 30, 2030, Title V staff, in collaboration with partners, will implement at least 80% of the recommendations identified from the North Dakota Occupant Protection Program Assessment created in 2025. These objectives are discussed in more detail below. For further information about Vision Zero, please visit https://visionzero.nd.gov/.

Motor vehicle crashes remain a leading cause of injury and death among children in North Dakota. According to the NDDOT from 2020 to 2024, the state recorded a death rate of 3.2 per 100,000 children under 18 years of age, with 234 injuries per 100,000 attributed to vehicle crashes during the same period. The severity of these injuries, as categorized by law enforcement crash reports, is as follows:

- Suspected serious injury: 17.6 per 100,000 population
- Suspected minor injury: 132.1 per 100,000 population
- Possible injury: 85.2 per 100,000 population

When analyzing the data by age group for the years 2020-2024:

- Children aged 0-13 experienced a death rate of 1.3 per 100,000 and an injury rate of 89 per 100,000.
- Children aged 14-17 had a fatality rate of 1.7 per 100,000 and an injury rate of 145 per 100,000.

The Governors Highway Safety Administration emphasizes that young drivers frequently engage in risky behaviors due to a lack of experience and maturity. This increases their likelihood of speeding, consuming alcohol, and neglecting to wear seat belts—factors that significantly contribute to a higher fatality rate. In North Dakota, in 2023, a crash involving a teen driver occurred every four hours, and a teen lost their life in a crash every 52 days. Although teens represent only 6% of licensed drivers, they are involved in nearly 20% of all crashes. Furthermore, drivers aged 14-19 were responsible for 6% of fatal crashes, with 45 teens having lost their lives in vehicle accidents over the past five years.

Recognizing the significant impact of motor vehicle crashes on North Dakota's youth, Title V staff are dedicated to supporting existing initiatives aimed at enhancing the safety of young drivers and vehicle occupants. To achieve priority one, efforts will focus on active participation in committees that work towards improving young driver safety. Once engaged in these committees, the objective will be to identify and explore additional strategies to reduce motor vehicle fatalities and serious injuries among young people. This will involve collaboration with partners to gather insights, provide financial support as needed, and implement solutions to address existing gaps in prevention efforts. An Evidence-Based Strategy Measure (ESM) has been established with the goal of achieving a 10% reduction in serious injuries and fatalities among teens involved in motor vehicle crashes. Additionally, Title V staff will seek to identify a project that can be supplemented through networking with committee members. Potential partners for initiating this strategy include the Young Drivers Sub-Committee, Vision Zero Coordinators, and Driver Education Teachers. Partnerships and collaboration are essential, as various stakeholders across the state engage

with youth to achieve shared outcomes in promoting safety.

Next, to achieve the second priority, Title V staff, in collaboration with their partners, will develop and implement strategies to enhance Child Passenger Safety (CPS) programming, specifically targeting childcare providers, foster care providers, and grandparents. Staff will work closely with department employees to identify the most effective approaches for training individuals responsible for transporting children, in accordance with CPS best practices. Potential partners that will be engaged in this initiative include the Foster Care program, Early Childhood, Early Head Start, the NDDOT, CPS Advisory Committee, and agencies that work closely with grandparents.

In 2025, the NDDOT partnered with the National Highway Traffic Safety Administration (NHTSA) to conduct an Occupant Protection (OP) Assessment within the state. The objective of this assessment was to provide a comprehensive review of North Dakota's statewide OP program by identifying programmatic strengths, accomplishments, challenges, and recommendations for improvement. This assessment serves as a vital tool for planning, developing, and implementing OP programs and for making informed decisions regarding the prioritization of initiatives and the optimal use of available resources. The assessment is conducted by a team of five individuals with demonstrated subject matter expertise in occupant protection. Recommendations for enhancing occupant protection for children have been proposed and will be integrated into this plan over the next five years to strengthen CPS programming. The specific recommendations that will be implemented are outlined below.

The first step will involve the statewide adoption and use of the National Digital Care Seat Check Form (NDCF) by all certified CPS Technicians. This initiative aims to enhance data collection and analysis, which will be instrumental in driving outreach and messaging efforts. By improving the quality of data collection, staff will provide reliable evidence to support future initiatives. Title V staff will conduct training on NDCF data for all North Dakota CPS Technicians. Furthermore, staff will analyze and share the findings with stakeholders and the public to ensure transparency and foster collaboration.

To enhance law enforcement officers' confidence and better prepare them for identifying the proper use of child restraints during enforcement stops, staff will develop a reference guide outlining the most common errors associated with child restraint usage. Additionally, it is crucial to utilize standardized CPS materials to train both new and current law enforcement officers. These materials will emphasize the correct use of child restraints and seat belts for children, equipping officers with the necessary knowledge for effective traffic stops and accurate completion of crash reports. The dissemination of these materials will be facilitated by coordinating CPS presentations with law enforcement academies, ensuring that officers receive comprehensive training on this critical aspect of child safety.

Lastly, enhancing the CPS website by creating a dynamic, interactive experience for the public is a key recommendation that will be initiated. In addition to the existing educational resources, updates will include the incorporation of active links to current state and local resources, as well as opportunities for programs to promote various information, upcoming activities, and events.
Given that young adults, not only in North Dakota, but across the nation, are at an increased risk of injury or death from motor vehicle crashes, it is imperative to implement effective prevention strategies aimed at reducing or preventing teen driver crashes.

**MCH Population Domain: Crosscutting**

**SPM: State Mandates: Implement North Dakota State Mandates for the Maternal and Child Health Population**

**North Dakota Priority Goal: To implement all North Dakota state mandates delegated to the North Dakota Department of Health Title V/Maternal and Child Health Programs.**

**FY2026 Annual Plan Narrative (October 1, 2025-September 30, 2026)**

Priorities are frequently shaped by state mandates, which typically reflect the evolving needs expressed within the state over time. The incorporation of these mandates exemplifies a successful federal-state partnership that honors the unique priorities of each state. North Dakota has established several mandates aimed at improving the health of

the maternal and child health (MCH) population, which guide Title V work efforts and necessitate the allocation of significant resources for effective implementation. A comprehensive list of these mandates can be found in Section V of the Supporting Documents, Title V-MCH State Mandates, and further details are discussed below.

Responsibilities of the North Dakota Department of Health and Human Services (NDDHHS) are addressed in North Dakota Century Code (N.D.C.C.), Chapter 23-01. The State Health Officer (SHO) of the NDDHHS is responsible for the administration of programs carried out with allotments made to the state by Title V. The NDDHHS functions in compliance with Chapter 28-32, Administrative Agencies Practice Act, N.D.C.C. Programs funded by the federal-state Title V MCH Block Grant include: Children with Special Health Care Needs (CSHCN), child/teen passenger safety, injury/violence prevention, newborn screening, MCH epidemiology, obesity prevention, nutrition, breastfeeding, school health/nursing and infant and child death services (sudden infant death syndrome).

Several mandates in N.D.C.C. address Title V CSHCN-related responsibilities within the NDDHHS. Chapter 23-01-34 includes program administration for CSHCN, including the provision of services and assistance to CSHCN and their families and the development and operation of clinics for the identification, screening, referral, and treatment of CSHCN. Chapter 23-01-41 requires the establishment and administration of an autism spectrum disorder database. Chapter 23-41 mandates administrative duties of state and county agencies, confidential birth reports for newborns with visible congenital deformities, and services for individuals with Russell Silver Syndrome. Chapter 25-17-03 mandates treatment for individuals with phenylketonuria or maple syrup urine disease through the provision of medical food and low-protein modified food products.

To meet the requirements of N.D.C.C. Chapter 14-02.1, Abortion Control Act, Section 14-02.1-02.1, Printed Information – Referral Service, the NDDHHS developed and published an *Information About Pregnancy and Abortion* booklet. This publication consists of objective information on specific topics to include: information and resources on various agencies and services available to assist a pregnant woman through pregnancy (provided through an on-line directory of services); anatomical information along with colored photos of development of the unborn child at two-week gestational increments; information regarding the obligations of the father; and materials that describe various surgical and drug-induced methods of abortion as well as any risk factors associated with those methods. In addition to the required information, content was also added on the harmful efforts of tobacco use during and after pregnancy. The booklet will continue to be updated on an as-needed basis to ensure that information is accurate, up-to-date, and evidence-based. The booklet, updated in March 2024, is available online at https://www.hhs.nd.gov/sites/www/files/documents/DOH%20Legacy/Information_About_Pregnancy_and_Abortion.pd . Hard copy booklets will continue to be available upon request. During the 2023 legislative session, a bill was introduced, SB 2185, which was a bill for an act to provide for an appropriation to the Department of Health and Human Services for the development of a pregnancy and parenting resource website. Title V staff launched life.nd.gov on August 1, 2023 that provides information and links to social services, financial assistance, adoption services, pregnancy and parenting information, maternal and childbirth life services, planning guidance, care centers and agencies, and other available public and private resources for expectant families and new parents. Title V staff will continue to maintain and update the website with resources.

N.D.C.C 50-25.1-15 allows a parent or a parent's agent (another person acting with the parent's consent) who feels they are unable to take care of their infant, to surrender the infant without facing prosecution for abandonment. To be protected by the Baby Safe Haven Law, the child must be unharmed, under one year of age, and surrendered to an on-duty staff person or, if an infant is less than sixty days old, left in a newborn safety device, at an approved location in an unharmed condition, working for a Baby Safe Haven approved location.*There is currently no Baby Safe Haven Baby Boxes installed in North Dakota. An MCH Public Health Specialist at NDDHHS will develop and implement a public awareness campaign to provide information, public service announcements, and educational materials regarding this section to the public, including medical providers, law enforcement, and social service agencies. For additional information visit the resource page at https://www.hhs.nd.gov/cfs/safe-haven and the Baby Safe Haven training at: https://babysafehaven.pcand.org/.

N.D.C.C. Chapter 23-45, Umbilical Cord Blood Disposition, Section 23-45-02. Umbilical cord blood - Information pamphlet – Distribution, requires the NDDHHS to prepare a pamphlet that includes information on medical processes involved in the collection of umbilical cord blood; any risks of cord blood collection for both mother and baby; the current and potential future uses for the collected cord blood; the cost of cord blood donation; and options

for ownership and future use of the donated material. The pamphlet must be available on the NDDHHS website and be distributed upon request at no charge. The NDDHHS elected to use and disseminate the pamphlet from the Cord Blood Registry titled Parent's Guide to Cord Blood Banking (https://parentsguidecordblood.org/sites/default/files/uploaded-files/pgcb_brochure_usa.pdf). This pamphlet is free to patients, hospitals and other entities that choose to utilize the information. The Title V grant supports the costs associated with these unfunded, state mandates and MCH staff members have been assigned responsibility for these activities.

N.D.C.C. Chapters 23-01-03.1 and 25-17 mandate that North Dakota have a newborn screening program. The Newborn Screening and Follow-up Program (NBSFP) is currently housed within Special Health Services (SHS) in the Public Health Division of NDDHHS. Newborn screening (NBS) is performed shortly after birth to identify newborns who may have a potentially life-altering and/or life-threatening disorder that could cause serious illness, disability, or death if not identified and treated early. Newborn screening has three parts: blood spot, hearing, and heart screening. Blood spot and heart screening are included within this mandated section. Hearing screening is not mandated in North Dakota. The national Advisory Committee on Heritable Disorders in Newborn and Children (ACHDNC) provides recommendations to state newborn screening programs which disorders should be included on their state panel. The disorders included in the recommendations supported by ACHDNC are known as the Recommended Uniform Screening Panel (RUSP). Currently, North Dakota screens for 32 of the 37 core conditions that are included on the RUSP (blood spot, hearing and heart screening are included as core conditions). As new conditions are added to the RUSP, the North Dakota Newborn Screening Advisory Committee reviews them and determines the feasibility of adding them to the state screening panel. The feasibility of screening is dependent on several factors that may include the program's readiness to: 1) approve the screening; 2) conduct laboratory screening; 3) conduct short and long-term follow-up; 4) provide information technology support; 5) access a medical specialist specific to the disorder; 6) educate providers and community; and 7) fully implement statewide newborn screening. The approving authority for the NBSFP to add a new disorder in North Dakota is the SHO. In the next fiscal year, the NBSFP will work with the NBS Advisory Committee to review the five core conditions North Dakota is currently not screening for to address program readiness and feasibility.

The North Dakota NBSPFP is mandated to provide education and plans to continue providing annual in-person training to midwives, birthing facilities and various clinics throughout North Dakota. The North Dakota NBSFP is planning to develop educational materials targeted at parents, the general public as well as providers. The NBSFP will continue to seek innovative ways to engage partners and the families served via virtual platforms.

The screening and follow-up of newborns is performed in collaboration with the University of Iowa State Hygienic Laboratory and the University of Iowa Hospitals and Clinics, as well as SHS. Intermediate and long-term follow-up after NBS continues to be addressed in SHS by:

- Providing follow-up contacts, resource information and care coordination for children with abnormal newborn screening results.
- Providing financial support for metabolic disorder clinics that result in coordinated disease management.
- Providing no-cost or at-cost medical food and care coordination for newborns and individuals with phenylketonuria (PKU) and maple syrup urine disease (MSUD).
- Providing diagnostic and treatment services for children birth to age 21 who meet medical and financial eligibility criteria.

Along with the follow-up calls for babies with abnormal newborn screening results, SHS assists families with referrals for services, care coordination, and support. Information is provided regarding the SHS Financial Coverage program as well as other state-wide resources (e.g., WIC, North Dakota Medicaid, Early Intervention) to assist the family in meeting their needs, and to provide them support and direction during a time that can be very stressful and overwhelming. After a child is diagnosed with a condition through newborn screening, the baby enters the long-term follow-up program until the age of six and the family is contacted on a quarterly basis for the first year of their child's life and annually thereafter. This ongoing communication with the family helps to ensure the child remains healthy and the family has access to all the resources that they find valuable such as insurance, medication, transportation, and community supports. Collaboration with specialty care providers who see patients with a critical congenital heart disease or conditions identified through blood spot screening will continue through their Newborn Screening

Advisory Committee and ongoing communication with the program.

The NBSFP works closely with the North Dakota Early Hearing, Detection and Intervention (EHDI) program which is based out of the North Dakota Center for Persons with Disabilities (NDCPD) at Minot State University. The NDCPD is the NDDHHS bona fide agent that applies for funding opportunities relating to EHDI. The NBSFP Director is the State EHDI Coordinator and is the liaison between the state and EHDI program. The NBSFP and EHDI programs provide education and trainings to birthing facilities and various clinics throughout the state. This collaboration benefits both programs, the families that are served and the health care professionals providing the services directly to families. This partnership will continue and the NBSFP will include EHDI and hearing screening on the development of any educational resources geared to the public or providers.

Financial eligibility for the SHS Financial Coverage program is legislatively mandated at 185% of the federal poverty level. All current NBS conditions are approved medical conditions for SHS coverage. Title V supports staff in managing the NBSFP, including a program director, long-term follow-up coordinator, and administrative support. In addition, Title V funds support contracts for a Medical Director and metabolic disorder clinic. A portion of Title V funds and state funds will continue to support medical consultation and genetic counseling services for children with abnormal newborn screening results.

Federally, the MCH Block Grant enables the state to address the following on behalf of CSHCN and their families: 1) to provide and promote family-centered, community-based, coordinated care (including care coordination services) for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families, and 2) to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI, to the extent medical assistance for such services is not provided under title XIX. Specifics regarding the SHS role in providing rehabilitation services is described below.

North Dakota is a 209(b) state, which means Supplemental Security Income (SSI) beneficiaries under 16 years of age are not automatically eligible for North Dakota Medicaid. If assets are an issue affecting North Dakota Medicaid eligibility, children eligible for SSI can be covered under the children and family coverage groups where asset testing is not required. The state CSHCN program pays for or provides rehabilitative services for eligible children that are served by Title V to the extent services are not provided by North Dakota Medicaid. State CSHCN program staff conduct outreach, information and referral activities targeted to the SSI population. On a monthly basis, Disability Determination Services provides referrals electronically to the state CSHCN program. In response, state CSHCN staff provide a direct mailing to families notifying them about potential programs that could be of assistance. This assures that children are consistently being referred to the Title V program and that families receive information about program benefits and needed services.

The Title V and CSHCN Directors assure compliance for these state mandates and oversee staff assigned to carry out the roles and responsibilities related to the mandates. Title V staff share program accomplishments and challenges at bi-monthly Title V meetings. These meetings serve as an avenue for program updates, sharing and collaboration.

**MCH Population Domain: Crosscutting**

**SPM: Access to Services: Improve access to health-related services to improve the health and well-being of the MCH population**

**North Dakota Priority Goal: Increase awareness and the utilization of statewide services or resources.**

**FY2026 Annual Plan Narrative (October 1, 2025-September 30, 2026)**

Raising awareness of available services and resources across the state is crucial for ensuring their effective utilization, which is why this was selected as one of North Dakota's cross-cutting priorities for the 2025–2030 grant cycle. Two overarching objectives were established to initiate this priority: (1) By September 30, 2030, Title V will improve collaboration with North Dakota Medicaid to increase access to services for high-risk populations; and (2) By September 30, 2030, Title V will expand access to essential healthcare services through partnerships. Each of

these objectives are discussed further below.

To achieve the first objective, by September 30, 2030, Title V will improve collaboration with North Dakota Medicaid to increase access to services for high-risk populations. Title V staff will identify various methods to increase access to Medicaid-eligible health services for infants within the first 15 months of life. This initiative aligns with Medicaid quality measures and aims to improve maternal and infant health outcomes. One Medicaid service for infants includes well-baby visits, also known as Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services. These visits are vital from birth to 15 months, when infants are particularly vulnerable, and provide critical opportunities to monitor development, administer immunizations, and identify emerging health or social needs. The American Academy of Pediatrics (AAP) and Bright Futures recommend nine or more well-child visits by the time a child turns 15 months of age, and two or more well-child visits for children between 15 and 30 months of age. Well-child visits should include a health history, physical exam, immunizations, vision and hearing screening, developmental/behavioral assessment, oral health risk assessment, and parenting education on a wide range of topics. (https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-child-chartpack.pdf). These visits are especially important for families facing barriers to preventive care. North Dakota's recent Medicaid postpartum extension to 12 months provides continuity for mothers to access healthcare while supporting their infants' medical needs. (https://www.hhs.nd.gov/humanservices/medicaid/about/newmom). The continuous coverage helps with early identification and management of health issues and chronic conditions, which can affect bonding between mother and baby and her ability to care for her child. Additionally, it can potentially improve maternal and infant outcomes, reduce emergency department visits, and increase follow-up care. (https://aspe.hhs.gov/sites/default/files/documents/31c91a9fb03bfb5048ef508ec6e9f991/ASPE-Postpartum-Utilization-Brief-Final.pd)

An Evidence-based Strategy Measure (ESM) has been established to monitor progress over time regarding the number of well-baby visits completed for Medicaid-enrolled infants aged 0 to 15 months. Data will be analyzed across various demographic variables to facilitate the introduction of additional activities aimed at addressing potential disparities identified through these variables.
According to North Dakota's 2023 Medicaid data, out of 8,141 infants enrolled in Medicaid, 3,875 (47.5%) had completed a well-baby visit. The objective is to increase the percentage of Medicaid-enrolled infants who have received a well-baby visit from 47.5% to 60% by the year 2030, achieving an annual increase of 2.48%.

In year one, the first priority will be carried out with a focus on two primary activities. First, the team will establish a task force in collaboration with Medicaid and relevant Maternal and Child Health (MCH) partners, aimed at identifying and addressing gaps in access to MCH services for Medicaid-enrolled individuals. Additionally, home visiting initiatives will be prioritized during this first year, as they have demonstrated significant reach and impact across North Dakota.

There are several organizations that are successfully completing home visiting programs that Title V has partnered with but would like to strengthen relationships in order to improve service delivery and eliminate silos. Although these are not currently funded by Title V, common goals exist. For example, the Maternal and Child Health Home Visiting (MIECHV) program is administered by Families FlourishND (https://www.pcand.org/miechv). In Fiscal Year 2023, the North Dakota MIECHV program showcased strong performance and positive outcomes. The program successfully served 161 households and completed 2,192 home visits across both rural counties (Grant, Mercer, Rolette) and non-rural counties (Burleigh and Morton). Key outcomes included 98.9% of enrolled children had family members who engaged in reading, storytelling, or singing with them daily, and 90.2% of caregivers were screened for depression within three months of enrollment or delivery (https://mchb.hrsa.gov/). North Dakota's home visiting programs employ evidence-based models such as the Nurse-Family Partnership (NFP) and Parents as Teachers (PAT) (https://www.nursefamilypartnership.org/wp-content/uploads/2017/07/ND_2024-State-Profile-1.pdf). The NFP program specifically reported notable results including 85% of babies were born at term, 92% of mothers initiated breastfeeding, 96% of clients aged 18 or older were employed by 24 months, and 63% of babies received all recommended immunizations by 24 months (https://www.nursefamilypartnership.org/wp-content/uploads/2017/07/ND_2024-State-Profile-1.pdf).

Despite ongoing collaboration among organizations providing MCH services, access to these services varies significantly across the state. This variability is often reflective of county-level differences, with some individuals more

readily accessing certain services than others. The rural nature of North Dakota's landscape, characterized by limited infrastructure and service availability, is a critical factor. Additionally, discrepancies in service implementation across regions contribute to disparities in access. While the Title V MCH program has a strong history of collaboration with Medicaid, the formation of a joint task force will formalize coordination and alignment efforts. Initially, the task force will focus on identifying appropriate partners and primarily addressing service gaps related to home visiting. The North Dakota Home Visiting Coalition, along with individual home visiting programs, will play a vital role in this initiative. Some of the home visiting programs that the Title V MCH program will collaborate with include NFP and PAT, which are funded by the MIECHV grant program. Healthy Families North Dakota (HFND) is another evidence-based home visiting program designed to enhance maternal and child health, promote early childhood development, and improve family economic stability. HFND has already agreed to join the task force and has reviewed this plan.

Additionally, family home visiting represents an area where referral and financial support gaps may exist, and the task force could identify opportunities for improvement. In the second year and beyond, strategies can be developed to address these gaps. Working closely with stakeholders involved in program communications may be an initial step in this process. The task force will evaluate whether home visiting programs have effectively integrated messaging in channels that reach the target populations. Additionally, entry into services will be mapped to ensure that all eligible individuals are effectively reached through targeted messaging and appropriately referred to available home visiting programs.

The second activity aimed at achieving this objective will involve initiating a review of baseline data around the following areas: well baby visits in the first 15 months of life, common services referred to or denied for families (such as the Women, Infants, and Children (WIC) program), and breastfeeding rates among Medicaid-enrolled infants. These three factors are critical for supporting healthy child development and strengthening family stability. WIC referrals serve as a vital gateway to supplemental nutrition, breastfeeding support, and nutrition education. The program plays a significant role in preventing early childhood hunger and ensuring adequate nutrition during periods of rapid growth and brain development. According to the United States Department of Agriculture (USDA), a substantial portion of WIC-eligible Medicaid enrollees nationwide are not participating in the program: 65% of Medicaid beneficiaries aged 1 through 4 and upwards of 86% of pregnant Medicaid enrollees do not participate in WIC (https://www.fns.usda.gov/research/wic/eligibility-and-program-reach-estimates-2021). Similarly, North Dakota's 2022 Pregnancy Risk Assessment Monitoring System (PRAMS) data show similar trends with 85.7% of mothers reporting not participating in WIC. In terms of breastfeeding, the Centers for Disease Control (CDC) reported that in 2021, 83.5% of mothers in North Dakota ever breastfed, with fewer breastfeeding at 6 and 12 months (61% and 41.8% respectively). In addition, 53.6% breastfed exclusively at 3 months and 31.4% at 6 months (https://www.cdc.gov/breastfeeding-data/about/rates-by-state.html). The American College of Obstetricians and Gynecologists (ACOG) recommends exclusive breastfeeding for the first 6 months of life, with continued breastfeeding while complementary foods are introduced during the infant's first year of life (https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/02/breastfeeding-challenges). Furthermore, matching Medicaid enrollee data with WIC enrollee data also allows state and local WIC agencies to conduct targeted WIC outreach directly to eligible families who are not enrolled.

Breastfeeding, likewise, is closely tied to improved immune function, cognitive development, and a reduced risk of chronic illnesses. However, for many Medicaid-enrolled families, consistent breastfeeding support remains limited, often due to a lack of lactation services or messaging that does not reflect cultural norms or preferences. Seeing how few mothers are able to initiate but not sustain exclusive breastfeeding, the Title V MCH program and Medicaid will explore ways to improve WIC enrollment rates while promoting breastfeeding through programs like the Infant Friendly Workplace program and continuous coverage of lactation support.

The second overarching objective, Title V will expand access to essential healthcare services through partnerships, will be initiated by two key strategies. First, Title V staff will actively participate in various collaboratives, coalitions, and boards dedicated to addressing priorities outlined in the State Health Implementation Plan (SHIP). North Dakota's 2024–2029 SHIP serves as a five-year strategic framework aimed at improving the health and well-being of residents across the state. Developed through comprehensive data analysis and collaboration with an array of partners, the SHIP acts as a unifying guide for public health efforts. It facilitates the alignment of efforts across government agencies, healthcare systems, nonprofits, and community organizations, while also informing how

resources are allocated, programs are developed, and policies are shaped to ensure meaningful impact. The plan outlines four statewide priorities: strengthening the workforce, cultivating wellness, expanding access and connection, and building community resilience (https://www.hhs.nd.gov/sites/www/files/documents/DOH%20Legacy/Systems%20and%20Performance/ND%20Stat2029.pdf). The Title V MCH program focus on well-child visits, referrals like WIC, breastfeeding, and oral health directly supports the SHIP's third priority by ensuring that families are connected to high-quality care early in life.

To bring this plan into action, the state established the Multi-Partner Health Collaborative (MPHC)**.** The MPHC is a statewide public-private coalition that will support outreach and service integration. The MPHC's goal groups, which include community, tribal, and healthcare partners, help drive shared priorities under North Dakota's SHIP. The North Dakota Department of Health and Human Services (NDDHHS) will provide operational support, including staffing and progress tracking through data dashboards.

Research demonstrates that cross-sector collaboration among public health, healthcare, and social service organizations, working in partnership with communities, is a highly effective strategy to improve health outcomes and ensure everyone has the chance to live their healthiest lives. These collaborations not only strengthen the capacity of partner organizations by fostering new skills, improving productivity, and building stronger relationships, but they can also result in broader public health outcomes such as reduced mortality, improved disease management, and higher immunization rates (https://phaboard.org/reports/all-hands-on-deck-addressing-health-and-health-equity-through-cross-sector-collaboration).

Evidence from a U.S.-based study by Kegler and Swan (2012) further supports this, showing that active partner engagement in coalitions contributes to community capacity-building outcomes, emphasizing the importance of inclusive and participatory collaboration (https://doi.org/10.1093/her/cyr083). Even in preparing this plan, the Title V MCH team consulted with multiple partners, ensuring there was co-creation of plans to improve access to essential health services. Gaps most likely lie in the spaces between services; therefore, partnership with all those who impact MCH is key to closing service gaps in entry, referral, and access to services.

North Dakota's Title V program will partner with the Oral Health program to promote access to dental care, especially given cost and provider shortages in rural areas. North Dakotans have identified oral health as an important gap in healthcare. Oral health is deeply interconnected with overall systemic health. Research shows that poor oral health, particularly conditions like periodontal disease, can increase the risk of chronic illnesses such as diabetes, cardiovascular disease, rheumatoid arthritis, and respiratory infections. Beyond its physical implications, oral health significantly influences mental, social, and economic well-being. Untreated dental conditions can result in chronic pain, infections, difficulty eating, and poor nutrition, all of which can impact daily functioning and quality of life. In children, oral disease is associated with missed school days and hindered learning, while in adults, it contributes to reduced work productivity and increased healthcare costs. These impacts highlight the broader societal and economic burden of poor oral health. Title V staff will actively participate on the Oral Health Coalition to ensure that oral health concerns for MCH are addressed during meetings.

By braiding oral health initiatives into this MCH cross-cutting priority, North Dakota underscores the message that true health integration means no aspect of health is overlooked. Good oral health supports nutrition, self-esteem, employability, and chronic disease prevention, all of which are essential for healthy mothers and children.

Additionally, ensuring that women have access to high-quality prenatal services throughout the state is essential for providing babies with the healthiest start in life. Healthy pregnancies contribute to positive birth outcomes. By collaborating with the North Dakota Perinatal Quality Collaborative (NDPQC) and the state's birthing facilities, maternal and newborn public health initiatives can be advanced to optimize health outcomes for mothers and newborns, irrespective of the location of birth within the state. Staff members will participate on the NDPQC on behalf of state Title V.

The second strategy for collaboration will prioritize engagement with North Dakota's five Tribal Nations: Standing Rock Sioux Tribe, Spirit Lake Nation, Turtle Mountain Band of Chippewa Indians, Three Affiliated Tribes of the Fort Berthold Reservation (Mandan, Hidatsa, and Arikara Nation), and Sisseton-Wahpeton Oyate. These sovereign Nations represent distinct jurisdictions with unique health systems, infrastructure, and governance structures that

must be considered in all public health coordination. In year one, efforts will focus on identifying a specific systems-level healthcare access issue within at least one of these geographic regions, with targeted strategies developed to address the identified gaps.

For example, healthcare systems operating within Tribal jurisdictions for preventive and routine care often utilize different electronic health record systems compared to those utilized by regional facilities that provide higher-acuity services or specialty care. This discrepancy can create challenges in care coordination, particularly during transitions between local routine care and external services for more complex health needs, as well as ensuring continuity of care upon returning to the local system. Addressing these gaps will require enhanced collaboration across jurisdictions to improve health information sharing, referral systems, and care transitions. Effective coordination with Tribal Nations is essential for strengthening public health infrastructure in these regions and reducing systemic barriers to healthcare access within American Indian/Alaska Native (AI/AN) Jurisdictions.

In summary, the emphasis on well-baby visits is rooted in the life course perspective, which highlights the enduring benefits of early health interventions. Well-baby visits are positioned as a critical foundation for lifelong health, addressing both developmental milestones and upstream social determinants of health. By leveraging partnerships and maximizing collaboration, we can effectively identify and address gaps in health services. Participation in coalitions and collaboratives, along with close cooperation with Medicaid and programs such as home visiting, will facilitate the identification and resolution of these gaps over the next five years. With sustained investment and inclusive partnerships, North Dakota aims to ensure that all individuals, particularly its youngest and most vulnerable residents, have access to essential health services.

## III.F. Public Input

### Section III.F. Public Input

Public input is essential and integral to North Dakota's Title V Maternal and Child Health (MCH) Block Grant application and annual report during their development and after their transmission.

In the summer of 2023, planning began for the 2025 needs assessment and prioritization process. Acknowledging the critical need for a comprehensive data collection initiative to gather public input, the North Dakota Title V leadership team opted to engage North Dakota State University (NDSU) for assistance in this effort.
In the fall of 2024, NDSU, in collaboration with Title V staff, developed a comprehensive online stakeholder survey encompassing a range of select-all-that-apply and short-answer questions pertaining to women, infants, and children across all MCH population domains. This survey was disseminated to over 200 stakeholders statewide, including a diverse array of providers, families, family support organizations, state personnel, community organizations, and other key leaders working closely with the women, infant, and child population. The survey remained open for just over two weeks, during which approximately 200 responses were collected, yielding a substantial amount of valuable public input. NDSU subsequently compiled a detailed report outlining the results of the online survey, which can be accessed in Section V. Supporting Documents. Next, in February 2025, the Title V Leadership Team convened to analyze the survey results alongside other relevant state and national data to facilitate the prioritization process. This process involved an independent review of the data, ranking priorities, and determining the top priority for each domain. Once this independent work was complete, the team convened again and collaboratively compared insights. Following a thorough discussion and prioritization, draft priorities and strategies were established.

These draft priorities were subsequently published on the North Dakota Department of Health and Human Services (NDDHHS) website to solicit broader public comment. The public was invited to provide feedback on the draft priorities for one week, ensuring alignment with community perspectives.

In addition, a previous survey conducted by the NDDHHS regarding the State Health Improvement Plan (SHIP) and State Health Assessment (SHA) solicited feedback from community partners. These survey results will also be incorporated into the needs assessment. The SHA summary can be viewed here https://www.hhs.nd.gov/sites/www/files/documents/DOH%20Legacy/Data%20%26%20Stats/State%20Health%20As and the SHIP can be viewed here https://www.hhs.nd.gov/sites/www/files/documents/DOH%20Legacy/Systems%20and%20Performance/ND%20State 2029.pdf

The Pregnancy Risk Assessment Monitoring System (PRAMS) Survey has been an important component of the previous state's needs assessment processes and was again utilized in the 2025 needs assessment as an avenue for seeking public input regarding MCH efforts through the development of the PRAMS Steering Committee. The PRAMS Steering Committee was instrumental in developing the North Dakota PRAMS questionnaire and marketing materials. North Dakota's questionnaire has two types of questions, those which must be asked by all participating states, and those that are state-specific questions. In shaping the North Dakota PRAMS specific questions for the questionnaire, the Steering Committee took into consideration 1) the areas where the state had no alternate data sources, 2) emerging issues in the state, and 3) the risk factor areas in which the state has not been showing improvements. This led to the inclusion of questions on topics such as prenatal care access barriers, maternal substance abuse, oral health care barriers, Adverse Childhood Experiences (ACEs), among others. Receiving input and feedback from the PRAMS Steering Committee and other partners are critical to ensure continued success with MCH priorities. In addition, PRAMS for Dads is an additional work effort initiated in June 2023 to ensure fathers are included in education and data collection.

In addition to the needs assessment process, public and stakeholder input is actively gathered throughout the year. The Title V and Children with Special Health Care Needs (CSHCN) Directors regularly provide updates on the MCH grant and grant application processes to various stakeholder groups. These include local public health entities, Special Health Services Advisory Councils, the Early Childhood Education Council, the North Dakota State Council on Developmental Disabilities, the Interagency Coordinating Council, and Family Voices of North Dakota. Each of

these groups comprises a diverse range of representatives from across the state, who collectively contribute valuable insights to inform and guide public health initiatives.

Furthermore, the Title V Director has fostered relationships with staff who administer the Pediatric Mental Health Care Access (PMHCA) project. This project is led by the Behavioral Health Unit. The Title V Director is actively engaged in conversations, which helps to identify opportunities for collaboration and new partnerships. The Behavioral Health Planning Council (BHPC) has been appointed as the program's advisory committee, serving as an avenue for input and feedback.

Next, the Community Engagement Unit has proven to be an effective mechanism for outreach, aiding in the establishment of partnerships with a broader array of stakeholders. Key components of the MCH grant focus on promoting health and mitigating health challenges. The formation and growth of advisory boards have been important avenues for MCH public feedback and input. In addition, four Tribal Health Liaisons within the Community Engagement Unit are dedicated to initiating and nurturing relationships, as well as enhancing communication strategies with tribal partners.

Additionally, an MCH Dashboard displaying North Dakota Federally Available Data was developed by Title V staff to provide a comprehensive overview of the state's performance across various MCH population domains. The dashboard includes links to the work plans and contact information for each population domain lead, allowing community members and partners to engage in future strategic planning and implementation efforts or to provide input and feedback. The dashboard can be accessed here: https://app.powerbigov.us/view?r=eyJrIjoiMmM1NmZjNjgtYWNjZS00ODc5LTk2MjktZTYxZDFkMDAwZmQyIiwidCI6IjJkZWEwNDY0LWRhNTEtNGE4(

In February of 2024, the NDDHHS Newborn Screening staff conducted two family focus groups and one phone interview in collaboration with an independent contractor to gather valuable feedback and input to ultimately utilize family lived experiences to help drive programmatic change. The participants in these focus groups were parents of children enrolled in their Long-Term Follow-Up program between 2019 and 2024. During the focus groups, parents were asked general questions about receiving their child's diagnosis, follow-up care perceptions, as well as the usefulness of the Long-Term Follow-Up program. Parents were encouraged to share any information they felt was important to improve the services and system of care. Additionally, another set of focus groups will be held for providers to gather similar input from their perspective.

Finally, an annual news release is disseminated to major media outlets across the state, detailing the priority needs identified for the MCH population through the statewide needs assessment. The release also announces the availability of the Title V/MCH application and annual report for public comment. Additionally, the press release is shared on the NDDHHS social media platforms. Copies of the application and annual report are distributed each year to select entities, such as Family Voices of North Dakota, and are made available to other organizations and individuals upon request. Historically, inquiries regarding the grant and requests for the application and annual report have been minimal.

All these activities increase stakeholder knowledge of MCH and provide opportunities for public comment before, during, and after the application process. North Dakota recognizes the importance of public input to ensure the challenges and needs of the MCH population are being identified and appropriately addressed.

## III.G. Technical Assistance

### Section III. G. Technical Assistance

North Dakota’s Title V Program has identified the following potential areas of needed technical assistance:

- Technical assistance to address new national performance measures, including the new universal measures, as well as new and innovative strategies around improving cross-sector collaborations.
- Education and training are needed regarding strategies to stretch and maximize funding to support priority initiatives.
- Training to support and enhance systems-level skills of Title V staff, with special emphasis on incorporating quality improvement and evidence-based strategies to improve outputs of key work activities.
- Opportunities to grow emerging MCH leaders with special emphasis on the MCH Leadership Competencies (https://www.mchnavigator.org/trainings/competencies.php).
- Training on how to utilize data to formulate strong objectives, strategies, and activities (e.g., data-driven decision-making).

**IV. Title V-Medicaid IAA/MOU**

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Final-Title V Medicaid MOU 7-2020.pdf

## V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - MCH Workforce Capacity 6.2025.pdf

Supporting Document #02 - ND State Health Improvement Plan 2024-2029.pdf

Supporting Document #03 - SHS Program Data Report FFY 24 (CSHCN).pdf

Supporting Document #04 - State Mandates for HSC 2025.pdf

Supporting Document #05 - DRAFT-MCH Needs Assessment Report from NDSU 7.2.2025.pdf

## VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Combination Org Chart 6.2025 .pdf

## VII. Appendix

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## Form 2
## MCH Budget/Expenditure Details

**State: North Dakota**

| | FY 26 Application Budgeted | |
|---|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 1,790,674 | |
| A. Preventive and Primary Care for Children | $ 787,023 | (43.9%) |
| B. Children with Special Health Care Needs | $ 573,443 | (32%) |
| C. Title V Administrative Costs | $ 160,234 | (9%) |
| 2. Subtotal of Lines 1A-C<br>(This subtotal does not include Pregnant Women and All Others) | $ 1,520,700 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 1,243,162 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 100,000 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 0 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 0 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 1,343,162 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 1,206,293 | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Total lines 1 and 7) | $ 3,133,836 | |
| 9. OTHER FEDERAL FUNDS<br>Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2. | | |
| 10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9) | $ 345,000 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 3,478,836 | |

| OTHER FEDERAL FUNDS | FY 26 Application Budgeted |
|---|---|
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Screening Co-Propel Grant | $ 345,000 |

| | FY 24 Annual Report Budgeted | | FY 24 Annual Report Expended | |
|---|---|---|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 1,759,550<br>(FY 24 Federal Award: $ 1,790,674) | | $ 1,790,674 | |
| A. Preventive and Primary Care for Children | $ 588,145 | (33.4%) | $ 596,692 | (33.3%) |
| B. Children with Special Health Care Needs | $ 695,000 | (39.5%) | $ 805,305 | (44.9%) |
| C. Title V Administrative Costs | $ 105,573 | (6%) | $ 124,180 | (7%) |
| 2. Subtotal of Lines 1A-C<br>(This subtotal does not include Pregnant Women and All Others) | $ 1,388,718 | | $ 1,526,177 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 1,264,816 | | $ 1,206,398 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 55,000 | | $ 133,527 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 0 | | $ 0 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 0 | | $ 0 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 1,319,816 | | $ 1,339,925 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 1,206,293 | | | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Total lines 1 and 7) | $ 3,079,366 | | $ 3,130,599 | |
| 9. OTHER FEDERAL FUNDS<br>Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2. | | | | |
| 10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9) | $ 182,094 | | $ 213,889 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 3,261,460 | | $ 3,344,488 | |

| OTHER FEDERAL FUNDS | FY 24 Annual Report Budgeted | FY 24 Annual Report Expended |
|---|---|---|
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Screening State Evaluation Program | $ 182,094 | $ 209,700 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Screening Co-Propel Grant | | $ 4,189 |

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Federal Allocation, B. Children with Special Health Care Needs:** |
| | **Fiscal Year:** | **2024** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** More funds were spent in the CSHCN domain than originally anticipated, This is likely due to factors such as increased spending in medical claims for CSHCN and accelerated spending by contract grantees. More money was also received than originally budgeted. | |
| 2. | **Field Name:** | **Federal Allocation, C. Title V Administrative Costs:** |
| | **Fiscal Year:** | **2024** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** The amount of dollars spent on administrative costs were more than originally anticipated due to factors such as increases in staff salaries and general inflation for MCH program administration costs. More money was also received than originally budgeted. | |
| 3. | **Field Name:** | **4. LOCAL MCH FUNDS** |
| | **Fiscal Year:** | **2024** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** The amount of local MCH local funds spent was greater than originally anticipated, likely due to factors such as grantees over-matching on contracts. | |
| 4. | **Field Name:** | **7. TOTAL STATE MATCH** |
| | **Fiscal Year:** | **2024** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** Less match was received from the local level than originally anticipated. This could be due to less general funds or the inability for grantees at the local level to provide enough match. | |
| 5. | **Field Name:** | **Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Screening State Evaluation Program** |
| | **Fiscal Year:** | **2024** |
| | **Column Name:** | **Annual Report Expended** |

| | | |
|---|---|---|
| | **Field Note:**<br>Spent more than originally budgeted due to carry-over funding. | |
| 6. | **Field Name:** | **Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Screening Co-Propel Grant** |
| | **Fiscal Year:** | **2024** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>Did not anticipate this grant when budget when the FFY24 MCH budget was submitted. | |

**Data Alerts:**

- The value in Line 7, Total State Match, Annual Report Expended is less than 75% of the value in Line 1, Federal Allocation, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.

## Form 3a
## Budget and Expenditure Details by Types of Individuals Served

**State: North Dakota**

### I. TYPES OF INDIVIDUALS SERVED

| IA. Federal MCH Block Grant | FY 26 Application Budgeted | FY 24 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 89,990 | $ 96,812 |
| 2. Infants < 1 year | $ 134,984 | $ 145,217 |
| 3. Children 1 through 21 Years | $ 787,023 | $ 596,692 |
| 4. CSHCN | $ 573,443 | $ 805,305 |
| 5. All Others | $ 45,000 | $ 22,468 |
| Federal Total of Individuals Served | $ 1,630,440 | $ 1,666,494 |

| IB. Non-Federal MCH Block Grant | FY 26 Application Budgeted | FY 24 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 182,182 | $ 157,295 |
| 2. Infants < 1 year | $ 250,500 | $ 179,766 |
| 3. Children 1 through 21 Years | $ 326,408 | $ 411,962 |
| 4. CSHCN | $ 430,132 | $ 482,913 |
| 5. All Others | $ 33,750 | $ 16,948 |
| Non-Federal Total of Individuals Served | $ 1,222,972 | $ 1,248,884 |
| Federal State MCH Block Grant Partnership Total | $ 2,853,412 | $ 2,915,378 |

**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

None

**Data Alerts: None**

## Form 3b
## Budget and Expenditure Details by Types of Services

**State: North Dakota**

### II. TYPES OF SERVICES

| IIA. Federal MCH Block Grant | FY 26 Application Budgeted | FY 24 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 335,197 | $ 381,891 |
| A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One | $ 138,764 | $ 108,421 |
| B. Preventive and Primary Care Services for Children | $ 104,682 | $ 81,791 |
| C. Services for CSHCN | $ 91,751 | $ 191,679 |
| 2. Enabling Services | $ 554,299 | $ 662,549 |
| 3. Public Health Services and Systems | $ 901,178 | $ 746,234 |
| 4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service | | |
| Pharmacy | | $ 69,604 |
| Physician/Office Services | | $ 53,785 |
| Hospital Charges (Includes Inpatient and Outpatient Services) | | $ 15,819 |
| Dental Care (Does Not Include Orthodontic Services) | | $ 3,164 |
| Durable Medical Equipment and Supplies | | $ 11,073 |
| Laboratory Services | | $ 27,214 |
| Other | | |
| metabolic food, direct service contracts | | $ 201,232 |
| Direct Services Line 4 Expended Total | | $ 381,891 |
| **Federal Total** | $ 1,790,674 | $ 1,790,674 |

| IIB. Non-Federal MCH Block Grant | FY 26 Application Budgeted | FY 24 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 439,957 | $ 186,823 |
| A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One | $ 254,389 | $ 104,584 |
| B. Preventive and Primary Care Services for Children | $ 146,247 | $ 62,169 |
| C. Services for CSHCN | $ 39,321 | $ 20,070 |
| 2. Enabling Services | $ 357,275 | $ 372,662 |
| 3. Public Health Services and Systems | $ 611,308 | $ 689,399 |
| 4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service | | |
| Pharmacy | | $ 0 |
| Physician/Office Services | | $ 0 |
| Hospital Charges (Includes Inpatient and Outpatient Services) | | $ 0 |
| Dental Care (Does Not Include Orthodontic Services) | | $ 0 |
| Durable Medical Equipment and Supplies | | $ 0 |
| Laboratory Services | | $ 16,948 |
| Other | | |
| metabolic food, direct service contracts | | $ 169,875 |
| Direct Services Line 4 Expended Total | | $ 186,823 |
| **Non-Federal Total** | $ 1,408,540 | $ 1,248,884 |

**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

None

## Form 4
## Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

**State: North Dakota**

**Total Births by Occurrence: 11,079** **Data Source Year: 2024**

**1. Core RUSP Conditions**

| Program Name | (A) Aggregate Total Number Receiving at Least One Valid Screen | (B) Aggregate Total Number of Out-of-Range Results | (C) Aggregate Total Number Confirmed Cases | (D) Aggregate Total Number Referred for Treatment |
|---|---|---|---|---|
| Core RUSP Conditions | 11,065 (99.9%) | 367 | 25 | 25 (100.0%) |

| Program Name(s) | | | | |
|---|---|---|---|---|
| 3-Hydroxy-3-Methyglutaric Aciduria | 3-Methylcrotonyl-Coa Carboxylase Deficiency | Argininosuccinic Aciduria | Biotinidase Deficiency | Carnitine Uptake Defect/Carnitine Transport Defect |
| Citrullinemia, Type I | Classic Galactosemia | Classic Phenylketonuria | Congenital Adrenal Hyperplasia | Critical Congenital Heart Disease |
| Cystic Fibrosis | Glutaric Acidemia Type I | Glycogen Storage Disease Type II (Pompe) | Guanidinoacetate Methyltransferase (GAMT) Deficiency | Hearing Loss |
| Holocarboxylase Synthase Deficiency | Homocystinuria | Isovaleric Acidemia | Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency | Maple Syrup Urine Disease |
| Medium-Chain Acyl-Coa Dehydrogenase Deficiency | Methylmalonic Acidemia (Cobalamin Disorders) | Methylmalonic Acidemia (Methylmalonyl-Coa Mutase) | Mucopolysaccharidosis Type I (MPS I) | Mucopolysaccharidosis Type II (MPS II) |
| Primary Congenital Hypothyroidism | Propionic Acidemia | S, ßeta-Thalassemia | S,C Disease | S,S Disease (Sickle Cell Anemia) |
| Severe Combined Immunodeficiences | Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1 | ß-Ketothiolase Deficiency | Trifunctional Protein Deficiency | Tyrosinemia, Type I |
| Very Long-Chain Acyl-Coa Dehydrogenase Deficiency | X-Linked Adrenoleukodystrophy | | | |

**2. Other Newborn Screening Tests**

None

**3. Screening Programs for Older Children & Women**

None

**4. Long-Term Follow-Up**

After a newborn is confirmed with a diagnosis through newborn screening, they are enrolled in the long-term follow-up program (with consent from the parent/guardian) through age six.

**Form Notes for Form 4:**

CY2024: The aggregate total number of children who received at least one screen is 11,065. The data may vary because there may have been babies that were not born in North Dakota that were transferred to a North Dakota facility after birth. There were 102 newborn screening refusals received at the state. Of the 367 out of range results: 8 children were deceased prior to confirmatory screening, 3 were lost to follow up prior to confirmatory screening

**Field Level Notes for Form 4:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Total Births by Occurrence** |
| | **Fiscal Year:** | **2024** |
| | **Column Name:** | **Total Births by Occurrence Notes** |
| | **Field Note:**<br>Data Source: North Dakota Vital Records, 2024<br>Occurrent Births include both North Dakota resident births and out of state resident births. | |
| 2. | **Field Name:** | **Data Source Year** |
| | **Fiscal Year:** | **2024** |
| | **Column Name:** | **Data Source Year Notes** |
| | **Field Note:**<br>Data Source: North Dakota Vital Records, 2024 | |
| 3. | **Field Name:** | **Core RUSP Conditions - Total Number Receiving At Least One Screen** |
| | **Fiscal Year:** | **2024** |
| | **Column Name:** | **Core RUSP Conditions** |
| | **Field Note:**<br>is the total number of initial screens submitted within both databases (OE & INSP)<br>Data source: ND Vital Records, 2024 | |
| 4. | **Field Name:** | **Core RUSP Conditions - Total Number of Out-of-Range Results** |
| | **Fiscal Year:** | **2024** |
| | **Column Name:** | **Core RUSP Conditions** |
| | **Field Note:**<br>Data Source: ND DHHS Newborn Screening Program, 2024 | |
| 5. | **Field Name:** | **Core RUSP Conditions - Total Number Confirmed Cases** |
| | **Fiscal Year:** | **2024** |
| | **Column Name:** | **Core RUSP Conditions** |
| | **Field Note:**<br>Data Source: ND DHHS Newborn Screening Program, 2024 | |
| 6. | **Field Name:** | **Core RUSP Conditions - Total Number Referred For Treatment** |
| | **Fiscal Year:** | **2024** |
| | **Column Name:** | **Core RUSP Conditions** |
| | **Field Note:**<br>- Data Source: ND DHHS Newborn Screening Program, 2024 | |

**Data Alerts: None**

## Form 5
## Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

**State: North Dakota**

**Annual Report Year 2024**

### Form 5a – Count of Individuals Served by Title V
### (Direct & Enabling Services Only)

| | | Primary Source of Coverage | | | | |
|---|---|---|---|---|---|---|
| Types Of Individuals Served | (A) Title V Total Served | (B) Title XIX % | (C) Title XXI % | (D) Private / Other % | (E) None % | (F) Unknown % |
| 1. Pregnant Women | | | | | | |
| 2. Infants < 1 Year of Age | | | | | | |
| 3. Children 1 through 21 Years of Age | | | | | | |
| 3a. Children with Special Health Care Needs 0 through 21 years of age^ | | | | | | |
| 4. Others | | | | | | |
| Total | | | | | | |

### Form 5b – Total Percentage of Populations Served by Title V
### (Direct, Enabling, and Public Health Services and Systems)

| Populations Served by Title V | Reference Data | Used Reference Data? | Denominator | Total % Served | Form 5b Count (Calculated) | Form 5a Count |
|---|---|---|---|---|---|---|
| 1. Pregnant Women | | | | | | |
| 2. Infants < 1 Year of Age | | | | | | |
| 3. Children 1 through 21 Years of Age | | | | | | |
| 3a. Children with Special Health Care Needs 0 through 21 years of age^ | Not Available | | Not Available | | | |
| 4. Others | | | | | | |

^Represents a subset of all infants and children.

**Form Notes for Form 5:**

**Field Level Notes for Form 5a:**

None

**Field Level Notes for Form 5b:**

None

**Data Alerts:**

| | |
|---|---|
| 1. | Form 5 has not yet been started. Please access and complete the form. |
| 2. | This form has not yet been started. Please fill out all sections in the form. |

## Form 6
## Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

**State: North Dakota**

**Annual Report Year 2024**

### I. Unduplicated Count by Race/Ethnicity

| | (A) Total | (B) Non-Hispanic White | (C) Non-Hispanic Black or African American | (D) Hispanic | (E) Non-Hispanic American Indian or Native Alaskan | (F) Non-Hispanic Asian | (G) Non-Hispanic Native Hawaiian or Other Pacific Islander | (H) Non-Hispanic Multiple Race | (I) Other & Unknown |
|---|---|---|---|---|---|---|---|---|---|
| 1. Total Deliveries in State | | | | | | | | | |
| Title V Served | | | | | | | | | |
| Eligible for Title XIX | | | | | | | | | |
| 2. Total Infants in State | | | | | | | | | |
| Title V Served | | | | | | | | | |
| Eligible for Title XIX | | | | | | | | | |

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

None

## Form 7
## Title V Program Workforce

**State: North Dakota**

Form 7 Entry Page

| A. Title V Program Workforce FTEs | |
|---|---|
| **Title V Funded Positions** | |
| 1. Total Number of FTEs | 20.22 |
| 1a. Total Number of FTEs (State Level) | 15.02 |
| 1b. Total Number of FTEs (Local Level) | 5.20 |
| 2. Total Number of MCH Epidemiology FTEs (subset of A. 1) | 0.25 |
| 3. Total Number of FTEs eliminated in the past 12 months | 0.22 |
| 4. Total Number of Current Vacant FTEs | 0 |
| 4a. Total Number of Vacant MCH Epidemiology FTEs | 0 |
| 5. Total Number of FTEs onboarded in the past 12 months | 1 |

| B. Training Needs (Optional) | |
|---|---|
| 1 | Ethics |
| 2 | Negotiation and Conflict Resolution |
| 3 | Policy |
| 4 | Systems Approaches |

**Form Notes for Form 7:**

None

**Field Level Notes for Form 7:**

Form 7 Field Level Notes Table

| | | |
|---|---|---|
| 1. | **Field Name:** | **Total Number of FTEs (State Level)** |
| | **Field Note:** See Section V. Supporting Documents-MCH Workforce Capacity for a detailed breakdown of state-level FTE through North Dakota Title V | |
| 2. | **Field Name:** | **Total Number of FTEs (Local Level)** |
| | **Field Note:** In FFY25, Title V funded 21/28 Local Public Health Units (LPHUs) and 5 Community-Based Organizations (CBOs). Approximating 0.2 FTE per contract for a total of 5.2 FTE's at the local level through Title V funding. | |
| 3. | **Field Name:** | **Total Number of MCH Epidemiology FTEs** |
| | **Field Note:** See Section V. Supporting Documents-MCH Workforce Capacity for a detailed breakdown of state-level FTE through North Dakota Title V, including epidemiology staff. | |
| 4. | **Field Name:** | **Total Number of FTEs eliminated in the past 12 months** |
| | **Field Note:** This small decrease in FTE status is not due to the elimination of positions, but to the ability of Title V members to also work and charge to other projects besides MCH based upon changing/evolving responsibilities. | |
| 5. | **Field Name:** | **Total Number of Current Vacant FTEs** |
| | **Field Note:** Only able to verify at the state-level. | |
| 6. | **Field Name:** | **Total Number of Vacant MCH Epidemiology FTEs** |
| | **Field Note:** Only able to verify at the state-level. | |
| 7. | **Field Name:** | **Total Number of FTEs onboarded in the past 12 months** |
| | **Field Note:** 1 FTE at the state-level was onboarded for CSHCN programs in the Special Health Services Unit. State Title V does not receive onboarding data from the local-level, so this is only for state-level staff. | |
| 8. | **Field Name:** | **Training Needs Line 1** |
| | **Field Note:** MCH Leadership Competency #3--According to the MCH Navigator Self Assessment from October 2024. See Section III.C.1.b.ii.c Title V Workforce Capacity and Workforce Development. | |

Form 7 Field Level Notes Table

| | | |
|---|---|---|
| 9. | **Field Name:** | **Training Needs Line 2** |
| | **Field Note:**<br>MCH Leadership Competency #6--According to the MCH Navigator Self Assessment from October 2024. See Section III.C.1.b.ii.c Title V Workforce Capacity and Workforce Development. | |
| 10. | **Field Name:** | **Training Needs Line 3** |
| | **Field Note:**<br>MCH Leadership Competency #12--According to the MCH Navigator Self Assessment from October 2024. See Section III.C.1.b.ii.c Title V Workforce Capacity and Workforce Development. | |
| 11. | **Field Name:** | **Training Needs Line 4** |
| | **Field Note:**<br>MCH Leadership Competency #11--According to the MCH Navigator Self Assessment from October 2024. See Section III.C.1.b.ii.c Title V Workforce Capacity and Workforce Development. | |

## Form 8
## State MCH and CSHCN Directors Contact Information

**State: North Dakota**

| 1. Title V Maternal and Child Health (MCH) Director | |
|---|---|
| Name | Kimberly Hruby |
| Title | Special Health Services Director/Title V Director |
| Address 1 | 600 E. Boulevard Ave., Dept. 301 |
| Address 2 | |
| City/State/Zip | Bismarck / ND / 58505 |
| Telephone | (701) 328-4854 |
| Extension | |
| Email | krhruby@nd.gov |

| 2. Title V Children with Special Health Care Needs (CSHCN) Director | |
|---|---|
| Name | Danielle Hoff |
| Title | Special Health Services Assistant Director/CSHCN Director |
| Address 1 | 600 E. Boulevard Ave., Dept. 301 |
| Address 2 | |
| City/State/Zip | Bismarck / ND / 58505 |
| Telephone | (701) 328-4669 |
| Extension | |
| Email | dwhoff@nd.gov |

| 3. State Family Leader (Optional) | |
|---|---|
| Name | Melissa (Moe) Swanson |
| Title | AMCHP Family Delegate/Family Voices of ND Representative |
| Address 1 | 2211 117th Ave. SE |
| Address 2 | |
| City/State/Zip | Valley Chity / ND / 58072 |
| Telephone | (701) 793-8339 |
| Extension | |
| Email | mswanson@encompassfss.net |

| 4. State Youth Leader (Optional) | |
|---|---|
| Name | |
| Title | |
| Address 1 | |
| Address 2 | |
| City/State/Zip | |
| Telephone | |
| Extension | |
| Email | |

| 5. SSDI Project Director | |
|---|---|
| Name | Anastasia Stepanov |
| Title | State System Development Initiative (SSDI) Coordinator |
| Address 1 | 600 E. Boulevard Ave., Dept. 301 |
| Address 2 | |
| City/State/Zip | Bismarck / ND / 58505 |
| Telephone | (701) 328-1292 |
| Extension | |
| Email | astepanov@nd.gov |

| 6. State MCH Toll-Free Telephone Line | |
|---|---|
| State MCH Toll-Free “Hotline” Telephone Number | (800) 755-2714 |

**Form Notes for Form 8:**

None

## Form 9
## List of Priority Needs – Needs Assessment Year

**State: North Dakota**

**Application Year 2026**

| No. | Priority Need | Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period) |
|---|---|---|
| 1. | Postpartum Visit: A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth, and B) Percent of women who attended a postpartum checkup and received recommended care comp | New |
| 2. | Safe Sleep: Infants placed to sleep: A) on their backs B) on a separate sleep surface C) without soft objects D) in the same room as an adult | New |
| 3. | Food Sufficiency: Percent of children, ages 0 through 11, whose households were food sufficient in the past year | New |
| 4. | Medical Home-Care Coordination: Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination | New |
| 5. | Mental Health Treatment: Percent of adolescents, ages 12 through 17, who receive needed mental health treatment and counseling | New |
| 6. | Medical Home-Overall: Increase the number of children with special health care needs engaged in medical home | New |
| 7. | State Mandates: Implement North Dakota State Mandates for the Maternal and Child Health Population | Continued |
| 8. | Vision Zero: Eliminate fatalities and serious injuries caused by motor vehicle crashes | Revised |
| 9. | Access to Services: Improve access to health-related services to improve the health and well-being of the MCH population | New |

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

**Field Name:**

Priority Need 1

**Field Note:**
North Dakota Priority Goal: Identify, reduce, or eliminate barriers preventing women from receiving recommended postpartum care components, including but not limited to mental health screening, breastfeeding support, care coordination, etc.

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

**Field Name:**

Priority Need 2

**Field Note:**
North Dakota Priority Goal: Support services, programs, and activities that encourage safe sleep.

Data Source: National Vital Statistics System (NVSS) data published by the Centers for Disease Control and Prevention (CDC) regarding infant mortality; Pregnancy Risk Assessment Monitoring System (PRAMS)

**Field Name:**

Priority Need 3

**Field Note:**
North Dakota Priority Goal: Improve accessibility to healthy food options through community resources (schools, food banks, health units, etc.).

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

**Field Name:**

Priority Need 4

**Field Note:**
North Dakota Priority Goal: Improve care coordination to link the MCH population to essential services and resources.

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

**Field Name:**

Priority Need 5

**Field Note:**
North Dakota Priority Goal: Identify, reduce, or eliminate barriers preventing adolescents from receiving mental health treatment and counseling.

Data Source: National Survey of Children's Health (NSCH), Youth Risk Behavior Survey (YRBS)

**Field Name:**

Priority Need 6

**Field Note:**
North Dakota Priority Goal: Improve the system of care for children with special health care needs.

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

**Field Name:**

Priority Need 7

**Field Note:**
North Dakota Priority Goal: To implement all North Dakota state mandates delegated to the North Dakota Department of Health Title V/Maternal and Child Health Programs.

Data Source: North Dakota state data

**Field Name:**

Priority Need 8

**Field Note:**
North Dakota Priority Goal: Reduce serious motor vehicle injuries and fatalities to North Dakotans younger than 21 years of age

Data Source: North Dakota data from the North Dakota Department of Transportation (DOT), Child Fatality Review Committee, and MCH Programmatic Data

**Field Name:**

Priority Need 9

**Field Note:**
North Dakota Priority Goal: Increase awareness and the utilization of statewide services or resources.

Data Source: North Dakota Medicaid Data and other North Dakota state-level data

## Form 10
## National Outcome Measures (NOMs)

**State: North Dakota**

**Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.**

None

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

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 62.8 | 8.4 | 57 | 9,071 |
| 2021 | 63.7 | 8.4 | 58 | 9,103 |
| 2020 | 61.6 | 8.1 | 58 | 9,420 |
| 2019 | 57.1 | 7.6 | 57 | 9,984 |
| 2018 | 47.2 | 6.8 | 48 | 10,173 |
| 2017 | 61.7 | 7.7 | 64 | 10,375 |
| 2016 | 45.0 | 6.4 | 49 | 10,891 |
| 2015 | 45.9 | 7.6 | 37 | 8,057 |
| 2014 | 65.9 | 8.0 | 69 | 10,472 |
| 2013 | 45.9 | 7.1 | 42 | 9,154 |
| 2012 | 54.5 | 7.8 | 49 | 8,996 |
| 2011 | 37.5 | 6.5 | 33 | 8,796 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM SMM - Notes:**

None

**Data Alerts: None**

**NOM - Maternal mortality rate per 100,000 live births - MM**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2019_2023 | 24.1 ϟ | 7.0 ϟ | 12 ϟ | 49,839 ϟ |
| 2018_2022 | 21.6 ϟ | 6.5 ϟ | 11 ϟ | 50,828 ϟ |
| 2017_2021 | 21.2 ϟ | 6.4 ϟ | 11 ϟ | 51,998 ϟ |
| 2016_2020 | 20.6 ϟ | 6.2 ϟ | 11 ϟ | 53,269 ϟ |
| 2015_2019 | NR ⚑ | NR ⚑ | NR ⚑ | NR ⚑ |
| 2014_2018 | NR ⚑ | NR ⚑ | NR ⚑ | NR ⚑ |

**Legends:**

⚑ Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

**NOM MM - Notes:**

None

**Data Alerts: None**

**NOM - Teen birth rate, ages 15 through 19, per 1,000 females - TB**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2023 | 11.2 | 0.7 | 299 | 26,808 |
| 2022 | 11.7 | 0.7 | 305 | 25,978 |
| 2021 | 12.9 | 0.7 | 317 | 24,554 |
| 2020 | 13.7 | 0.8 | 319 | 23,203 |
| 2019 | 15.6 | 0.8 | 355 | 22,784 |
| 2018 | 16.4 | 0.9 | 372 | 22,718 |
| 2017 | 16.2 | 0.8 | 368 | 22,705 |
| 2016 | 20.3 | 0.9 | 469 | 23,107 |
| 2015 | 22.5 | 1.0 | 527 | 23,460 |
| 2014 | 24.1 | 1.0 | 564 | 23,431 |
| 2013 | 24.1 | 1.0 | 563 | 23,347 |
| 2012 | 26.3 | 1.1 | 603 | 22,929 |
| 2011 | 28.3 | 1.1 | 647 | 22,890 |
| 2010 | 28.9 | 1.1 | 659 | 22,824 |
| 2009 | 28.7 | 1.1 | 663 | 23,133 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM TB - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2023 | 7.1 % | 0.3 % | 681 | 9,646 |
| 2022 | 7.1 % | 0.3 % | 683 | 9,565 |
| 2021 | 6.6 % | 0.3 % | 672 | 10,110 |
| 2020 | 6.9 % | 0.3 % | 693 | 10,057 |
| 2019 | 6.8 % | 0.3 % | 708 | 10,450 |
| 2018 | 6.6 % | 0.2 % | 698 | 10,634 |
| 2017 | 6.7 % | 0.2 % | 720 | 10,732 |
| 2016 | 6.6 % | 0.2 % | 752 | 11,374 |
| 2015 | 6.2 % | 0.2 % | 700 | 11,309 |
| 2014 | 6.2 % | 0.2 % | 704 | 11,359 |
| 2013 | 6.4 % | 0.2 % | 679 | 10,597 |
| 2012 | 6.2 % | 0.2 % | 625 | 10,104 |
| 2011 | 6.7 % | 0.3 % | 637 | 9,523 |
| 2010 | 6.7 % | 0.3 % | 607 | 9,103 |
| 2009 | 6.4 % | 0.3 % | 572 | 9,000 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM LBW - Notes:**

None

**Data Alerts: None**

**NOM - Percent of preterm births (<37 weeks gestation) - PTB**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2023 | 10.3 % | 0.3 % | 994 | 9,638 |
| 2022 | 10.3 % | 0.3 % | 987 | 9,559 |
| 2021 | 9.6 % | 0.3 % | 966 | 10,102 |
| 2020 | 9.8 % | 0.3 % | 987 | 10,052 |
| 2019 | 9.5 % | 0.3 % | 993 | 10,450 |
| 2018 | 9.6 % | 0.3 % | 1,018 | 10,633 |
| 2017 | 8.8 % | 0.3 % | 944 | 10,728 |
| 2016 | 9.1 % | 0.3 % | 1,040 | 11,379 |
| 2015 | 8.4 % | 0.3 % | 955 | 11,311 |
| 2014 | 8.4 % | 0.3 % | 948 | 11,353 |
| 2013 | 8.5 % | 0.3 % | 902 | 10,593 |
| 2012 | 9.1 % | 0.3 % | 918 | 10,103 |
| 2011 | 8.5 % | 0.3 % | 805 | 9,526 |
| 2010 | 9.7 % | 0.3 % | 887 | 9,102 |
| 2009 | 9.2 % | 0.3 % | 826 | 8,997 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM PTB - Notes:**

None

**Data Alerts: None**

**NOM - Stillbirth rate per 1,000 live births plus fetal deaths - SB**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 4.9 | 0.7 | 47 | 9,614 |
| 2021 | 5.1 | 0.7 | 52 | 10,164 |
| 2020 | 6.0 | 0.8 | 61 | 10,120 |
| 2019 | 6.3 | 0.8 | 66 | 10,520 |
| 2018 | 5.6 | 0.7 | 60 | 10,696 |
| 2017 | 5.2 | 0.7 | 56 | 10,793 |
| 2016 | 6.2 | 0.7 | 71 | 11,454 |
| 2015 | 6.1 | 0.7 | 69 | 11,383 |
| 2014 | 5.2 | 0.7 | 59 | 11,418 |
| 2013 | 5.3 | 0.7 | 56 | 10,655 |
| 2012 | 7.0 | 0.8 | 71 | 10,177 |
| 2011 | 5.4 | 0.8 | 52 | 9,579 |
| 2010 | 6.0 | 0.8 | 55 | 9,159 |
| 2009 | 5.0 | 0.7 | 45 | 9,046 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM SB - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 4.3 | 0.7 | 41 | 9,589 |
| 2021 | 4.2 | 0.7 | 43 | 10,138 |
| 2020 | 6.6 | 0.8 | 67 | 10,095 |
| 2019 | 6.2 | 0.8 | 65 | 10,485 |
| 2018 | 5.3 | 0.7 | 57 | 10,665 |
| 2017 | 5.0 | 0.7 | 54 | 10,766 |
| 2016 | 6.7 | 0.8 | 76 | 11,418 |
| 2015 | 6.9 | 0.8 | 78 | 11,350 |
| 2014 | 5.3 | 0.7 | 60 | 11,390 |
| 2013 | 6.6 | 0.8 | 70 | 10,627 |
| 2012 | 5.5 | 0.7 | 56 | 10,136 |
| 2011 | 6.8 | 0.9 | 65 | 9,561 |
| 2010 | 7.2 | 0.9 | 66 | 9,133 |
| 2009 | 5.2 | 0.8 | 47 | 9,026 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM PNM - Notes:**

None

**Data Alerts: None**

**NOM - Infant mortality rate per 1,000 live births - IM**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 4.4 | 0.7 | 42 | 9,567 |
| 2021 | 2.8 | 0.5 | 28 | 10,112 |
| 2020 | 5.5 | 0.7 | 55 | 10,059 |
| 2019 | 7.5 | 0.9 | 78 | 10,454 |
| 2018 | 5.6 | 0.7 | 60 | 10,636 |
| 2017 | 4.4 | 0.6 | 47 | 10,737 |
| 2016 | 6.4 | 0.8 | 73 | 11,383 |
| 2015 | 7.2 | 0.8 | 81 | 11,314 |
| 2014 | 5.1 | 0.7 | 58 | 11,359 |
| 2013 | 6.0 | 0.8 | 64 | 10,599 |
| 2012 | 6.3 | 0.8 | 64 | 10,106 |
| 2011 | 6.5 | 0.8 | 62 | 9,527 |
| 2010 | 6.8 | 0.9 | 62 | 9,104 |
| 2009 | 6.3 | 0.8 | 57 | 9,001 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM IM - Notes:**

None

**Data Alerts: None**

**NOM - Neonatal mortality rate per 1,000 live births - IM-Neonatal**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 3.0 | 0.6 | 29 | 9,567 |
| 2021 | 2.0 | 0.4 | 20 | 10,112 |
| 2020 | 3.6 | 0.6 | 36 | 10,059 |
| 2019 | 4.6 | 0.7 | 48 | 10,454 |
| 2018 | 3.4 | 0.6 | 36 | 10,636 |
| 2017 | 3.3 | 0.6 | 35 | 10,737 |
| 2016 | 4.4 | 0.6 | 50 | 11,383 |
| 2015 | 4.4 | 0.6 | 50 | 11,314 |
| 2014 | 2.9 | 0.5 | 33 | 11,359 |
| 2013 | 4.7 | 0.7 | 50 | 10,599 |
| 2012 | 3.3 | 0.6 | 33 | 10,106 |
| 2011 | 4.0 | 0.7 | 38 | 9,527 |
| 2010 | 5.1 | 0.8 | 46 | 9,104 |
| 2009 | 3.3 | 0.6 | 30 | 9,001 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM IM-Neonatal - Notes:**

None

**Data Alerts: None**

**NOM - Post neonatal mortality rate per 1,000 live births - IM-Postneonatal**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 1.4 ϟ | 0.4 ϟ | 13 ϟ | 9,567 ϟ |
| 2021 | NR ⚑ | NR ⚑ | NR ⚑ | NR ⚑ |
| 2020 | 1.9 ϟ | 0.4 ϟ | 19 ϟ | 10,059 ϟ |
| 2019 | 2.9 | 0.5 | 30 | 10,454 |
| 2018 | 2.3 | 0.5 | 24 | 10,636 |
| 2017 | 1.1 ϟ | 0.3 ϟ | 12 ϟ | 10,737 ϟ |
| 2016 | 2.0 | 0.4 | 23 | 11,383 |
| 2015 | 2.7 | 0.5 | 31 | 11,314 |
| 2014 | 2.2 | 0.4 | 25 | 11,359 |
| 2013 | 1.3 ϟ | 0.4 ϟ | 14 ϟ | 10,599 ϟ |
| 2012 | 3.1 | 0.6 | 31 | 10,106 |
| 2011 | 2.5 | 0.5 | 24 | 9,527 |
| 2010 | 1.8 ϟ | 0.4 ϟ | 16 ϟ | 9,104 ϟ |
| 2009 | 3.0 | 0.6 | 27 | 9,001 |

**Legends:**

⚑ Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

**NOM IM-Postneonatal - Notes:**

None

**Data Alerts: None**

**NOM - Preterm-related mortality rate per 100,000 live births - IM-Preterm Related**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 135.9 | 37.7 | 13 | 9,567 |
| 2021 | 108.8 | 32.8 | 11 | 10,112 |
| 2020 | 198.8 | 44.5 | 20 | 10,059 |
| 2019 | 210.4 | 44.9 | 22 | 10,454 |
| 2018 | 131.6 | 35.2 | 14 | 10,636 |
| 2017 | 130.4 | 34.9 | 14 | 10,737 |
| 2016 | 193.3 | 41.3 | 22 | 11,383 |
| 2015 | 167.9 | 38.6 | 19 | 11,314 |
| 2014 | 140.9 | 35.2 | 16 | 11,359 |
| 2013 | 235.9 | 47.2 | 25 | 10,599 |
| 2012 | 158.3 | 39.6 | 16 | 10,106 |
| 2011 | 147.0 | 39.3 | 14 | 9,527 |
| 2010 | 164.8 | 42.6 | 15 | 9,104 |
| 2009 | 122.2 | 36.9 | 11 | 9,001 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM IM-Preterm Related - Notes:**

None

**Data Alerts: None**

**NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births - IM-SUID**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | NR | NR | NR | NR |
| 2021 | NR | NR | NR | NR |
| 2020 | 129.2 | 35.9 | 13 | 10,059 |
| 2019 | 124.4 | 34.5 | 13 | 10,454 |
| 2018 | NR | NR | NR | NR |
| 2017 | NR | NR | NR | NR |
| 2016 | 105.4 | 30.5 | 12 | 11,383 |
| 2015 | 150.3 | 36.5 | 17 | 11,314 |
| 2014 | 88.0 | 27.9 | 10 | 11,359 |
| 2013 | 94.3 | 29.9 | 10 | 10,599 |
| 2012 | 197.9 | 44.3 | 20 | 10,106 |
| 2011 | 167.9 | 42.0 | 16 | 9,527 |
| 2010 | 109.8 | 34.8 | 10 | 9,104 |
| 2009 | 166.6 | 43.1 | 15 | 9,001 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM IM-SUID - Notes:**

None

**Data Alerts: None**

**NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations - NAS**

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 6.1 | 0.8 | 55 | 9,016 |
| 2021 | 7.5 | 0.9 | 68 | 9,114 |
| 2020 | 7.7 | 0.9 | 71 | 9,279 |
| 2019 | 6.2 | 0.8 | 61 | 9,802 |
| 2018 | 4.0 | 0.6 | 41 | 10,212 |
| 2017 | 4.4 | 0.7 | 44 | 10,085 |
| 2016 | 4.7 | 0.7 | 50 | 10,603 |
| 2015 | 4.8 | 0.8 | 38 | 7,939 |
| 2014 | 4.8 | 0.7 | 49 | 10,175 |
| 2013 | 3.7 | 0.7 | 31 | 8,416 |
| 2012 | 3.0 | 0.6 | 24 | 8,081 |
| 2011 | 1.7 | 0.4 | 14 | 8,472 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM NAS - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children meeting the criteria developed for school readiness - SR**

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 65.1 % | 3.6 % | 19,149 | 29,393 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM SR - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year - TDC**

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 11.5 % | 1.2 % | 19,592 | 170,954 |
| 2021_2022 | 12.2 % | 1.2 % | 20,704 | 170,110 |
| 2020_2021 | 11.6 % | 1.2 % | 19,480 | 167,517 |
| 2019_2020 | 9.9 % | 1.2 % | 16,341 | 164,925 |
| 2018_2019 | 10.3 % | 1.3 % | 16,668 | 162,102 |
| 2017_2018 | 10.8 % | 1.5 % | 17,302 | 160,082 |
| 2016_2017 | 9.6 % | 1.3 % | 15,231 | 158,169 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM TDC - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2023 | 18.3 | 4.4 | 17 | 93,059 |
| 2022 | 23.8 | 5.1 | 22 | 92,494 |
| 2021 | 12.6 | 3.7 | 12 | 94,949 |
| 2020 | 19.0 | 4.5 | 18 | 94,626 |
| 2019 | 15.8 | 4.1 | 15 | 94,649 |
| 2018 | 14.9 | 4.0 | 14 | 94,099 |
| 2017 | 14.1 | 3.9 | 13 | 92,484 |
| 2016 | 12.8 | 3.7 | 12 | 93,530 |
| 2015 | 19.6 | 4.6 | 18 | 91,835 |
| 2014 | 18.1 | 4.5 | 16 | 88,621 |
| 2013 | 19.9 | 4.8 | 17 | 85,223 |
| 2012 | 17.4 | 4.7 | 14 | 80,401 |
| 2011 | 22.0 | 5.3 | 17 | 77,351 |
| 2010 | 17.2 | 4.8 | 13 | 75,740 |
| 2009 | 18.9 | 5.1 | 14 | 73,913 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM CM - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2023 | 37.4 | 5.9 | 40 | 106,949 |
| 2022 | 38.3 | 6.1 | 40 | 104,569 |
| 2021 | 44.8 | 6.6 | 46 | 102,589 |
| 2020 | 42.1 | 6.6 | 41 | 97,332 |
| 2019 | 39.7 | 6.5 | 38 | 95,645 |
| 2018 | 23.2 | 4.9 | 22 | 94,930 |
| 2017 | 44.8 | 6.9 | 42 | 93,853 |
| 2016 | 34.1 | 6.0 | 32 | 93,820 |
| 2015 | 36.1 | 6.2 | 34 | 94,131 |
| 2014 | 30.4 | 5.7 | 28 | 92,162 |
| 2013 | 39.7 | 6.6 | 36 | 90,573 |
| 2012 | 46.7 | 7.3 | 41 | 87,701 |
| 2011 | 44.5 | 7.1 | 39 | 87,706 |
| 2010 | 48.1 | 7.4 | 42 | 87,264 |
| 2009 | 50.0 | 7.5 | 44 | 88,015 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM AM - Notes:**

None

**Data Alerts: None**

**NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 - AM-Motor Vehicle**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2021-2023 | 16.2 | 3.2 | 26 | 160,855 |
| 2020_2022 | 20.2 | 3.6 | 31 | 153,288 |
| 2019_2021 | 19.1 | 3.6 | 28 | 146,396 |
| 2018_2020 | 11.2 | 2.8 | 16 | 142,639 |
| 2017_2019 | 11.3 | 2.8 | 16 | 141,830 |
| 2016_2018 | 10.5 | 2.7 | 15 | 143,001 |
| 2015_2017 | 20.0 | 3.7 | 29 | 145,163 |
| 2014_2016 | 19.1 | 3.6 | 28 | 146,923 |
| 2013_2015 | 21.0 | 3.8 | 31 | 147,485 |
| 2012_2014 | 22.7 | 3.9 | 33 | 145,625 |
| 2011_2013 | 26.3 | 4.3 | 38 | 144,479 |
| 2010_2012 | 26.6 | 4.3 | 38 | 143,039 |
| 2009_2011 | 24.4 | 4.1 | 35 | 143,509 |
| 2008_2010 | 24.3 | 4.1 | 35 | 144,259 |
| 2007_2009 | 30.1 | 4.5 | 44 | 146,356 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM AM-Motor Vehicle - Notes:**

None

**Data Alerts: None**

**NOM - Adolescent suicide rate, ages 10 through 19 per 100,000 - AM-Suicide**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2021_2023 | 10.5 | 1.8 | 33 | 314,107 |
| 2020_2022 | 9.5 | 1.8 | 29 | 304,490 |
| 2019_2021 | 12.9 | 2.1 | 38 | 295,566 |
| 2018_2020 | 12.9 | 2.1 | 37 | 287,907 |
| 2017_2019 | 14.1 | 2.2 | 40 | 284,428 |
| 2016_2018 | 12.0 | 2.1 | 34 | 282,603 |
| 2015_2017 | 11.0 | 2.0 | 31 | 281,804 |
| 2014_2016 | 10.4 | 1.9 | 29 | 280,113 |
| 2013_2015 | 11.2 | 2.0 | 31 | 276,866 |
| 2012_2014 | 11.5 | 2.1 | 31 | 270,436 |
| 2011_2013 | 10.9 | 2.0 | 29 | 265,980 |
| 2010_2012 | 12.2 | 2.2 | 32 | 262,671 |
| 2009_2011 | 13.3 | 2.3 | 35 | 262,985 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM AM-Suicide - Notes:**

None

**Data Alerts: None**

**NOM - Adolescent firearm mortality rate, ages 10 through 19 per 100,000 - AM-Firearm**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2021_2023 | 8.6 | 1.7 | 27 | 314,107 |
| 2020_2022 | 6.9 | 1.5 | 21 | 304,490 |
| 2019_2021 | 9.1 | 1.8 | 27 | 295,566 |
| 2018_2020 | 8.3 | 1.7 | 24 | 287,907 |
| 2017_2019 | 8.1 | 1.7 | 23 | 284,428 |
| 2016_2018 | 7.4 | 1.6 | 21 | 282,603 |
| 2015_2017 | 6.4 | 1.5 | 18 | 281,804 |
| 2014_2016 | 6.1 | 1.5 | 17 | 280,113 |
| 2013_2015 | 6.1 | 1.5 | 17 | 276,866 |
| 2012_2014 | 6.3 | 1.5 | 17 | 270,436 |
| 2011_2013 | 6.0 | 1.5 | 16 | 265,980 |
| 2010_2012 | 6.5 | 1.6 | 17 | 262,671 |
| 2009_2011 | 8.0 | 1.7 | 21 | 262,985 |
| 2008_2010 | 7.6 | 1.7 | 20 | 264,518 |
| 2007_2009 | 5.6 | 1.5 | 15 | 267,803 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM AM-Firearm - Notes:**

None

**Data Alerts: None**

**NOM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 - IH-Child**

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 91.6 | 9.5 | 94 | 102,587 |
| 2021 | 101.3 | 9.8 | 106 | 104,689 |
| 2020 | 122.8 | 10.8 | 129 | 105,085 |
| 2019 | 97.0 | 9.6 | 102 | 105,132 |
| 2018 | 89.6 | 9.2 | 94 | 104,901 |
| 2017 | 90.9 | 9.4 | 94 | 103,467 |
| 2016 | 91.4 | 9.3 | 96 | 105,035 |
| 2015 | 104.9 | 11.7 | 81 | 77,234 |
| 2014 | 108.6 | 10.5 | 108 | 99,409 |
| 2013 | 116.5 | 11.1 | 111 | 95,311 |
| 2012 | 132.9 | 12.2 | 119 | 89,523 |
| 2011 | 156.4 | 13.5 | 135 | 86,344 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM IH-Child - Notes:**

None

**Data Alerts: None**

**NOM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 - IH-Adolescent**

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022 | 230.5 | 14.9 | 241 | 104,569 |
| 2021 | 237.8 | 15.2 | 244 | 102,589 |
| 2020 | 259.9 | 16.3 | 253 | 97,332 |
| 2019 | 224.8 | 15.3 | 215 | 95,645 |
| 2018 | 207.5 | 14.8 | 197 | 94,930 |
| 2017 | 235.5 | 15.8 | 221 | 93,853 |
| 2016 | 218.5 | 15.3 | 205 | 93,820 |
| 2015 | 221.0 | 17.7 | 156 | 70,598 |
| 2014 | 238.7 | 16.1 | 220 | 92,162 |
| 2013 | 234.1 | 16.1 | 212 | 90,573 |
| 2012 | 312.4 | 18.9 | 274 | 87,701 |
| 2011 | 306.7 | 18.7 | 269 | 87,706 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM IH-Adolescent - Notes:**

None

**Data Alerts: None**

**NOM - Percent of women, ages 18 through 44, in excellent or very good health - WHS**

**Data Source: Behavioral Risk Factor Surveillance System (BRFSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2023 | 51.5 % | 2.2 % | 72,416 | 140,620 |
| 2022 | 55.8 % | 2.4 % | 77,637 | 139,141 |
| 2021 | 61.9 % | 2.2 % | 86,514 | 139,653 |
| 2020 | 60.6 % | 2.7 % | 82,050 | 135,346 |
| 2019 | 57.4 % | 2.6 % | 77,682 | 135,349 |
| 2018 | 60.1 % | 2.6 % | 80,832 | 134,417 |
| 2017 | 59.1 % | 2.1 % | 80,354 | 135,932 |
| 2017 | 59.1 % | 2.1 % | 80,354 | 135,932 |
| 2016 | 60.3 % | 2.3 % | 81,864 | 135,763 |
| 2015 | 62.5 % | 2.4 % | 83,712 | 133,958 |
| 2014 | 61.8 % | 2.3 % | 80,855 | 130,791 |
| 2013 | 64.7 % | 2.0 % | 80,183 | 123,949 |
| 2012 | 62.4 % | 2.3 % | 74,440 | 119,220 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**NOM WHS - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children, ages 0 through 17, in excellent or very good health - CHS**

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 92.6 % | 1.0 % | 167,175 | 180,498 |
| 2021_2022 | 92.1 % | 1.0 % | 166,360 | 180,575 |
| 2020_2021 | 91.8 % | 1.1 % | 162,700 | 177,216 |
| 2019_2020 | 91.4 % | 1.2 % | 159,081 | 173,974 |
| 2018_2019 | 91.4 % | 1.2 % | 157,834 | 172,702 |
| 2017_2018 | 91.6 % | 1.4 % | 158,535 | 173,127 |
| 2016_2017 | 91.7 % | 1.2 % | 157,579 | 171,889 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM CHS - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children, ages 2 through 4, and adolescents, ages 6 through 17, who are obese (BMI at or above the 95th percentile) - OBS**

**Data Source: WIC**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2020 | 15.9 % | 0.7 % | 488 | 3,072 |
| 2018 | 15.4 % | 0.5 % | 703 | 4,560 |
| 2016 | 14.3 % | 0.5 % | 677 | 4,723 |
| 2014 | 14.4 % | 0.5 % | 659 | 4,586 |
| 2012 | 14.0 % | 0.5 % | 685 | 4,883 |
| 2010 | 14.5 % | 0.5 % | 794 | 5,484 |
| 2008 | 14.2 % | 0.5 % | 720 | 5,072 |

**Legends:**

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 13.4 % | 1.5 % | 15,523 | 115,631 |
| 2021_2022 | 14.6 % | 1.6 % | 16,586 | 113,519 |
| 2020_2021 | 15.0 % | 1.7 % | 16,702 | 111,151 |
| 2019_2020 | 13.7 % | 1.6 % | 14,645 | 106,961 |
| 2018_2019 | 14.9 % | 1.8 % | 15,494 | 104,002 |
| 2017_2018 | 13.3 % | 1.8 % | 13,390 | 100,683 |
| 2016_2017 | 13.0 % | 1.6 % | 12,799 | 98,653 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM OBS - Notes:**

None

**Data Alerts: None**

**NOM - Percent of women who experience postpartum depressive symptoms - PPD**

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2023 | 15.6 % | 1.9 % | 1,392 | 8,941 |
| 2022 | 10.5 % | 1.6 % | 960 | 9,121 |
| 2021 | 13.2 % | 1.7 % | 1,275 | 9,693 |
| 2020 | 14.5 % | 1.6 % | 1,377 | 9,471 |
| 2019 | 16.1 % | 1.7 % | 1,594 | 9,898 |
| 2018 | 11.7 % | 1.3 % | 1,184 | 10,101 |
| 2017 | 9.9 % | 1.5 % | 985 | 9,993 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**NOM PPD - Notes:**

None

**Data Alerts: None**

**NOM - Percent of women who experience postpartum anxiety symptoms - PPA**

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2023 | 25.8 % | 2.3 % | 2,308 | 8,942 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**NOM PPA - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children, ages 6 through 11, who have a behavioral or conduct disRecordOrder - BCD**

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 11.5 % | 1.9 % | 7,213 | 62,467 |
| 2021_2022 | 13.5 % | 2.1 % | 8,433 | 62,504 |
| 2020_2021 | 11.9 % | 2.2 % | 7,231 | 60,514 |
| 2019_2020 | 9.2 % | 1.9 % | 5,450 | 59,087 |
| 2018_2019 | 7.4 % | 1.5 % | 4,310 | 58,290 |
| 2017_2018 | 6.7 % | 1.5 % | 3,868 | 57,715 |
| 2016_2017 | 7.4 % | 1.6 % | 4,191 | 56,858 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM BCD - Notes:**

None

**Data Alerts: None**

**NOM - Percent of adolescents, ages 12 through 17, who have depression or anxiety - ADA**

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 25.9 % | 2.9 % | 15,319 | 59,206 |
| 2021_2022 | 26.1 % | 2.9 % | 14,748 | 56,564 |
| 2020_2021 | 17.9 % | 2.4 % | 10,055 | 56,062 |
| 2019_2020 | 16.4 % | 2.4 % | 8,838 | 53,839 |
| 2018_2019 | 19.4 % | 2.8 % | 9,991 | 51,581 |
| 2017_2018 | 20.0 % | 3.1 % | 10,220 | 50,981 |
| 2016_2017 | 18.6 % | 2.6 % | 9,589 | 51,487 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM ADA - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system - SOC**

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 17.7 % | 2.5 % | 8,664 | 48,993 |
| 2021_2022 | 12.6 % | 2.0 % | 6,050 | 48,177 |
| 2020_2021 | 14.2 % | 2.2 % | 6,032 | 42,367 |
| 2019_2020 | 13.4 % | 2.4 % | 5,306 | 39,614 |
| 2018_2019 | 9.0 % | 1.7 % | 3,698 | 40,916 |
| 2017_2018 | 9.0 % | 2.1 % | 3,491 | 38,633 |
| 2016_2017 | 11.3 % | 2.3 % | 4,258 | 37,672 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM SOC - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children, ages 6 months through 5, who are flourishing - FL-YC**

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 78.2 % | 2.7 % | 41,876 | 53,518 |
| 2021_2022 | 80.4 % | 2.5 % | 44,655 | 55,565 |
| 2020_2021 | 85.5 % | 2.0 % | 46,102 | 53,949 |
| 2019_2020 | 86.9 % | 2.2 % | 48,968 | 56,329 |
| 2018_2019 | 86.9 % | 2.6 % | 50,068 | 57,603 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM FL-YC - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-CA**

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 32.6 % | 3.4 % | 12,776 | 39,245 |
| 2021_2022 | 34.8 % | 3.6 % | 13,583 | 39,063 |
| 2020_2021 | 35.5 % | 3.9 % | 11,609 | 32,747 |
| 2019_2020 | 36.9 % | 4.3 % | 11,113 | 30,107 |
| 2018_2019 | 47.5 % | 4.6 % | 14,769 | 31,111 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM FL-CA - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-Child Adolescent**

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 59.7 % | 2.1 % | 72,225 | 120,902 |
| 2021_2022 | 58.8 % | 2.1 % | 69,105 | 117,483 |
| 2020_2021 | 62.1 % | 2.1 % | 71,308 | 114,850 |
| 2019_2020 | 65.7 % | 2.3 % | 74,133 | 112,761 |
| 2018_2019 | 69.8 % | 2.3 % | 76,996 | 110,351 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM FL-Child Adolescent - Notes:**

None

**Data Alerts: None**

**NOM - Percent of children, ages 0 through 17, who have experienced 2 or more Adverse Childhood Experiences - ACE**

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2022_2023 | 19.6 % | 1.6 % | 34,745 | 177,511 |
| 2021_2022 | 17.8 % | 1.5 % | 31,475 | 176,864 |
| 2020_2021 | 16.0 % | 1.4 % | 27,836 | 173,505 |
| 2019_2020 | 18.8 % | 1.7 % | 32,374 | 172,088 |
| 2018_2019 | 20.7 % | 1.8 % | 35,427 | 170,976 |
| 2017_2018 | 20.4 % | 1.9 % | 34,832 | 171,089 |
| 2016_2017 | 18.0 % | 1.7 % | 30,596 | 169,742 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM ACE - Notes:**

None

**Data Alerts: None**

## Form 10
## National Performance Measures (NPMs)

**State: North Dakota**

**NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV**

| Federally Available Data | | |
|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | |
| | **2023** | **2024** |
| Annual Objective | | |
| Annual Indicator | 93.2 | 91.5 |
| Numerator | 8,561 | 8,211 |
| Denominator | 9,189 | 8,969 |
| Data Source | PRAMS | PRAMS |
| Data Source Year | 2022 | 2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Field Level Notes for Form 10 NPMs:**

None

**NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV**

| Federally Available Data | | |
|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | |
| | **2023** | **2024** |
| Annual Objective | | |
| Annual Indicator | 85.7 | 74.2 |
| Numerator | 7,331 | 6,044 |
| Denominator | 8,555 | 8,148 |
| Data Source | PRAMS | PRAMS |
| Data Source Year | 2022 | 2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Field Level Notes for Form 10 NPMs:**

None

**NPM - A) Percent of infants placed to sleep on their backs - SS**

| Federally Available Data | |
|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 75.4 |
| Numerator | 6,568 |
| Denominator | 8,714 |
| Data Source | PRAMS |
| Data Source Year | 2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Field Level Notes for Form 10 NPMs:**

None

**NPM - B) Percent of infants placed to sleep on a separate approved sleep surface - SS**

| Federally Available Data | |
|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 25.7 |
| Numerator | 2,245 |
| Denominator | 8,747 |
| Data Source | PRAMS |
| Data Source Year | 2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Field Level Notes for Form 10 NPMs:**

None

**NPM - C) Percent of infants placed to sleep without soft objects or loose bedding - SS**

| Federally Available Data | |
|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 73.7 |
| Numerator | 6,512 |
| Denominator | 8,834 |
| Data Source | PRAMS |
| Data Source Year | 2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Field Level Notes for Form 10 NPMs:**

None

**NPM - D) Percent of infants room-sharing with an adult during sleep - SS**

| Federally Available Data | |
|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 71.8 |
| Numerator | 6,403 |
| Denominator | 8,916 |
| Data Source | PRAMS |
| Data Source Year | 2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Field Level Notes for Form 10 NPMs:**

None

**NPM - Percent of children, ages 0 through 11, whose households were food sufficient in the past year - FS**

| Federally Available Data | |
|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 68.7 |
| Numerator | 80,878 |
| Denominator | 117,702 |
| Data Source | NSCH |
| Data Source Year | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Field Level Notes for Form 10 NPMs:**

None

**NPM - Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling - MHT**

| Federally Available Data | |
|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 89.5 |
| Numerator | 11,931 |
| Denominator | 13,324 |
| Data Source | NSCH |
| Data Source Year | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Field Level Notes for Form 10 NPMs:**

None

**NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs**

| Federally Available Data | | |
|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | |
| | **2023** | **2024** |
| Annual Objective | | |
| Annual Indicator | 41.2 | 49.6 |
| Numerator | 15,526 | 24,324 |
| Denominator | 37,687 | 48,993 |
| Data Source | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | 2021_2022 | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Field Level Notes for Form 10 NPMs:**

None

**NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children**

| Federally Available Data | | |
|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - All Children** | | |
| | **2023** | **2024** |
| Annual Objective | | |
| Annual Indicator | 52.3 | 55.2 |
| Numerator | 94,277 | 99,691 |
| Denominator | 180,420 | 180,515 |
| Data Source | NSCH-All Children | NSCH-All Children |
| Data Source Year | 2021_2022 | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Field Level Notes for Form 10 NPMs:**

None

**NPM - Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination - MH_CC - Child Health - All Children**

| Federally Available Data | |
|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - All Children** | |
| | **2024** |
| Annual Objective | |
| Annual Indicator | 74.9 |
| Numerator | 68,642 |
| Denominator | 91,695 |
| Data Source | NSCH-All Children |
| Data Source Year | 2022_2023 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2026** | **2027** | **2028** | **2029** | **2030** |
| Annual Objective | | | | | |

**Field Level Notes for Form 10 NPMs:**

None

## Form 10
## National Performance Measures (NPMs) (2021-2025 Needs Assessment Cycle)

**State: North Dakota**

**2021-2025: NPM - A) Percent of infants who are ever breastfed - BF**

| Federally Available Data | | |
|---|---|---|
| **Data Source: National Vital Statistics System (NVSS)** | | |
| | **2023** | **2024** |
| Annual Objective | 89 | 91 |
| Annual Indicator | 84.8 | 84.1 |
| Numerator | 7,558 | 7,697 |
| Denominator | 8,911 | 9,154 |
| Data Source | NVSS | NVSS |
| Data Source Year | 2022 | 2023 |

**Field Level Notes for Form 10 NPMs:**

None

**2021-2025: NPM - B) Percent of infants breastfed exclusively through 6 months - BF**

| Federally Available Data | | |
|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | |
| | **2023** | **2024** |
| Annual Objective | 29 | 31 |
| Annual Indicator | 28.6 | 26.2 |
| Numerator | 6,736 | 6,173 |
| Denominator | 23,569 | 23,550 |
| Data Source | NSCH | NSCH |
| Data Source Year | 2021_2022 | 2022_2023 |

**Field Level Notes for Form 10 NPMs:**

None

**2021-2025: NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CHILD** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 33 | 43 | 41 | 43 | 45 |
| Annual Indicator | 41.3 | 40.2 | 38.2 | 31.9 | 31.1 |
| Numerator | 25,974 | 24,470 | 22,897 | 19,703 | 19,307 |
| Denominator | 62,891 | 60,820 | 59,972 | 61,720 | 62,113 |
| Data Source | NSCH-CHILD | NSCH-CHILD | NSCH-CHILD | NSCH-CHILD | NSCH-CHILD |
| Data Source Year | 2018_2019 | 2019_2020 | 2020_2021 | 2021_2022 | 2022_2023 |

**Field Level Notes for Form 10 NPMs:**

None

**2021-2025: NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 77 | 77 | 72 | 76 |
| Annual Indicator | 75.5 | 75.0 | 67.6 | 68.0 | 74.0 |
| Numerator | 37,391 | 39,331 | 37,880 | 37,986 | 42,723 |
| Denominator | 49,536 | 52,409 | 56,000 | 55,881 | 57,763 |
| Data Source | NSCH | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | 2019 | 2019_2020 | 2020_2021 | 2021_2022 | 2022_2023 |

**Field Level Notes for Form 10 NPMs:**

None

**2021-2025: NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC - Children with Special Health Care Needs**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 34 | 28 | 28 | 30 | 32 |
| Annual Indicator | 26.1 | 27.5 | 27.7 | 25.0 | 28.9 |
| Numerator | 3,271 | 3,339 | 3,707 | 4,265 | 6,427 |
| Denominator | 12,512 | 12,121 | 13,390 | 17,081 | 22,226 |
| Data Source | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | 2018_2019 | 2019_2020 | 2020_2021 | 2021_2022 | 2022_2023 |

**Field Level Notes for Form 10 NPMs:**

None

**2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: Behavioral Risk Factor Surveillance System (BRFSS)** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 64 | 73 | 70 | 72 | 74 |
| Annual Indicator | 72.3 | 66.8 | 69.4 | 72.3 | 75.2 |
| Numerator | 96,797 | 89,779 | 94,912 | 99,011 | 103,481 |
| Denominator | 133,888 | 134,347 | 136,859 | 137,010 | 137,519 |
| Data Source | BRFSS | BRFSS | BRFSS | BRFSS | BRFSS |
| Data Source Year | 2019 | 2020 | 2021 | 2022 | 2023 |

**Field Level Notes for Form 10 NPMs:**

None

## Form 10
## State Performance Measures (SPMs)

**State: North Dakota**

**SPM 1 - Vision Zero--Eliminate fatalities and serious injuries caused by motor vehicle crashes**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | | | | | |

**Field Level Notes for Form 10 SPMs:**

None

**SPM 2 - North Dakota State Mandates--Implement North Dakota state mandates delegated to North Dakota Department of Health and Human Services' Title V / Maternal and Child Health Program.**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | Yes | Yes | Yes | Yes | Yes |
| Annual Indicator | Yes | Yes | Yes | Yes | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | ND Century Code, ND Administrative Rules | ND Century Code, ND Administrative Rules | The North Dakota Century Code, North Dakota Admini | The North Dakota Century Code | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2026 | 2027 | 2028 | 2029 | 2030 |
| Annual Objective | | | | | |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: 2019 North Dakota Century Code, North Dakota Administrative Code for North Dakota Department of Health, and Title V / Maternal and Child Health Program. | |
| 2. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: 2020 North Dakota Century Code, North Dakota Administrative Code for North Dakota Department of Health, and Title V / Maternal and Child Health Program. | |
| 3. | **Field Name:** | **2021** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: 2020 North Dakota Century Code, North Dakota Administrative Code for North Dakota Department of Health, and Title V / Maternal and Child Health Program. | |
| 4. | **Field Name:** | **2022** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>2022-Data Source: The North Dakota Century Code, North Dakota Administrative Code for North Dakota Department of Health and Human Services, and Title V / Maternal and Child Health Program. Calendar Year data - CY | |
| 5. | **Field Name:** | **2023** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>2023-Data Source: The North Dakota Century Code, North Dakota Administrative Code for North Dakota Department of Health and Human Services, and Title V / Maternal and Child Health Program. Calendar Year data - CY | |

## Form 10
## State Performance Measures (SPMs) (2021-2025 Needs Assessment Cycle)

**2021-2025: SPM 1 - Vision Zero – Eliminate fatalities and serious injuries caused by motor vehicle crashes.- By 2025, Increase the number of car seat checkups offered by the NDDoH for North Dakotans from 69 to 100.**

| **Measure Status:** | **Active** | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | | 70 | 72 | 76 |
| Annual Indicator | 50 | 63 | 68 | 85 | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | The North Dakota Department of Health (NDDOH) and | The North Dakota Department of Health (NDDOH) and | The North Dakota Department of Health and Human S | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: CY 2020:The North Dakota Department of Health (NDDOH), the North Dakota Department of Transportation, and the National Digital Car Seat Check Form:<br><br>https://carseatcheckform.org/national-dashboard<br>Data reported is for federal fiscal year. | |
| 2. | **Field Name:** | **2021** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: CY 2021:The North Dakota Department of Health (NDDOH), the North Dakota Department of Transportation, and the National Digital Car Seat Check Form:<br><br>https://carseatcheckform.org/national-dashboard<br>Data reported is for federal fiscal year. | |
| 3. | **Field Name:** | **2022** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>CY 2022: The North Dakota Department of Health & Human Services, Family Health and Wellness Unit. Data reported is for Federal Fiscal Year. | |
| 4. | **Field Name:** | **2023** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>CY 2023: The North Dakota Department of Health & Human Services, Family Health and Wellness Unit. Data reported is for Federal Fiscal Year. | |

**2021-2025: SPM 3 - Maternal and Child Health (MCH) Workforce Development-The number of individuals enrolled in the Maternal and Child Health (MCH) Certificate Program.**

| **Measure Status:** | **Active** | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 45 | 10 | 15 | 20 |
| Annual Indicator | 35 | 4 | 4 | 14 | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | The North Dakota Department of Health. | The North Dakota Department of Health. | The North Dakota Department | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: The North Dakota Department of Health.<br>The data reported in 2019 is for : Workforce Development - the number of individuals who receive MCH workforce development that report public health competency. | |
| 2. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: The North Dakota Department of Health.<br>The data reported in 2020 is for : Workforce Development - the number of individuals who receive MCH workforce development that report public health competency. | |
| 3. | **Field Name:** | **2021** |
| | **Column Name:** | **State Provided Data** |

| | | |
|---|---|---|
| | **Field Note:**<br>Data Source:The North Dakota Department of Health (NDDoH), tracking and reporting from the North Dakota State University's contract.<br><br>There was a wodring change for reporting for the Calendar year 2022:<br><br>The wording changed from MCH Workforce Development - the number of individuals who receive MCH workforce development that report public health competency-changed to-SPM 3 - Maternal and Child Health (MCH) Workforce Development-The number of individuals enrolled in the Maternal and Child Health (MCH) Certificate Program.<br><br>4 were enrolled in the Maternal and Child Health (MCH) Certificate Program as of August 6, 2022. | |
| 4. | **Field Name:** | **2022** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>CY 2022: Data Source: The North Dakota Department of Health and Human Services (NDDHHS), tracking and reporting from the North Dakota State University's contract. | |
| 5. | **Field Name:** | **2023** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>We include our students who are enrolled full-time in our MPH program who are participating in the MCH subplan (they are taking the courses that were designated for the certificate, but they fulfill part of the degree requirements for the full MPH.<br>For 2023-2024, there were 2 certificate students.<br>Data source: he North Dakota Department of Health and Human Services (NDDHHS), tracking and reporting from the North Dakota State University's contract. | |

## Form 10
## Evidence-Based or –Informed Strategy Measures (ESMs)

**State: North Dakota**

## Form 10
## Evidence-Based or -Informed Strategy Measures (ESMs) (2021-2025 Needs Assessment Cycle)

**2021-2025: ESM BF.2 - Number of businesses designated Infant Friendly Workplaces.**

| **Measure Status:** | **Active** | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 150 | 155 | 165 | 175 |
| Annual Indicator | 136 | 145 | 155 | 190 | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | North Dakota Department of Health. Family Health a | North Dakota Department of Health. Family Health a | The North Dakota Department of Health and Human Se | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | North Dak | |
| Provisional or Final ? | Final | Final | Final | Final | |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data source: North Dakota Department of Health. Family Health and Wellness Division.Data reported is for federal fiscal year. | |
| 2. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data source: North Dakota Department of Health. Family Health and Wellness Division.Data reported is for federal fiscal year. | |
| 3. | **Field Name:** | **2021** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data source: North Dakota Department of Health. Family Health and Wellness Division.Data reported is for federal fiscal year. | |
| 4. | **Field Name:** | **2022** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>CY 2022: Data source:The North Dakota Department of Health and Human Services. Family Health and Wellness Unit. Data is reported for Federal Fiscal year. | |
| 5. | **Field Name:** | **2023** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: North Dakota Department of Health and Human Services | |

**2021-2025: ESM PA-Child.1 - Number of communities actively involved with the physical activity / nutrition strategies.**

| Measure Status: | Active | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | | 30 | 24 | 28 |
| Annual Indicator | 0 | 0 | 20 | 61 | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | North Dakota Department of Health. Family Health a | North Dakota Department of Health. Family Health a | The North Dakota Department of Health and Human S | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: North Dakota Department of Health. Family Health and Wellness Division.Data reported is for federal fiscal year. | |
| 2. | **Field Name:** | **2021** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: North Dakota Department of Health. Family Health and Wellness Division. The data reported is for Federal Fiscal Year.<br><br>This ESM: 8.1.1- was modified with wording change to capture data for Federal Fiscal Year 2022. | |
| 3. | **Field Name:** | **2022** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>CY 2022: Data source: The North Dakota Department of Health and Human Services. Family Health and Wellness Unit.<br>This ESM: 8.1.1- was modified with wording change to capture data for Federal Fiscal Year 2022. | |
| 4. | **Field Name:** | **2023** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>CY 2023: Data source: The North Dakota Department of Health and Human Services. Family Health and Wellness Unit. | |

**2021-2025: ESM AWV.1 - Percent of Medicaid EPSDT eligible adolescents, ages 15 through 18, who received at least one initial or periodic screen.**

| Measure Status: | Active | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | | 26 | 28 | 30 |
| Annual Indicator | 24.9 | 29.8 | 29.8 | 29.7 | |
| Numerator | 1,961 | 2,721 | 2,721 | 3,142 | |
| Denominator | 7,863 | 9,117 | 9,117 | 10,563 | |
| Data Source | North Dakota Department of Human Services, Early a | North Dakota Department of Human Services, Early a | Data Source-The North Dakota Department of Health | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2021 | 2022 | |
| Provisional or Final ? | Final | Final | Provisional | Final | |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>North Dakota Department of Human Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. This is also referred to as Health Tracks. The annual EPSDT report (form CMS-416). Data reported is federal fiascal year. | |
| 2. | **Field Name:** | **2021** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>North Dakota Department of Human Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. This is also referred to as Health Tracks. The annual EPSDT report (form CMS-416). Data reported is federal fiascal year. | |
| 3. | **Field Name:** | **2022** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>CY 2022: Data Source:The North Dakota Department of Health & Human Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. This is also referred to as Health Tracks. The annual EPSDT report (form CMS-416). Data is for federal fiscal year.<br>The data reported is for Federal Fiscal Year 2021. | |
| 4. | **Field Name:** | **2023** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>CY 2023: Data Source: The North Dakota Department of Health & Human Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. This is also referred to as Health Tracks. The annual EPSDT report (form CMS-416). Data is for federal fiscal year.<br>The data reported is for Federal Fiscal Year 2023. | |

**2021-2025: ESM AWV.2 - Number of adolescents, ages 12 through 17, with a reported visit to an emergency department (ED) involving depression within the last year.**

| **Measure Status:** | **Active** | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | | 330 | 310 | 290 |
| Annual Indicator | 293 | 358 | 272 | 259 | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | North Dakota's Electronic Surveillance System for | North Dakota's Electronic Surveillance System for | The North Dakota Department of Health and Human S | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: North Dakota's Electronic Surveillance System for the Early Notification of Community-Based Epidemics (Essence). This system captures syndromic surveillance data from approximately 84% of hospitals in the state. Data reported is for the calendar year.<br>Note: Data for this specific query indicates those with a sole or primary reason for the visit as being related to depression. These numbers represent a syndrome definition that utilizes both ICD-10 codes and the chief complaint with key words. Not every hospital submits both ICD-10 and chief complaint. Some hospitals only submit data on ND residents, so transient populations may not be included. Finally, an increase in the number may be due to actual increases or could be due to an increase in the number of facilities participating. | |
| 2. | **Field Name:** | **2021** |
| | **Column Name:** | **State Provided Data** |

| | | |
|---|---|---|
| | **Field Note:**<br>Data Source: North Dakota Department of Health. North Dakota's Electronic Surveillance System for the Early Notification of Community-Based Epidemics (Essence). This system captures syndromic surveillance data from approximately 84% of hospitals in the state.Data reported is for the calendar year.<br><br>Note: Data for this specific query indicates those with a sole or primary reason for the visit as being related to depression. These numbers represent a syndrome definition that utilizes both ICD-10 codes and the chief complaint with key words. Not every hospital submits both ICD-10 and chief complaint. Some hospitals only submit data on ND residents, so transient populations may not be included. Finally, an increase in the number may be due to actual increases or could be due to an increase in the number of facilities participating. | |
| 3. | **Field Name:** | **2022** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source:The North Dakota Department of Health & Human Services. North Dakota's Electronic Surveillance System for the Early Notification of Community-Based Epidemics (Essence).<br><br>CY 2023: Here is the description of ND Essence: The Electronic Surveillance System for the Early Notification of Community-Based Epidemics (Essence), captures syndromic surveillance data from approximately 84% of the hospitals in the State. This data consists of emergency department, urgent care and walk-in-clinic visit information. The purpose is to capture and analyze health-indicator data to identify abnormal health conditions, events, and enable early detection of outbreaks.<br><br>Caveats of this data:<br>1.These numbers represent a syndrome definition that utilizes both ICD-10 codes and chief complaint which looks for key words. These should not be considered a true "number of cases." Syndromes may also contain "noise" meaning that the syndrome data may count actual non-related events.<br>2.NOT every hospital submits both ICD and chief complaint so some visits may be missing.<br>3.Some hospitals only submit data on ND residents. Transient populations may not be included; therefore, underestimating the impact.<br>4.Increase in number may be due to actual increases or it may be due to increase in number of facilities participating. | |
| 4. | **Field Name:** | **2023** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Data Source: The North Dakota Department of Health & Human Services. North Dakota's Electronic Surveillance System for the Early Notification of Community-Based Epidemics (Essence).

CY 2023: Here is the description of ND Essence: The Electronic Surveillance System for the Early Notification of Community-Based Epidemics (Essence), captures syndromic surveillance data from approximately 84% of the hospitals in the State. This data consists of emergency department, urgent care and walk-in-clinic visit information. The purpose is to capture and analyze health-indicator data to identify abnormal health conditions, events, and enable early detection of outbreaks.

Caveats of this data:
1.These numbers represent a syndrome definition that utilizes both ICD-10 codes and chief complaint which looks for key words. These should not be considered a true "number of cases." Syndromes may also contain "noise" meaning that the syndrome data may count actual non-related events.
2.NOT every hospital submits both ICD and chief complaint so some visits may be missing.
3.Some hospitals only submit data on ND residents. Transient populations may not be included; therefore, underestimating the impact.
4.Increase in number may be due to actual increases or it may be due to increase in number of facilities participating.

**2021-2025: ESM TAHC.1 - Percentage of individuals ages 14 through 21 served in SHS multidisciplinary clinics that received a transition assessment.**

| Measure Status: | Active | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 80 | 80 | 85 | 90 | 95 |
| Annual Indicator | 74.4 | 81.2 | 70.6 | 73.2 | |
| Numerator | 99 | 125 | 96 | 101 | |
| Denominator | 133 | 154 | 136 | 138 | |
| Data Source | The North Dakota Department of Health. Division of | The North Dakota Department of Health. Division of | The North Dakota Department of Health | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: 2019-North Dakota Department of Health, Division of Special Health Services. Client data listed in PRS through SHS multidisciplinary clinics indicating receiving a transition assessment.<br>Data Issues: None<br>Note: The data is collected based on state fiscal year (July through June). | |
| 2. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: 2019-North Dakota Department of Health, Division of Special Health Services. Client data listed in PRS through SHS multidisciplinary clinics indicating receiving a transition assessment.<br>Data Issues: None<br>Note: The data is collected based on State fiscal year (July through June). | |
| 3. | **Field Name:** | **2021** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: 2019-North Dakota Department of Health, Division of Special Health Services. Client data listed in PRS through SHS multidisciplinary clinics indicating receiving a transition assessment.<br><br>Note: The data is collected based on State fiscal year (July through June). | |
| 4. | **Field Name:** | **2022** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>CY 2022: Data Source:The North Dakota Department of Health & Human Services. Special Health Services Unit. Utilizing State Fiscal Year Data as Reported by SHS Grantees. SFY-The data is collected based on State Fiscal Year (SFY) (July through June). | |
| 5. | **Field Name:** | **2023** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: North Dakota Department of Health and Human Services, 2023<br>Special Health Services Unit. Utilizing State Fiscal Year Data as Reported by SHS Grantees. SFY-The data is collected based on State Fiscal Year (SFY) (July through June). | |

**2021-2025: ESM TAHC.2 - Number of educational opportunities provided to health care professionals/providers from Title V regarding health care transition.**

| Measure Status: | Active | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 10 | 10 | 8 | 10 |
| Annual Indicator | 8 | 8 | 6 | 5 | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | The North Dakota Department of Health. Division of | The North Dakota Department of Health. Division of | The North Dakota Department of Health and Human S | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: The North Dakota Department of Health. Division of Special Health Services. Data reported is for federal fiscal year. | |
| 2. | **Field Name:** | **2021** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: The North Dakota Department of Health. Division of Special Health Services. Data reported is for federal fiscal year. | |
| 3. | **Field Name:** | **2022** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>CY 2022: Data Source:The North Dakota Department of Health & Human Services. Special Health Services Unit.Utilizing Federal Fiscal Year Data.FFY | |
| 4. | **Field Name:** | **2023** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>CY 2023: Data Source: The North Dakota Department of Health & Human Services. Special Health Services Unit. Utilizing Federal Fiscal Year Data. FFY | |

**2021-2025: ESM TAHC.3 - Number of educational opportunities provided to school personnel from Title V regarding health care transition.**

| Measure Status: | Active | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | 2 | 3 | 4 | 5 |
| Annual Indicator | 1 | 0 | 0 | 1 | |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | The North Dakota Department of Health. Division of | The North Dakota Department of Health. Division of | The North Dakota Department of Health and Human Se | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: The North Dakota Department of Health. Division of Special Health Services. Utilizing Federal Fiscal Year Data. | |
| 2. | **Field Name:** | **2021** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: The North Dakota Department of Health. Division of Special Health Services. Data reported is for federal fiscal year..<br>Note: Due to COVID 19,educational opportunities were not provided to school personnel. | |
| 3. | **Field Name:** | **2022** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>CY 2022: Data Source:The North Dakota Department of Health and Human Services. Special Health Services Unit.Utilizing Federal Fiscal Year Data.FFY. | |
| 4. | **Field Name:** | **2023** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>CY 2023: Data Source: The North Dakota Department of Health and Human Services. Special Health Services Unit. Utilizing Federal Fiscal Year Data. FFY. | |

**2021-2025: ESM TAHC.4 - Percentage of families served by family support contracts who received education and / or training on healthcare transition.**

| Measure Status: | Active | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | | 13 | 16 | 19 |
| Annual Indicator | 3.6 | 10.6 | 16.1 | 8.7 | |
| Numerator | 286 | 763 | 919 | 979 | |
| Denominator | 7,902 | 7,170 | 5,709 | 11,315 | |
| Data Source | The North Dakota Department of Health. Division of | The North Dakota Department of Health. Division of | The North Dakota Department of Health and Human S | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2020 | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | Final | |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: The North Dakota Department of Health. Division of Special Health Services. Data reported is for federal fiscal year. | |
| 2. | **Field Name:** | **2021** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data Source: The North Dakota Department of Health. Division of Special Health Services. Data reported is for federal fiscal year. | |
| 3. | **Field Name:** | **2022** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>CY 2022: Data Source:The North Dakota Department of Health and Human Services. Special Health Services Unit.Utilizing Federal Fiscal Year Data.FFY. | |
| 4. | **Field Name:** | **2023** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>CY 2023. Data Source: The North Dakota Department of Health and Human Services. Special Health Services Unit. Utilizing Federal Fiscal Year Data. FFY. | |

**2021-2025: ESM WWV.3 - Number of women ages 18 through 44 receiving a preventative health visit through services provided by MCH grantees.**

| Measure Status: | Active | | | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | | 78 | 88 |
| Annual Indicator | 0 | 68 | 77 | |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | The North Dakota Department of Health, Division of | The North Dakota Department of Health and Human S | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2021** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** Data Source:The North Dakota Department of Health, Division of Family Health and Wellness.Utilizing Federal Fiscal Year Data (October-September) as furnished through interim and annual reporting from MCH grantees. | |
| 2. | **Field Name:** | **2022** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** CY 2022: Data Source:The North Dakota Department of Health and Human Services, Family Health and Wellness Unit.Utilizing Federal Fiscal Year Data (October-September) as furnished through interim and annual reporting from MCH grantees. | |

**2021-2025: ESM WWV.4 - The percentage of women receiving women's preventative health educational materials.**

| Measure Status: | Active | | | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | | | 50 | 60 |
| Annual Indicator | 0 | 68 | 28 | |
| Numerator | 0 | | 13,984 | |
| Denominator | 100 | | 50,009 | |
| Data Source | Data Source-The North Dakota Department of Health, | The North Dakota Department of Health and Human Se | North Dakota Department of Health and Human Servic | |
| Data Source Year | 2021 | 2022 | 2023 | |
| Provisional or Final ? | Final | Final | Final | |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2021** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** Data Source: The North Dakota Department of Health, Division of Family Health and Wellness. Utilizing Federal Fiscal Year Data (October-September) as furnished through interim and annual reporting from MCH grantees. | |
| 2. | **Field Name:** | **2022** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** CY 2022: Data Source: The North Dakota Department of Health and Human Services, Family Health and Wellness Unit. Utilizing Federal Fiscal Year Data (October-September) as furnished through interim and annual reporting from MCH grantees. | |
| 3. | **Field Name:** | **2023** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** CY 2023: Data Source: The North Dakota Department of Health and Human Services, Family Health and Wellness Unit. Utilizing Federal Fiscal Year Data (October-September) as furnished through interim and annual reporting from MCH grantees.<br>The denominator (number of women enrolled into Medicaid ages 18-44). Data Source: ND Medicaid | |

## Form 10
## State Performance Measure (SPM) Detail Sheets

**State: North Dakota**

### SPM 1 - Vision Zero--Eliminate fatalities and serious injuries caused by motor vehicle crashes
### Population Domain(s) – Cross-Cutting/Systems Building

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | North Dakota Goal: Reduce serious motor vehicle injuries and fatalities to North Dakotans younger than 21 years of age<br>Measurement: By 2030, reduce serious injuries and fatalities among teens in motor vehicle crashes by 10%, from 55.6% to 45.6% |
| **Definition:** | **Unit Type:** Percentage<br>**Unit Number:** 100<br>**Numerator:** The number of teenage serious injuries and fatalities in motor vehicle crashes in North Dakota.<br>**Denominator:** The number of teenage motor vehicle crashes in North Dakota. |
| **Healthy People 2030 Objective:** | This aligns with IVP-06: Reduce deaths from motor vehicle crashes |
| **Data Sources and Data Issues:** | Data Source: Calendar year data from the North Dakota Department of Transportation and the NDDHHS Public Health Division.<br><br>Data Issues: This excludes ped/bikes/OHV/Motorcycle etc. |
| **Significance:** | Enhancing roadway safety is critical to the health and well-being of the citizens of North Dakota and to the others who travel on North Dakota roads. The North Dakota Vision Zero program is based on the premise that even one crash related death is unacceptable. North Dakota's Vison Zero's core principle acknowledges motor vehicle crash deaths are preventable. Human error on the roadway necessitates safeguards to reduce crash fatalities and an interdisciplinary, data-driven approach provides the foundation. |

**SPM 2 - North Dakota State Mandates--Implement North Dakota state mandates delegated to North Dakota Department of Health and Human Services' Title V / Maternal and Child Health Program.**
**Population Domain(s) – Cross-Cutting/Systems Building**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | North Dakota Goal: To implement all North Dakota state mandates delegated to the North Dakota Department of Health and Human Services' Title V/Maternal and Child Health Programs.<br>Measurement: Yes/No |
| **Definition:** | **Unit Type:** Text<br>**Unit Number:** Yes/No<br>**Numerator:** North Dakota Title V/Maternal Child Health mandates implemented.<br>**Denominator:** |
| **Healthy People 2030 Objective:** | Reduce the rate of infant deaths — MICH-02<br>Increase the proportion of newborns who get screened for hearing loss by age 1 month — HOSCD-01<br>Reduce maternal deaths — MICH-04<br>Increase the proportion of women who get screened for postpartum depression — MICH-D01<br>Increase the proportion of children who receive a developmental screening — MICH-17<br>Increase the proportion of children with developmental delays who get intervention services by age 4 years — EMC-R01<br>Increase the proportion of children and adolescents who receive care in a medical home — MICH-19<br>Increase the proportion of children and adolescents with special health care needs who have a system of care — MICH-20 |
| **Data Sources and Data Issues:** | North Dakota Century Code, North Dakota Administrative Code for the North Dakota Department of Health and Human Services, and the Title V/Maternal and Child Health Program. |
| **Significance:** | Priorities are often influenced by state mandates, which in turn, are generally reflective of expressed need within the state over time. Inclusion of these mandates epitomizes the successful federal/state partnership by honoring a state’s unique priorities. |

**SPM 3 - Access to Services--Improve access to health-related services to improve the health and well-being of the MCH population**
**Population Domain(s) – Cross-Cutting/Systems Building**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>North Dakota Goal: Increase awareness and the utilization of statewide services or resources<br>Measurement: Percentage of Medicaid-enrolled babies with at least one well-baby visit prior to 15 months of age</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of babies enrolled in North Dakota Medicaid with at least one well-baby visit prior to 15<br>months of age.</td></tr>
<tr><td>Denominator:</td><td>Number of North Dakota Medicaid-enrolled babies in the calendar year.</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>The National Committee for Quality Assurance (NCQA) recommends a minimum of six well-child visits by 15 months. This is consistent with the Healthy People 2030 emphasis on preventive pediatric care.<br><br>This aligns with MICH-17: Developmental screenings for children aged 9-35 months.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: North Dakota Medicaid claims data<br><br>Data Issues: For Medicaid claims data, there is a time lag in when claims data becomes available.</td></tr>
<tr><td>Significance:</td><td>Well-baby visits, also known as Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services, are vital during the from birth to 15 months, when infants are particularly vulnerable. These visits provide critical opportunities to monitor development, administer immunizations, and identify emerging health or social needs. The American Academy of Pediatrics (AAP) and Bright Futures recommend nine or more well-child visits by the time a child turns 15 months of age, and two or more well-child visits for children between 15 and 30 months of age. Well-child visits should include a health history, physical exam, immunizations, vision and hearing screening, developmental/behavioral assessment, oral health risk assessment, and parenting education on a wide range of topics1.<br><br>These visits are especially important for low-income families facing barriers to preventive care. ND’s recent Medicaid postpartum extension to 12 months provides continuity for mothers to access healthcare while supporting their infants’ medical needs2. The continuous coverage helps with early identification and management of health issues and chronic conditions, which can affect bonding between mother and baby and her ability to care for her child. It can potentially improve maternal and infant outcomes, reduce ER visits, and increase follow-up care3.<br><br>1. Centers for Medicare & Medicaid Services. (2024, January). Findings from the 2022 Child Core Set Chart Pack. U.S. Department of Health and Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-child-chartpack.pdf</td></tr>
</table>

2. North Dakota Health and Human Services. (2023, January 1). ND Medicaid extends health care coverage for pregnant and new mothers. https://www.hhs.nd.gov/humanservices/medicaid/about/newmom
3. Whitman, A., Warrier, A., Gordon, S., Lee, A., Peters, C., De Lew, N., & Buchmueller, T. (2025, January). Postpartum health care use in Medicaid during the COVID-19 public health emergency: Implications for extending

**Form 10**
**State Performance Measure (SPM) Detail Sheets (2021-2025 Needs Assessment Cycle)**

**2021-2025: SPM 1 - Vision Zero – Eliminate fatalities and serious injuries caused by motor vehicle crashes.- By 2025, Increase the number of car seat checkups offered by the NDDoH for North Dakotans from 69 to 100.**
**Population Domain(s) – Cross-Cutting/Systems Building**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | By 2025, Increase the number of car seat checkups offered by the NDDoH for North Dakotans from 69 to 100 (5-year average). |
| **Definition:** | **Unit Type:** Count<br>**Unit Number:** 100<br>**Numerator:** Number of car seat checkups offered through the NDDoH for the calendar year.<br>**Denominator:** |
| **Data Sources and Data Issues:** | The North Dakota Department of Health (NDDOH), the North Dakota Department of Transportation,and the National Digital Car Seat Check Form:<br><br>https://carseatcheckform.org/national-dashboard |
| **Significance:** | Enhancing roadway safety is critical to the health and well-being of the citizens of North Dakota and to the others who travel on North Dakota roads. The North Dakota Vision Zero program is based on the premise that even one crash related death is unacceptable. North Dakota's Vison Zero's core principle acknowledges motor vehicle crash deaths are preventable. Human error on the roadway necessitates safeguards to reduce crash fatalities and an interdisciplinary, data-driven approach provides the foundation. |

**2021-2025: SPM 3 - Maternal and Child Health (MCH) Workforce Development-The number of individuals enrolled in the Maternal and Child Health (MCH) Certificate Program.**
**Population Domain(s) – Cross-Cutting/Systems Building**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To support workforce development of state Title V leaders, staff, and partners to meet current public health MCH policy and programmatic imperatives around health transformation, including ongoing transformation of the Title V Block Grant. |
| **Definition:** | **Unit Type:** Count<br>**Unit Number:** 100<br>**Numerator:** The number of individuals enrolled in the Maternal and Child Health (MCH) Certificate Program.<br>**Denominator:** |
| **Healthy People 2030 Objective:** | PHI-2 Increase the proportion of Tribal, State, and local public health personnel who receive continuing education consistent with the Core Competencies for Public Health Professionals.<br>PHI-2.1 (Developmental) Increase the proportion of tribal public health agencies that use Core Competencies for Public Health Professionals in continuing education for personnel.<br>PHI-2.2 Increase the proportion of state public health agencies that use Core Competencies for Public Health Professionals in continuing education for personnel.<br>PHI-2.3 Increase the proportion of local public health agencies that use Core Competencies for Public Health Professionals in continuing education for personnel. |
| **Data Sources and Data Issues:** | Data Source: The North Dakota Department of Health (NDDoH), tracking and reporting from the North Dakota State University’s contract. |
| **Significance:** | Maternal and Child Health (MCH) leadership involves a set of specific qualities and characteristics, including understanding MCH values, mission and goals, possession of core knowledge of MCH populations and needs, and pursuit of new knowledge and skills throughout one’s career. North Dakota’s workforce training needs include MCH leadership development, increasing understanding about health reform, adaptive skills to lead through change, skills to work effectively within integrated systems, and skills to measure the quality and return on investment of current programs. |

## Form 10
## State Outcome Measure (SOM) Detail Sheets

**State: North Dakota**

No State Outcome Measures were created by the State.

**Form 10**
**Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets**

**State: North Dakota**

**Form 10**
**Evidence-Based or -Informed Strategy Measure (ESM) (2021-2025 Needs Assessment Cycle)**

## 2021-2025: ESM BF.2 - Number of businesses designated Infant Friendly Workplaces.
## 2021-2025: NPM – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase the percent of infants who are breastfed and who are breastfed exclusively through six months. |
| **Definition:** | **Unit Type:** Count<br>**Unit Number:** 200<br>**Numerator:** Number of businesses designated Infant Friendly Workplaces.<br>**Denominator:** |
| **Data Sources and Data Issues:** | The Center for Disease Control and Prevention's (CDC) Guide to Strategies to Support Breastfeeding Mothers and Babies lists intentions to work full-time are associated with lower rates of breastfeeding initiation and shorter duration. The CDC's Implementation Guide for the Notice of Funding Opportunity: State Physical Activity and Nutrition Program lists evidence demonstrates supportive policies and programs at the workplace enable women to continue providing breast milk for their infants for significant periods after they return to work.<br><br>The Infant Friendly Workplace designation recognizes employers who implement breastfeeding support policies addressing adequate break time; a clean, private location for milk expression; and available resources for clean water and breast milk storage for employees. By providing technical assistance and education to employers about how to implement a breastfeeding support policy, more women will be supported at work and breastfeed longer, thereby increasing the percentage of infants who are breastfed exclusively for 6 months, NPM 4b.<br><br>By September 30, 2025, increase the number of businesses designated as Infant Friendly Workplaces from 133 to 200.<br>The North Dakota Department of Health & Human Services, Family Health and Wellness Unit. Data reported: Federal Fiscal Year (FFY) |
| **Evidence-based/informed strategy:** | The Infant Friendly Workplace designation recognizes employers who implement breastfeeding support policies addressing adequate break time; a clean, private location for milk expression; and available resources for clean water and breast milk storage for employees. By providing technical assistance and education to employers about how to implement a breastfeeding support policy, more women will be supported at work and |

| | |
|---|---|
| | breastfeed longer, thereby increasing the percentage of infants who are breastfed exclusively for 6 months, NPM 4b.<br>ESM 4.3. Number of businesses designated Infant Friendly Workplaces.<br>By September 30, 2025, increase the number of businesses designated as Infant Friendly Workplaces from 133 to 200. |
| **Significance:** | Number of businesses designated Infant Friendly Workplaces. This ESM will provide the number of workplaces across the state who have implemented a policy and became designated as an Infant Friendly Workplace.<br>The Infant Friendly Workplace designation recognizes employers who implement breastfeeding support policies addressing adequate break time; a clean, private location for milk expression; and available resources for clean water and breast milk storage for employees. By providing technical assistance and education to employers about how to implement a breastfeeding support policy, more women will be supported at work and breastfeed longer, thereby increasing the percentage of infants who are breastfed exclusively for 6 months, NPM 4b. |

**2021-2025: ESM PA-Child.1 - Number of communities actively involved with the physical activity / nutrition strategies.**
**2021-2025: NPM – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day - PA-Child**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase the percent of children, ages 6-11, who are physically active at least 60 minutes per day. |
| **Definition:** | **Unit Type:** Count<br>**Unit Number:** 75<br>**Numerator:** Number of communities actively involved with the physical activity / nutrition strategies.<br>**Denominator:** |
| **Data Sources and Data Issues:** | The North Dakota Department of Health & Human Services, Family Health and Wellness Unit.Data Reported for Federal Fiscal Year (FFY). |
| **Evidence-based/informed strategy:** | Number of communities actively involved with the physical activity/ nutrition strategies.<br>Working with communities will impact increased physical activity in children and potentially reduce obesity.<br>The CDC and MCH Navigator websites lists communities with the department of education to design and implement school-based physical activity programs at the state or district level as an example strategy for NPM 8.<br><br>Creating or modifying environments to make it easier for people to walk or bike helps increase physical activity and can make our communities better places to live. Communities designed to support physical activity are often called active communities. The Guide to Community Preventive Services recommends strategies to increase physical activity that are related to walkability. Examples include community-scale urban design, street-scale urban design, and improving access to places for physical activity, including providing maps and descriptive information.<br><br>https://www.cdc.gov/physicalactivity/community-strategies/index.htm<br>https://www.mchevidence.org/tools/npm/8-physical-activity.php<br>Engaging with communities, ND's tribal, frontier,urban, rural, ND REA's, FSCS, ND DPI, ND DoH, will elevate physical activity as a priority throughout the state by bringing multiple partners together to advance and align work across North Dakota agencies. |
| **Significance:** | Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in children and adolescents improves bone health, weight status, cardiorespiratory and cardiometabolic health, and brain health, including improved cognition and reduced depressive symptoms. Physical activity reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children |

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| | and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.<br>U.S. Department of Health and Human Services. Physical Activity Guidelines for Americans, 2nd edition. Washington, DC: U.S. Department of Health and Human Services; 2018. https://health.gov/sites/default/files/2019-09/Physical_Activity_Guidelines_2nd_edition.pdf<br><br>By Engaging with new communities, tribal frontier, rural, urban ND REA's, FSCS, ND DPI, ND DoH, will elevate physical activity as a priority throughout the state by bringing multiple partners together to advance and align work across North Dakota agencies.<br>. |

**2021-2025: ESM AWV.1 - Percent of Medicaid EPSDT eligible adolescents, ages 15 through 18, who received at least one initial or periodic screen.**
**2021-2025: NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of Medicaid EPSDT eligible adolescents that receive at least one initial or periodic screen.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of Medicaid EPSDT eligible adolescents, ages 15 through 18, who received at least one initial or periodic screen during the past year.</td></tr>
<tr><td>Denominator:</td><td>Number of Medicaid EPSDT eligible adolescents ages 15 through 18 during the past year.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>State-level data obtained from the North Dakota Department of Human Services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. This is also referred to as Health Tracks.<br><br>Supporting information for Medicaid obtained from the Kaiser Family Foundation (KFF).</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The goal of this measure is to increase the number of Medicaid EPSDT eligible adolescents that receive at least one initial or periodic screen. The Bright Futures Guidelines, created by the American Academy of Pediatrics (AAP) recommend that adolescents have an annual checkup from age 11 through 21. Ensuring adolescents are being seen at least once per year will assist with preventing adverse health outcomes and minimize risky behaviors. These annual preventative visits will offer the opportunity for adolescents to seek information address concerns while receiving proper education and resources from their health care providers.<br><br>EBP Data Sources:<br>•Bright Futures/AAP</td></tr>
<tr><td>Significance:</td><td>Adolescents face a variety of health risks and health problems including unintended pregnancies, sexually transmitted diseases, substance-use disorders, and depression, among others. Getting an annual well-visit provides an opportunity for adolescents to discuss any physical, emotional, and behavioral health issues they may have.<br><br>Medicaid provides comprehensive benefits for children, known as Early Periodic Screening Diagnosis and Treatment (EPSDT) services. Medicaid also provides health and long-term care for millions of America’s poorest and most vulnerable people. By working towards improving the number of Medicaid-eligible adolescents receiving their annual EPSDT visit, progress will be made with the sector of the adolescent population that needs it the most.</td></tr>
</table>

**2021-2025: ESM AWV.2 - Number of adolescents, ages 12 through 17, with a reported visit to an emergency department (ED) involving depression within the last year.**
**2021-2025: NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To decrease the number of adolescent emergency department (ED) visits for depression-related issues.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
<tr><td>Numerator:</td><td>Number of adolescents, ages 12 through 17, with a reported visit to an emergency department (ED) for depression within the last year.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>North Dakota’s Electronic Surveillance System for the Early Notification of Community-Based Epidemics (Essence). This system captures syndromic surveillance data from approximately 84% of hospitals in the state.<br><br>Data for this specific query indicates those with a sole or primary reason for the visit as being related to depression. These numbers represent a syndrome definition that utilizes both ICD-10 codes and the chief complaint with key words. Not every hospital submits both ICD-10 and chief complaint. Some hospitals only submit data on ND residents, so transient populations may not be included. Finally, an increase in the number may be due to actual increases or could be due to an increase in the number of facilities participating.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Evidence-based / informed strategy:The goal of this measure is to reveal improvement with access to preventative screening and routine behavioral health care if a decrease in depression-related encounters in the ED setting is noted.<br><br>EBP Data Sources:<br>•Bright Futures/AAP<br>•World Health Organization (WHO)<br>•National Alliance on Mental Illness (NAMI)</td></tr>
<tr><td>Significance:</td><td>According to the World Health Organization, adolescence is a crucial period for developing and maintaining social and emotional habits important for mental well-being. These include adopting healthy sleep patterns; taking regular exercise; developing coping, problem-solving, and interpersonal skills; and learning to manage emotions. Supportive environments in the family, at school and in the wider community are also important. An estimated 10-20% of adolescents globally experience mental health conditions, yet these remain underdiagnosed and undertreated.<br><br>Adolescents with mental health conditions are in turn particularly vulnerable to social exclusion, discrimination, stigma (affecting readiness to seek help), educational difficulties, risk-taking behaviors, physical ill-health and human rights violations.<br><br>It is crucial for access to behavioral health services and screenings be monitored closely, since the National Alliance on Mental Illness emphasizes that mental health screenings allow for early identification and intervention. Early identification and treatment leads to better outcomes. Early treatment may also lessen long-term disability and prevent years of suffering.</td></tr>
</table>

**2021-2025: ESM TAHC.1 - Percentage of individuals ages 14 through 21 served in SHS multidisciplinary clinics that received a transition assessment.**
**2021-2025: NPM – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC**

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| **Measure Status:** | Active |
| **Goal:** | To increase the percent of adolescents with and without special health care needs who have received the services necessary to make transitions to adult health care. |
| **Definition:** | <table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of individuals ages 14 through 21 receiving transition assessments in SHS multidisciplinary clinics annually.</td></tr><tr><td>**Denominator:**</td><td>Number of individuals ages 14 through 21 served in SHS multidisciplinary clinics annually.</td></tr></table> |
| **Data Sources and Data Issues:** | The North Dakota Department of Health. Division of Special Health Services (SHS). SHS will utilize State Fiscal Year Data as reported by SHS contract grantees to determine the number of transition assessments that were completed within the clinic for individuals ages 14 through 21. |
| **Evidence-based/informed strategy:** | It is important for North Dakota to not only fund various projects that develop infrastructure and capacity, but to also expand contracted clinic requirements to include quality improvement methods regarding transition assessments completed. This is essential to further enhance and increase utilization that is required for successful transitions from pediatric to adult health care.<br><br>According to GotTransition, use of a standardized transition readiness assessment (TRA) is helpful in engaging youth and parents/caregivers to set health priorities, addressing self-care skill needs to prepare them for an adult approach to care at age 18, and preparing them to independently use health care services. Clinicians can use the results of the TRA to jointly develop a plan of care with youth and parents/caregivers.<br><br>Funding projects to support health care transition and expanding reporting requirements will provide an opportunity for all young adults being seen in the clinic the chance to complete a TRA and empower themselves to become self-advocates. Health care providers will also have an opportunity to readily educate and address concerns from the child and their parent/guardian.<br><br>EBP Data Sources:<br>•GotTransition |
| **Significance:** | While North Dakota continually strives to improve upon transition, the state continues to trend below the national average on transition-related measures. This ESM focuses on ensuring TRAs are being completed by clinic grantees making it significant as it will provide valuable data to indicate the number of TRAs that are being completed within the clinics. This data will aid in determining the impact of these assessments, reveal any barriers or obstacles young adults are facing while in the transition phase, and will aid in activity and strategy development for stakeholders in North Dakota. |

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| | Establishing, enhancing, and continuously building upon TRA processes by making evidence-based decisions will aid in process improvement and drive change to ensure all steps that are necessary for transition are being adequately addressed by clinic staff.<br><br>Ensuring all clinic grantees are not only completing transition assessments with the child but taking the opportunity to provide transition education and address areas of concern is essential to certify young adults have the ability and confidence to take charge of their own health and develop a unique plan of care tailored to their own needs. |

**2021-2025: ESM TAHC.2 - Number of educational opportunities provided to health care professionals/providers from Title V regarding health care transition.**
**2021-2025: NPM – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percent of adolescents with and without special health care needs who have received the services necessary to make transitions to adult health care.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>50</td></tr>
<tr><td>Numerator:</td><td>Number of educational opportunities provided to health care professionals/providers from Title V regarding health care transition.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>North Dakota Department of Health. Division of Special Health Services (SHS) will utilize Federal Fiscal Year Data to determine the number of educational opportunities that were provided to health care providers.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>A core goal for North Dakota is to increase and enhance transition-focused education to health care providers and professionals. According to GotTransition, an updated systematic review of health care transition (HCT) studies published between May 2016 and December 2018 found statistically significant positive outcomes for youth with special health care needs as a result of a structured transition process. Providing various educational opportunities regarding the importance of HCT to health care professionals across North Dakota is vital to achieve a consistent, comprehensive, and successful transition for all young adults.<br>Providing education on GotTransition’s Six Core Elements of Transition will aid providers in defining the basic components of a structured HCT process. This HCT approach, recommended in the 2018 AAP/AAFP/ACP Clinical Report, can be customized for clinics/practices/health systems serving youth and parents/caregivers.<br>A 2020 review by the Journal of Pediatric Nursing found that a structured HCT process for youth with special health care needs can show improvements in adherence to care, disease-specific measures, quality of life, self-care skills, satisfaction with care, health care utilization, and HCT process of care.<br>With more education being offered and distributed to health care professionals on evidence-driven strategies, there will be an increase in awareness and knowledge regarding successful HCT processes. Addressing transition early will help mitigate potential issues and prepare youth for upcoming changes.<br><br>EBP Data Sources:<br>•GotTransition<br>•Journal of Pediatric Nursing<br>•AAP/AAFP/ACP</td></tr>
<tr><td>Significance:</td><td>This ESM will provide valuable insight into the number of educational opportunities on HCT are currently being offered. It will also reveal areas of education health care providers are seeking. This is a valuable opportunity for Title V staff to partner with health care providers to educate and support practice initiatives focused on preparation for transition to adulthood, including providing technical assistance to practices on using the Six Core Elements resources. This measure will put HCT on the radars of health care professionals and assist in successful transitions.</td></tr>
</table>

**2021-2025: ESM TAHC.3 - Number of educational opportunities provided to school personnel from Title V regarding health care transition.**
**2021-2025: NPM – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percent of adolescents with and without special health care needs who have received the services necessary to make transitions to adult health care.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>50</td></tr>
<tr><td>Numerator:</td><td>Number of educational opportunities provided to school personnel from Title V regarding health care transition.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>North Dakota Department of Health, Division of Special Health Services.<br><br>Utilizing Federal Fiscal Year Data (Education to school staff)</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The strategy for this measure is to increase and enhance health care transition education to school personnel from Title V staff through various methods. For a child with special health care needs, it often helps to begin planning for this transition in conjunction with the Individualized Education Plan (IEP) transition planning at school, which often begins around age 14. Communication among members of the student’s healthcare team outside the school and the school multidisciplinary team, including the school nurse, is critical to identifying the transition needs of the student and determining how to best address those needs (AAP, 2016).<br><br>EBP Data Sources:<br>•American Academy of Pediatrics<br>•GotTransition<br>•National Association of School Nurses (NASN)<br><br>.</td></tr>
<tr><td>Significance:</td><td>Children spend a significant amount of time in the school setting. According to the North Dakota Department of Public Instruction, middle school and high school students are required to have at least 1,050 hours of instruction time. By providing the school staff with education around health care transition and the tools, like the GotTransition Six Core Elements, they can utilize this information to educate adolescents. This will improve the number of students that receive proper information and help adolescents with a successful transition into adult healthcare.<br><br>According to the National Association of School Nurses (NASN), at the policy development and implementation level, school nurses provide system-level leadership and act as change agents, promoting education and healthcare reform. The school nurse can improve the quality of life for students and families through development and implementation of a transition plan to promote student health, academic success, and success in postsecondary endeavors.</td></tr>
</table>

**2021-2025: ESM TAHC.4 - Percentage of families served by family support contracts who received education and / or training on healthcare transition.**
**2021-2025: NPM – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - TAHC**

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| **Measure Status:** | Active |
| **Goal:** | To increase the percent of adolescents with and without special health care needs who have received the services necessary to make transitions to adult health care. |
| **Definition:** | <table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of families served by family support grantees receiving support, education and/or training on healthcare transition.</td></tr><tr><td>**Denominator:**</td><td>Total number of families served for all outcomes by family support grantees.</td></tr></table> |
| **Data Sources and Data Issues:** | The North Dakota Department of Health, Division of Special Health Services.<br><br>Utilizing Federal Fiscal Year Data (October-September) as furnished in a report by Family Voices of North Dakota. (Percent of families with transition as the area of service provided). |
| **Evidence-based/informed strategy:** | . The strategy for this measure is to provide funding to family support organizations that will train or assist families in expanding knowledge and leadership capacity around health care transition. Family engagement plays a crucial role in successfully delivering health care services. Family participation engages families in the planning development and evaluation of programs and policies at the community, organizational and policy levels (Association of Maternal and Child Health Programs [AMCHP], 2010). Data collection will show the impact that family support has on developing successful transition plans.<br><br>EBP Data Sources:<br>•AMCHP<br>•Family Voices |
| **Significance:** | Families of children with special health care needs (CSHCN) face complex challenges, many of which only another family with similar challenges may understand. Family-to-Family Information Centers, are a vital resource for families, and provide assistance with finding appropriate care, referrals to providers, and a range of other services (Family Voices, 2020). Family engagement plays a crucial role in successfully delivering health care services. Family participation engages families in the planning development and evaluation of programs and policies at the community, organizational and policy levels (Association of Maternal and Child Health Programs [AMCHP], 2010). Family support in North Dakota helps families feel empowered, build confidence, and become resilient, which results in optimal health and an improved quality of life for children and their families across the state. According to AMCHP, the most successful programs are those that require involvement from parents and families, regularly teach and train their staff about the importance of family engagement and provide guidance for family and staff on effective methods of enhancing family engagement (AMCHP, 2016; Family Voices, 2008). |

**2021-2025: ESM WWV.3 - Number of women ages 18 through 44 receiving a preventative health visit through services provided by MCH grantees.**
**2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV**

| | |
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| **Measure Status:** | Active |
| **Goal:** | To increase the number of women, ages 18 through 44 who have an annual preventive visit. |
| **Definition:** | <table><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of women ages 18 through 44 receiving a preventative health visit through services provided by MCH grantees.</td></tr><tr><td>**Denominator:**</td><td></td></tr></table> |
| **Data Sources and Data Issues:** | The North Dakota Department of Health & Human Services, Family Health and Wellness Unit.<br><br>Utilizing Federal Fiscal Year Data (October-September) as furnished through interim and annual reporting from MCH grantees. |
| **Evidence-based/informed strategy:** | The strategy for this measure focuses greatly on the ability to partner with others, both at the state and local level.<br>Local, trusted organizations are trusted leaders in their communities. When these organizations serve as messengers—providing group-based education to the low-income and minority women they serve--this is an effective and evidence-based strategy for improving well-woman care.<br><br>According to the MCH Evidence database, community-based group education is an evidence-based strategy for improving preventative health visits for women. (https://www.mchevidence.org/tools/strategies/1-2.php). This is also a key function of the MCH grantees.<br><br>When groups are based on race/ethnicity--bringing women of similar backgrounds together —the impact of group-based educational activities is highly effective in increasing preventative screening. (https://www.mchlibrary.org/evidence/established-results.php?q=&NPM=1%3A+Well-Woman+Visit&Intervention=Community-Based+Group+Education)<br><br>In a recent systematic review, medical mistrust among marginalized communities (low socioeconomic status and/or racial ethnic minorities) was directly related to poorer health outcomes.1 By utilizing providers with similar ethnic backgrounds, trust can be gained, and more medical visits might take place. |
| **Significance:** | A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy |

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| | weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes.<br><br>MCH grantees working towards improving well-woman health through preventative visits have been chosen though a participatory grant making process. Participatory grant making is an equitable, flexible, and progressive strategy for allocating funding. This is especially beneficial for partners with limited grant-writing experience, as they are invited to share a brief, informal proposal and budget. There is shared decision making between partners, and they mutually determine funding levels for each of the proposed projects.<br><br>Utilizing data obtained through these MCH grantees will better gauge potential gaps and allow for focused funding efforts throughout the priority cycle. Successful projects showing positive trends also have the opportunity for duplication in other areas of the state, particularly to underserved communities or specific populations of women unable to obtain preventative services. |

**2021-2025: ESM WWV.4 - The percentage of women receiving women's preventative health educational materials.**
**2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV**

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| **Measure Status:** | Active |
| **Goal:** | To increase the awareness of women, ages 18 through 44 who receive education regarding the importance of annual preventative visits. |
| **Definition:** | **Unit Type:** Percentage<br>**Unit Number:** 100<br>**Numerator:** Number of educational materials disseminated to women seen at pilot sites.<br>**Denominator:** Total number of women 18 through 44 seen at the pilot sites. |
| **Data Sources and Data Issues:** | The North Dakota Department of Health and Human Services<br><br>Data will be obtained from five pilot sites per calendar year assessing the number of educational materials disseminated to women being seen at these locations. |
| **Evidence-based/informed strategy:** | In an effort to improve knowledge and provide education to women, educational materials regarding preventative health and well-woman care will be integrated into five pilot sites that serve lower-income, minority women. These sites will provide education to women that may not get health information through traditional health sources and may be harder to reach. The organizations providing the information will likely be trusted messengers in their community, helping to reduce medical mistrust. According to the MCH Evidence database, community-based group education is an evidence-based strategy for improving preventative health visits for women. (https://www.mchevidence.org/tools/strategies/1-2.php).<br><br>According to the MCHbest Strategy Database, (https://www.mchevidence.org/tools/strategies/1-10.php) engagement of other MCH Programs to disseminate information and make referrals for well-woman visits is an effective strategy for improving well woman care. Educational materials that can be provided through other programs, such as home visiting, WIC, and Healthy Start can help connect women to their primary care providers and can be leveraged to improve well woman care. |
| **Significance:** | Educational materials that can be provided through other programs, such as home visiting, WIC, and Healthy Start can help connect women to their primary care providers, and since these services are targeted to lower-income women, this strategy fits well with our goal of improving well woman care for lower-income women.<br><br>This ESM falls in quadrant 2, measuring quality of effort, ‘how well did we do it?’ as we will assess percent of women in other evidence-based MCH Programs who receive information about the well-woman visit. By utilizing this data, Title V staff can more accurately assess the reach of programmatic educational materials and re-strategize if gaps are identified. |

## Form 11
## Other State Data

**State: North Dakota**

The Form 11 data are available for review via the link below.

Form 11 Data

## Form 12
## Part 1 – MCH Data Access and Linkages

**State: North Dakota**

**Annual Report Year 2024**

None

**Form Notes for Form 12:**

None

**Field Level Notes for Form 12:**

None

## Form 12
## Part 2 – Products and Publications (Optional)

**State: North Dakota**

**Annual Report Year 2024**

Products and Publications information has not been provided by the State.