

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: ND

APPLICATION YEAR: 2005

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I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

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

B. FACE SHEET

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

C. ASSURANCES AND CERTIFICATIONS

Signed assurances and certifications will be maintained on file in the North Dakota Department of Health, Division of Family Health.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

The CSHS Family Advisory Council provided input into the application by reviewing a summary of the performance measures specific to CSHCN, including proposed activities for the next year. Members were asked to provide suggestions for additions or changes to the FY 2005 Annual Plan.

Family Advisory Council members also participated in the rating of the characteristics to assess family participation in the State CSHCN program. Family rankings were averaged with CSHS staff rankings to derive the overall ranking reported for FY 2003.

Two news releases were sent to most major media outlets in the state. The first announced that the Title V application would be posted on the Department of Health (DoH) web site and was available for public comment on July 1, 2004. The second release requested public comment about the state's priority needs. The news release invited the public to provide comment via completion of a short questionnaire on the DoH web site.

The questionnaire asked respondents to indicate what actions could address any of the priority needs, what other priority needs should be included, and any other comments. A cover memo, a list of the priority needs and performance measures, and a copy of the news release was distributed to stakeholders via regular mail and email.

Comments were received from 15 individuals and included the need for more child care services, especially for special needs populations, more school nursing services, an increased emphasis on healthy weight and nutrition, more Early Head Start programs, and the need for more information and education about programs and services.

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Unlike many states, North Dakota (ND) is experiencing a declining population. Many youth continue to migrate out of the state and other residents are moving from the more rural and frontier counties to more urban areas for better employment opportunities. The state now has less than 8,000 births per year. These trends impact our frontier areas and have resulted in difficulty in maintaining services, including health care, in some areas of the state. Despite the decrease in population and births, the state continues to fund eleven public universities across the state in addition to two private universities.

/2002/ Although it was unexpected, ND did experience a slight increase in the 2000 Census, from a population of 638,800 in 1990 to 642,200 in the year 2000 (an increase of 3,400); despite the fact our births declined from 7,930 in 1998 to 7,536 in 1999 (a decrease of 394 births). This further illustrates the aging of the ND population. During those same ten years, only six counties saw a rise in population, with the remaining 47 counties showing a decline. Four of the six counties having an increase have larger cities within their borders and the other two counties have primarily American Indian residents.

/2003/ There were 7,676 resident births in 2000, a slight increase from 1999.

/2004/ 2001 saw 7,664 births, a decrease of 12 births from 2000. New census data reveals ND may have been over-counted in the 2000 Census by about 9,024 persons or 1.4 percent. The director at the State Data Center at ND State University now predicts the population decline in ND is bottoming out. There has been a population increase in eight counties between July 2001 and July 2002.

/2005/ There were 7,755 resident births in 2002 compared to 7,664 in 2001, an increase of 91 births./2005/

/2004/ ND's population is shifting from rural to urban as well as from west to east. In 2000, 54.6 percent of the population lived in urban areas of the state. By 2020, 53.8 percent of the state's population is expected to reside in the four largest counties of the state. By 2020, four out of every ten residents are expected to reside in the six eastern counties along the North Dakota-Minnesota border. Service access in sparsely populated areas of the state is likely to become increasingly challenging.

/2004/ Through 2020, the number of children and young adults in the state are expected to decline while pre-retirees and people age 65 and older are expected to increase. These demographic changes could impact resource allocations for other vulnerable populations if budget constraints continue over time.

/2005/ ND continues to face several demographic truths: population consolidation; loss of young families and youth; aging population; and a shifting labor force. One of the most significant issues faced by ND is the out migration of youth. Youth voice improved wages and opportunities as reasons for leaving the state. Governor Hoeven has appointed the ND Youth Development Council to address this issue. This Council's purpose is to advise and help the ND Workforce Development Council develop youth employment and training policy. It establishes links with other state and local youth service providers to bring an integrated approach to youth development. It provides strategic planning and policy recommendation role, as well as oversight of the youth programs under the Workforce Investment Act./2005/

The state's population is largely Caucasian. Native Americans are the largest minority group representing nearly five percent of the population, but close to 10 percent of all births in the state. There are pockets of refugees in the state from the former Soviet Union and Somalia. This population presents its own unique concerns for health care compounded by language and cultural differences. There are also a limited number of seasonal migrant workers in the eastern part of ND. Migrant health services in the state are administered by the state of Minnesota.

/2002/ The 2000 Census data shows ND with a white population of 92.4 percent, down from 95 percent in 1990. American Indians comprise the next largest population group at 4.9 percent; Blacks were 0.6 percent; Asians 0.6 percent; all others 0.4 percent; and, no Native Hawaiian. Approximately 1.2 percent was listed as having two or more races.

/2004/ ND's population is expected to become more diverse over time. Projections through 2025 indicate increases in Native American, Hispanic, Black and Asian populations.

/2004/ In 2001, ND ranked 47th in the nation in average wage per job. It also has one of the highest multiple jobholding rates in the nation. In 2001, nearly one out of every ten employed North Dakotans held more than one job. ND's labor force is shifting from the agricultural and energy sectors to the service and retail sectors. The number of North Dakotans employed in the agricultural and energy/mining sectors decreased by 10.0 percent and 9.3 percent respectively between 1990 to 2001, while the people employed in the service and retail sectors increased by 34.4 percent and 20.0 percent respectively during that same time period.

/2005/ ND's annual per capita personal income is below the national average. All but one county within ND has per capita income lower than the national average. Per capita income stands at \$17,769.00 for ND compared to the national average of \$21,587.00.//2005//

/2001/ The ND Legislature did not meet in 2000 so recent changes in legislation have not occurred. However, in the interim, the DoH has been asked to develop a plan for use of tobacco settlement funds. During the 1999 Legislative Session, it was determined that tobacco funds be divided as follows: 45 percent water projects; 45 percent common school fund; and 10 percent for public health. Although these funds will not be allocated for spending until the 2001 Legislative Session, the State Health Officer has presented a plan for their use to the Interim Legislative Committee. The issue has generated a high level of public interest, so further debate is anticipated before consensus is reached as to how tobacco settlement funds will actually be spent in the state.

/2002/ The 57th ND Legislative Assembly met during the first four months, holding the longest session in our state's history. Several bills relating to the maternal and child population were considered by the Legislature, with most of them being withdrawn, modified or defeated. Some related to the MCH population include:

- * HB 1369 related to mandated newborn hearing screening: Withdrawn.
- * HB 1376 related to funding for school nursing: Defeated.
- * HB 1411 related to bicycle helmets: Defeated.
- * HB 1440 related to nursing mothers in the workplace: Defeated.
- * HB 1441 related to Medical Assistance benefits and CHIP: Passed. Includes removal of Medicaid assets effective January 1, 2002 with sunset clause June 30, 2003. CHIP eligibility remains the same at 140 percent of poverty. Coordination of medical assistance and CHIP selected as an interim study. Development of a single application, county or state administration, affect of eliminating asset eligibility, standardizing definitions of income in Department of Human Services (DHS), and the feasibility of a federal waiver to allow family coverage will be explored.
- * SB 2239 related to newborn screening and treatment services for metabolic diseases: Passed. The MCH Division will address screening, diagnosis and follow-up, but the purchase of metabolic food was moved to the DHS, effective August 1, 2001.
- * SB 2276 related to loan repayment program for dentists: Passed. Placed in Department of Health (DoH) budget with funding coming from tobacco settlement funds.
- * SB 2292 related to required repayment of tuition paid by the state for dentists if they failed to return to ND to practice dentistry: Failed.
- * SB 2295 related to donated dental services: Failed. Placed in DoH budget .
- * SB 2330 was selected as an interim study to explore coordination of benefits for children with special needs under the age of 21 among, DPI, DHS, and private insurance companies to optimize resources and expand services.
- * SB 2354 related to alternatives to abortion: Was passed as bill to consider study during interim.

- * SB 2361 related to alternatives to abortion involving the DoH. Included updating manual for services for pregnant women and their children and provision of colored and detailed fetal development brochure to discourage abortion. Passed with amendments removing some abortion language and the establishment of a toll-free line by the DoH to respond to crisis pregnancy calls.
- * SB 2367 related to funding for school nurses: Defeated.
- * SB 2378 related to restricting children from riding in the back of pick-up trucks: Defeated.
- * SCR 4019 was selected as an interim study to address medical and financial privacy laws.

/2003/ Of the 10 percent tobacco settlement funds designated for public health; 40 percent are for community wide efforts in tobacco programs, 40 percent are for school-related activities and 20 percent go to local public health departments to use based on community need.

/2003/ The ND Legislature did not meet during 2002, however some interim activity did occur. The MCH Division, namely through the Family Planning Program, provided testimony on more than one occasion on SB 2354 on the study of alternatives to abortion.

/2004/ The 58th Legislative Assembly was held the first four months of 2003. Legislation affecting the MCH population was similar to that proposed in 2001, with similar results; few bills were passed. Funding for school nursing, mandated infant hearing detection and intervention, use of bike helmets, riding in the backs of pickups and seatbelts as a primary offense were some of the bills defeated this year that might have benefited children in the state. Legislation proposed to prohibit the state from using Title X Family Planning funding was defeated with a resolution being passed to write ND Congressmen protesting Title X regulations related to counseling on all three options. A bill proposed to teach only sexual abstinence in the schools was also defeated. Dental hygienists will be allowed to administer anesthesia if permitted by the dentist. The dental loan repayment continues. More global legislation affecting all state government addressed staffing issues, salary increases and information technology centralization. A bill to increase tobacco tax was defeated. The 58th Legislative Assembly concluded on April 25, 2003, but due to several bills being vetoed by the Governor, a special session started May 5, 2003. Under consideration were budget bills for education, corrections and information technology. Tobacco tax was revisited as the Governor had requested more funds be allotted to the DHS: Defeated.

/2004/ Some of the bills that were passed that impact the Medical Services Division and the MCH population include: 1) a medical assistance buy-in program for individuals with disabilities which also provides for personal care services for eligible medical assistance recipients, 2) establishment of a medical assistance drug use review program and drug prior authorization program along with an interim study of pharmacy benefit management, 3) a deficiency appropriation for medical assistance expenses for the period 1/1/03-6/30/03, and 4) the DHS appropriation. The budget that was approved poses many challenges including additional administrative cuts when the department had already incorporated a reduction of 200 full-time employees. Although specific plans are still being developed within the department to address the budget, it is anticipated within the Medical Services Division that service limits and co-pays for the Medicaid program will be initiated effective August or September 2003.

/2005/ The 10 percent of funds allocated to the NDDoH from the tobacco settlement funds go primarily to local health departments to conduct tobacco cessation and education efforts. Some funds were allocated by the legislature to Medicaid to provide treatment for women found to have cancer under the state's Women's Way Program. The only funds allotted to the DoH were funds to establish and maintain a Tobacco Advisory Committee whose members are appointed by the Governor. Currently in the process of contracting with a vendor to establish a Tobacco Quit Line.//2005//

/2003/ Staff in the CSHS Unit were not directly involved with interim legislative committee testimony other than to provide information upon request for the Medical Services Division Director. However, several studies relevant to MCH and CSHCN populations have been addressed by interim committees during the year, including: 1) mandated health insurance coverage, 2) coordination of

benefits for children with special needs, 3) medical privacy, and 4) coordination of Medicaid and Healthy Steps programs.

/2005/ The DHS was involved in many interim legislative studies and committees; however, the most significant for the MCH population were addressed through the Budget Section, specifically, the Budget Committee on Health Care which addressed the Medicaid and Children's Health Insurance Programs. Testimony for the Medical Assistance Program focused on the following:

**** An anticipated drop of three percentage points (down to 68.31 percent) in ND's federal medical assistance percentage (FMAP) as of July 1, 2004.***

**** Changes to the 25 year-old Medicaid Management Information System (MMIS) required for the Health Insurance Portability and Accountability Act (HIPAA), which resulted in a backlog of provider claims. DHS is currently in the planning phase for MMIS replacement.***

**** An update on the Medicaid Managed Care Program, which expanded from one to three counties in January 2004 and has 818 individuals currently enrolled. High-risk groups such as the aged, blind, or disabled are still not covered in the program.***

**** A report on the Children's Health Insurance program, which as of May 2004, had 2,412 children enrolled.***

**** A pharmacy report including information on Medicaid's new prior authorization program and the Medicare prescription drug program.//2005//***

/2002/ ND elected a new Governor in 2000; Governor John Hoeven succeeds Governor Schafer who chose not to run for a third term. Both are Republicans. Both legislative bodies, the House and Senate, have overwhelming Republican majorities.

/2004/ The political balance remained the same during the 2003 Legislative session. One of the new initiatives outlined by Governor Hoeven was Healthy ND. The DoH is taking a leading role in this initiative. A statewide Healthy ND Summit was held August 22 and 23 in Bismarck with over 130 persons from private business, public agencies, universities and volunteer organizations attending. Ten priority topics came out of this summit. Some were adjusted with the final ten topics being: 1) Increasing physical activity in youth; 2) Reducing health disparities; 3) Developing community wellness programs; 4) Improving school nutrition environment; 5) Reducing tobacco use; 6) Decreasing obesity; 7) Increasing third-party payment for prevention and health promotion; 8) Increasing workplace wellness; 9) Decreasing alcohol use by youth, and 10) Addressing mental health issues.

/2005/ Through Healthy ND, an overall strategic planning process is under way in preparation for the next legislative session, which will begin in January 2005. Committees submitted their priority policy recommendations to the advisory committee for review. To help prioritize the submitted recommendations, a Policy Development Grid/Questionnaire is being used to prioritize needs. The grid/questionnaire focuses on the following: nature of the problem, policy objective, goals/expected results, analysis of stakeholders, public interest, previous legislative activity and resources needed.//2005//

/2005/ In the Governor's 2004 State of the State Address, the following priorities were outlined:

**** Economic development - focus on Centers of Excellence, Opportunities 2020 Initiative, technology, and accountability***

**** Education - focus on teacher compensation***

**** Quality of life - focus on care for seniors and crime//2005//***

/2004/ Agriculture remains an important part of the state's economy.

ND now has local public health departments in all but two of its 53 counties, a total of 26 local public health agencies. Legislation passed in 1999 mandated that all public lands have coverage by a health department by January 1, 2001. For the most part, local public health departments provide primary preventive, population-based health care. All local staff have been offered, and most have participated in, core public health function training using the state of Washington model. The Title V MCH Division

collaborates with local health agencies to carry out state MCH objectives at the grass roots level.

/2002/ ND now has local public health departments in all 53 counties. Organizational structure of the 28 local agencies varies across the state, with some being multi-county, others city/county, single county or single district health departments.

/2004/ Local public health departments provide primary preventive services.

/2005/ Study Resolution 3054. Investigating the role and responsibilities of local public health in regards to bioterrorism and emergency preparedness. Public health agencies provided testimony at interim sessions./2005//

Most medical care in the state is provided by private health organizations. The majority of medical specialists are located in the eight major cities in the state. Being a large state geographically, extensive travel for health care is required. Several rural hospitals are seeking status as critical access hospitals to remain open and viable. At a minimum, preventive primary health care services and emergency care need to be provided in frontier areas.

/2002/ Hospitals in the state are suffering from policies that affect their financial status. MeritCare in Fargo has discussed discontinuing the Poison Control Center they had operated for many years and Medcenter One in Bismarck discontinued their Ask-A-Nurse program. This is magnified in the smaller, rural hospitals. Greater numbers of these smaller hospitals have applied for and been granted critical access status. It appears this may be only a temporary fix, and as populations continue to decline in these areas, other options will need to be sought.

/2004/ ND now has a contract with Hennepin County Poison Control Center in Minnesota to address our requests related to poisoning.

/2004/ There has been increased activity in the state to raise the number of Federally Qualified Health Clinics (FQHCs). ND has had the one FQHC in Fargo for some time. The ND Community Health Care Association (PCA) has been actively recruiting communities to establish FQHCs. There are now Health Centers located in Grafton (migrant), Bismarck (homeless) and Northland Healthcare Alliance's FQHC in Turtle Lake, McClusky and Rolette. Health systems in several of the larger communities of the state have announced closings of outreach clinic sites or other restructuring efforts due to budget cuts that could impact access to care. Some of the smaller communities that have lost these outreach services are reportedly interested in exploring development of community health centers. Funding to assist communities in applying for FQHC status was included in the DHS budget.

/2005/ ND currently has five Federally Qualified Health Centers with a total of 11 delivery sites. They are as follows:

**** Family HealthCare Center, Fargo***

**** Migrant Health Services Inc., Moorhead and Grafton***

**** Valley Community Health Centers, Northwood and Larimore***

**** Northland Community Health Centers, Turtle Lake, McClusky and Rolette***

**** Coal Country Community Health Centers, Beulah, Center and Halliday***

Unfortunately, the homeless program in Bismarck voluntarily surrendered their federal funding as of October 31, 2003, so there is no longer healthcare for the homeless in the Bismarck area. Community HealthCare Association of the Dakotas (the State's PCA) continues to work with many other communities in the state who might be viable options for CHCs in the future./2005//

The Native American population receives services in a variety of ways. Indian Health Service (IHS) is a provider of health care, but is reportedly under-funded. Native Americans who leave the reservations can receive basic care from IHS, but cannot be referred for contracted services outside the IHS service area.

/2002/ Provision of health care for the American Indian population, especially payment for services, is a source of confusion both on and off the reservations. Indian Health Service is perceived as a health care insurer both on and off the reservation. However, Indian Health Service is a provider of health care and American Indians need to apply for alternate insurers, such as Medicaid and SCHIP, when they are eligible for these programs. Cynthia Mala, former Director of the ND Indian Affairs Commission, held three conferences the past two years for providers and consumers of health care for American Indians on this topic. It is hoped that both American Indians and others will have a better understanding of this complex system through these efforts. The final conference was held in conjunction with the annual Dakota Conference on Rural and Public Health. Cynthia Mala has since resigned her position with the Indian Affairs Commission and a new director, Cheryl Kulas, has been appointed to the position.

Native American Reservations and Service Area continue to be funded for the federal Healthy Start program. Two of the reservations have formed a non-profit organization for fiscal purposes. Staff from the MCH Division are on the advisory board of Healthy Start, Inc.

/2003/ Initially, the Healthy Start Program received approval of their application, but funding was not available to support the initiative. Later the programs were funded to carry out the program through the Aberdeen Area.

/2004/ The Aberdeen Area American Indian Healthy Start Program did again receive funding. There has been minimal involvement with the program and ND MCH Program. Although contacted by the leadership in Aberdeen, no follow-up has occurred. Healthy Start Inc. continues to exist at Turtle Mountain, but they are the only reservation still involved.

The Medicaid Program administers the ND Healthy Steps Program (SCHIP). Regional Healthy Steps Workshops, sponsored by the Dakota Association of Community Health Centers, Inc. in partnership with the ND Medical Association and the DHS, were held in the fall of 1999. Many public health and county social service representatives attended and staff now provide outreach support for the program. The enrollment in Healthy Steps continues to grow. As of 6/30/2000, 1,860 children were enrolled; 170 or nine percent of which were Native American children. Enrollment in the program is tracked by county level so outreach efforts can be targeted to areas where it is most needed. Use of TANF funds to conduct outreach on one ND reservation is being explored.

/2002/ One major change will occur in Medicaid following action of the 2001 Legislature. Assets testing for children and family coverage groups for Medicaid eligibility will be removed effective January 1, 2002 with a sunset clause before the next legislative session. An attempt was also made to have eligibility for CHIP raised above 140 percent of poverty, but this was unsuccessful.

/2004/ As of March 2003, Healthy Steps enrollment was 2,096, down from 2,523 in 2002. For the immediate future, eligibility for the Healthy Steps program will continue to be determined by staff within the Medical Services Division at the state office. A bill introduced to include unborn children (individuals from conception to birth) under the children's health insurance program failed to pass during the last legislative session.

/2005/ Healthy Steps enrollment in May 2004 was 2,412.//2005//

/2004/ Children enrolled with Medicaid increased from 21,596 in March 2002 to 26,220 in March 2003. Medical assistance benefits to children and families coverage groups and pregnant women will continue to be provided without consideration of assets. A buy-in program for individuals with disabilities will be established for people whose family income is less than 250 percent of the FPL. Individuals must be 18-65 years of age and employed 40 hours per month.

/2005/Important updates with Medicaid include: 1) formation of a Medicaid Working Group that reports to the Governor to identify how Medicaid services can most effectively be delivered, recognizing the limitations of resources, 2) ability of individuals ages 18 through 64 with

disabilities who are gainfully employed to purchase coverage under the ND Medicaid Program, 3) planned initiation of service limits and co-pays for Medicaid eligible recipients, and 4) formation of a Medicaid Pediatric Services Task Force to address issues concerning children with disabilities.//2005//

/2005/ Over 53,000 individuals were eligible for Medicaid in March 2004. Approximately 50 percent of those eligible were under the age of 21, 16 percent were disabled, and 13 percent were classified as Aged. The new Medicaid buy-in program for North Dakotans with disabilities aged 18 to 65 went into effect June 1, 2004. The 2003 Legislature created the program to make health care more accessible.//2005//

/2003/ The DHS has developed a joint application form for Medicaid and Healthy Steps (SCHIP). Medicaid enrollment increased by 600 children following removal of the assets test, with Healthy Steps enrollment declining slightly.

In cooperation with the Medicaid Program, the state applied for and received a Robert Wood Johnson grant to increase outreach activities for ND Healthy Steps. The Children's Services Coordinating Committee is the lead agency, however, the Community Health Care Association (PCA) directs the project. Outreach is focused on two population groups, Native Indian families on two ND reservations and farm/ranch families statewide.

/2003/ The Dakota Medical Foundation in Fargo, ND has applied for the Robert Wood Johnson Covering Kids and Families grant this year. Statewide strategies in the proposal included: 1) preparing marketing and training materials, 2) providing training to key organizations that work with low-income families; 3) building an information system with the DHS; and, 4) facilitating an annual conference with stakeholders to prepare a strategic plan.

/2004/ The Dakota Medical Foundation in Fargo was successful in their application to RW Johnson for Covering Kids and Families. The project is a comprehensive, outcome-based structure for reducing the number of uninsured children in ND by increasing enrollment in Medicaid, Healthy Steps and the Caring Program. The three major components of this project are: 1) Statewide Project; 2) Enrollment Assistance Project; and 3) Enrollment Incentive Project. They plan to explore the feasibility of a single application form for all three programs.

/2005/ In late 2002, Dakota Medical Foundation (DMF) received a \$700,000.00 four-year grant from the Robert Wood Johnson Foundation to join the nation-wide Covering Kids & Families Initiative. The goal was to connect all eligible children to existing low-cost or free healthcare coverage programs offered within the state. DMF provided \$577,000.00 in additional funding and resources to add to the success of the ND Covering Kids & Families project. DMF's strategy to lessen the number of uninsured children and families in the state is to expand outreach, to simplify/coordinate program application processes, and to find ways to sustain efforts beyond the four-year grant. The initiative is separated by projects; the Enrollment Assistance Project, the Enrollment Incentive Project and Statewide Project. From January 2003 to January 2004, the number of children enrolled in coverage programs increased by 999. Caring Program enrollment increased from 625 to 704, Healthy Steps, the state children's health insurance program, increased from 2,111 to 2,306, and Medicaid increased from 25,575 to 26,300. Covering Kids and Families in 2003 focused on key individuals who work directly with children and families. Hundreds of child care providers, school nurses, principals, parish nurses, insurance agents, social services and business members were educated about ND's low-cost or free coverage programs, as well as available resources that help connect uninsured families to coverage. Through the combined efforts of Covering Kids and Families staff and those individuals educated about the programs, thousands of marketing materials were distributed statewide. The Family Health Division Director is a member of the Covering Kids and Families Advisory Committee.//2005//

/2003/ Dr. Bernard Hoggarth, a ND pediatrician, received a \$9,960.00 grant from the American

Academy of Pediatrics to help uninsured children obtain coverage. Outreach efforts identified in the grant included meetings with pediatricians, clinical staff and clinic business office staff to promote health coverage programs

With financial support from businesses, community and church groups and individuals, the ND Caring Foundation provides the Caring Program for Children, a specially designed health and dental benefit program for eligible children who are not covered by or eligible for Medicaid or other health insurance. Blue Cross/Blue Shield of ND, in cooperation with the Dental Service Corporation of ND, contributes all administrative costs for the program. The Caring Program for Children is an additional resource for families that do not have a source of health care coverage.

/2002/ The Caring for Children Program raised their eligibility requirements to 200 percent of poverty following the initiation of Healthy Steps (SCHIP). Approximately 450 are now enrolled.

/2003/ As of May 2002, 592 children were enrolled in the Caring for Children Program.

/2004/ As of June 2002, 625 children were enrolled in the Caring Program. Families are now referred to this program through the Covering Kids and Families Initiative.

/2004/ As of May 2003, 670 children were enrolled in the Caring Program.

/2005/ As of March 2004, 704 children were enrolled in the Caring Program. The Covering Kids and Families Initiative continues to connect uninsured families to coverage./2005//

The Medicaid managed care pilot project in Grand Forks County continues. Medicaid may expand the program to surrounding counties in the region. Clients in the area have their choice of the managed care plan or a primary care provider. The percent of Medicaid recipients that chose the managed care plan dropped this past year from around 60 percent to 40 percent. HMO activity outside Medicaid has not changed from previous years.

/2002/ The Medicaid Program still has a Health Care Organization (HCO instead of HMO or Health Maintenance Organization) pilot project in Grand Forks. The number of participants in the respective programs is 25 percent with the HMO and 75 percent with the Primary Care Physician (PCP Program). The Blue Cross/Blue Shield (Noridian) organization will be assuming responsibility for the project July 1, 2001, as the HCO in Grand Forks will cease to exist. The HCO pilot project had planned to expand their coverage to surrounding counties, but because of the early discussion of change in HMOs, this expansion did not occur. The only other ND HMO is in the Rugby area; the Heart of America has been in existence for 19 years. Some Minnesota HMO's are interested in covering the eastern part of the state as well.

/2003/ Eligible Medicaid recipients in Grand Forks County are able to choose between managed care plans. The first managed care plan is contracted through Noridian. Noridian utilizes the AltruCare Plan for care and care management. Since July 1, managed care organization (MCO) use has increased due to enhanced outreach and marketing. The second managed care plan is the Primary Care Provider Program, a statewide Medicaid program in which each client selects a provider to be their Primary Care Provider. ND Medicaid is proposing changes to the primary care provider program that was first implemented in January 1994. Proposed changes are provider network based; however, Medicaid enrollees will continue to be required to select an individual PCP.

/2004/ Managed care enrollment has increased beginning with the Noridian Mutual Insurance Co. as the contractor in July 2001; managed care continues to just be in Grand Forks County for now; approximate penetration rate in Altru Care for GF county is 26.4 percent. There are efforts to expand the Altru Care program to other surrounding counties, but currently are only available in one county.

/2005/ Effective January 1, 2004, MCO has expanded geographically to include Grand Forks, Walsh and Pembina Counties. Approximate penetration rate in Altru Care for Grand Forks

County is 26.4.//2005//

There is concern in the state that declining enrollment in Medicaid may be linked to changes in social welfare. Temporary Assistance to Needy Families (TANF), a program that replaced Aid to Families with Dependent Children (AFDC), may have resulted in families assuming they were not eligible for medical assistance when they actually were still eligible for the program. This concern may be addressed as enrollment in ND Healthy Steps continues.

In February 2000, 2,742 ND families received TANF, 36 percent less than in February 1997. By racial breakdown, 40.1 percent were white, 57.5 percent American Indian, 2.2 percent Black and 0.2 percent Asian.

/2003/ In April 2002, 3,150 ND families received a TANF grant up from 2,920 in April 2001.

/2004/ In March 2003, 3,284 families received a TANF grant up from 3,082 in March 2002.

/2005/ For the period July 2003-March 2004, there were 3,121 monthly average TANF cases.//2005//

ND received the Health Resources and Services Administration (HRSA) and Health Care Financing Administration (HCFA) Initiative entitled "CompCare." The state has requested assistance in two areas. Once children are enrolled in a health care plan, help is being requested to ensure these children receive primary preventive health care. Secondly, assistance is being sought in sorting out the health care options available to the Native American population living both on and off the reservation. Acceptance of Bright Futures as best practice for pediatric health care is also under consideration.

/2002/ CompCare Technical Assistance was awarded to the state last year. This year, technical assistance has been used to conduct eleven focus groups in the state targeting parents with children enrolled in private insurance, Medicaid or Healthy Steps (SCHIP). The purpose of these focus groups was to determine the rationale for use of or failure to use preventive health care. In 2002, these focus groups will be followed by a mail survey of health care providers, with a public meeting being held to disseminate the results of the surveys when all work is completed.

/2003/ Health Systems Research, Inc. (HSR) compiled a report of the focus group findings along with marketing recommendations. The CompCare TA Committee suggested a survey of health care providers prior to initiating a marketing plan. This survey of health care providers was conducted in May and June 2002. Results have not yet been received.

/2004/ The CompCare Survey of providers was not successful. Over 400 surveys were sent electronically to a wide variety of health care providers, with 20 surveys completed after several reminders. Discussion was then held about having a statewide meeting to introduce information from the focus groups and developing a marketing plan. The CompCare Committee had some reservations about such a meeting given the lack of interest in the topic when surveyed. As a group, it was decided to try and incorporate access to health care and other issues from the technical assistance into the Healthy ND initiative. MCH will address this as part of their strategic planning.

/2002/ ND wrote and received a point-in-time Prenatal Risk Assessment Monitoring System (PRAMS) grant. Most of the project will be contracted to an outside agency with a core internal state level committee working on and overseeing the project. An external advisory board will also be established for the grant.

/2003/ The PRAMS survey was initiated May 7, 2002. ND MCH Staff also participated in a pilot to evaluate Free Balance software as means of transmitting future grant applications electronically.

/2004/ The survey was completed with the 70 percent return rate achieved. The birth tape has been

submitted to CDC. Our contractor, the State Data Center at the North Dakota State University, will be doing data analysis and distribution of information during Year 3 of the grant.

/2005/ The contractor, the State Data Center at ND State University, has begun analysis of survey data and compiled a preliminary report. Additional analysis will be completed over the next several months for use in the 5-year needs assessment, state performance measurement and MCH programs./2005//

/2002/ ND is becoming more active in lead screening activities. The Environmental Section of the DoH wrote a grant to the Environmental Protection Agency (EPA) for funding to increase blood lead screening of children in high-risk areas. The MCH Division has written a grant to the Centers for Disease Control (CDC) for the purpose of conducting more blood lead screening, building laboratory capacity to analyze blood lead samples, and providing some funds for follow-up of identified cases of blood lead poisoning.

/2003/ ND did not receive the CDC grant for lead screening. Using EPA funds, there is an attempt to determine the prevalence of childhood blood lead screening in the state. Several local public health departments are participating in a targeted blood lead screening program. So far, 138 blood lead levels have been completed with no positive findings.

/2004/ Approximately 200 children were screened, with no positive cases being found. Continue to explore means to support continued lead screening in the state. Collaboration efforts between CDC, Environmental Section and Medicaid have lead to GIS mapping of positive cases. This should help clarify trouble areas for elevated blood levels.

/2005/ Using EPA funding, the Environmental Health and Community Health Sections planned and implemented a regional lead awareness conference in ND. The 2004 Conference on Lead Awareness brought together 125 local, state, federal, tribal and national partners. The goal of the conference was to build lead awareness and lead-poisoning prevention in the region. The conference highlighted issues pertaining to lead-based paint and the direction toward lead-poisoning prevention and public policy./2005//

/2005/ ND continues to collect Medicaid lead screening surveillance as well as blood lead levels of 10 ug/dL or greater./2005//

/2003/ The MCH Oral Health Program wrote a CDC grant in 2001 to fund oral health access and education activities. The grant was approved, but not funded. Funding has become available so ND will be addressing these issues. There are also plans to write for a Robert Wood Johnson grant for oral health access.

/2004/ ND did not receive the RW Johnson grant, but continues to address oral health issues with the CDC grant. The program was without staff for several months, but the program now has a new director and activities are continuing.

/2005/ The Oral Health Program is seeking funding from the State Oral Health Collaborative Systems Grant from HRSA. This grant will address fluoride varnish application by health professionals at well baby visits, increase the number of dentists in ND by recruiting from dental schools and incorporate clinical rotations at Community Health Care Centers, Federally Qualified Healthcare Centers or other suitable sites for dental students. Collaboration continues with other DoH Divisions to incorporate oral health into the various programs and activities. A new community-based dental clinic, Bridging the Dental Gap, will be opening in Bismarck in July 2004./2005//

/2004/ The DoH has been involved in reorganization and strategic planning under new leadership in the department. Dr. Dwelle is our new health officer and he has appointed Arvy Smith as Deputy State Health Officer. Other sections and divisions within the department have been realigned. The

MCH Division is now part of the Community Health Section, along with the Division of Health Promotion. Our former section was the Preventive Health Section, which also included the Divisions of Disease Control and Microbiology. Further reorganization is being planned for the Community Health Section. There are plans underway to flatten the organizational structure by having five to seven divisions instead of two. An executive administrator was employed to help Dr. Joyce, the section chief, with this reorganization. Once the plan is developed and implemented, the executive administrator position will be terminated. Several meetings have been held to allow staff to have input into reorganization. The plan is to have divisions in place by mid-August.

//2005/ In mid June 2003, reorganization of the Community Health Section was initiated. By September, six divisions had been formed to replace the previous two, with directors hired for each. The new divisions are: Cancer Prevention and Control, Chronic Disease, Family Health, Injury Prevention and Control, Nutrition and Physical Activity and Tobacco Prevention and Control. Some of these divisions have or will be adding additional programs and staff, so work is currently underway to accommodate more staff within the current workspace. The department has conducted an organization cultural survey as part of their strategic plan. The results of this survey should help evaluate staff attitudes related to the reorganization of the section.

Three of the six divisions receive funds from the Title V MCH Grant. These include Family Health, Injury Prevention and Control and Nutrition and Physical Activity. The Division of Family Health will take the leadership for administering the Title V Block Grant with assistance from the directors of the Divisions of Injury Prevention and Control and Nutrition and Physical Activity.//2005//

//2004/ Under the new leadership, strategic planning has also been addressed. A facilitator is working with the DoH to develop a strategic plan. Mission and vision statements have been developed for the department, sections and divisions. Each section developed objectives with milestones, timelines and outcomes. The MCH Division strategic plan can be accessed at the following URL:
<http://www.ndmch.com/CommunityHealthSectionStrategicPlanning.doc>

//2005/ The strategic plan continues to be a work in progress. Many of the key objectives have been addressed. The Community Health Section Division Directors have led their divisions through planning to develop overall objectives for the section as part of their strategic plan.

The Community Health Section's strategic plan will be re-evaluated on a regular basis in May and November annually.

The current Community Health Section strategic plan can be accessed at the following URL: <http://www.ndmch.com/CommunityHealthSectionStrategicPlanning.doc> //2005//

//2004/ Like all states, ND's DoH is heavily involved in bioterrorism activities. Three staff have been employed at the state level to manage both the CDC and HRSA bioterrorism programs. A public information specialist and additional epidemiologists have also been hired to address emergency issues. In addition, eight regional coordinators have been employed in local public health department to address bioterrorism. The section that has been formed for bioterrorism will be changing their name to Section on Emergency Preparedness and Response. The MCH Division's involvement in this process has been minimal.

//2005/ An update on activities occurring within the Emergency Preparedness and Response Section was provided at the Community Health Section and at the Local Public Health Administrators' and Director of Nurses' meetings. Communication technology was upgraded at the eight largest public health units. All public health units will receive communication technology upgrades by the end of the year. The state school nurse consultant worked with the director of the Emergency Preparedness and Response Section to support and provide funding for the ND School Nurse Organization members to attend Emergency Preparedness

and Response for School Nurses; presented by the National Association of School Nurses. A total of \$8,000.00 was given to support the training.//2005//

/2004/ ND submitted a State Planning Grant application to HRSA over a year ago and had received notification at that time it was approved, but unfunded. In May 2003, the DoH was notified that the grant would be funded. The purpose of the grant is to examine the uninsured and underinsured population in ND and to propose some viable options to assure access (per the Governor, the options must be budget neutral for the state). The amount of the grant is \$781,000.00 and is for one year, starting September 1, 2003. Dr. John Baird will be the program director for the grant with the bulk of the research being done by the University of ND. The Governor will appoint a task force with broad representation to oversee the grant and provide input. Thirty states have been awarded the grants with ND and Mississippi being the last two funded. The University of Minnesota has worked with several states and has developed a questionnaire. One of the major focuses will be trying to get good information on the underinsured. There is a growing body of evidence about what is working and what is not. About half the states have done focus groups and the general consensus is that small business buy-in is crucial. In follow-up information, it has been reported that the Governor would like a statewide health delivery system be developed through this initiative.

/2005/ ND has been funded by HRSA for a State Planning Grant of \$781,889.00, with a grant period of June 1, 2003-August 31, 2004. The purpose of the grant is to study health insurance coverage in the state and to develop options and plans for expanding coverage for the uninsured. Dr. John R. Baird, a state medical officer, oversees the grant and is coordinating a Governor's Health Insurance Advisory Committee. The Center for Rural Health at the University of ND has been coordinating the research. A household phone survey has just been completed, as well as household focus groups. Employer focus groups and focus groups of uninsured individuals will also be done. Forty-two states have received State Planning grants. We have looked at the experience of other states and reviewed our medical marketplace. As we recognize the gaps in health care access, we are developing options for coverage, which is a challenge in these fiscally tight times. Our governor has asked that policy recommendations be budget neutral. 8.2 percent of North Dakotans do not have health insurance. This is better than the national average, but still represents 51,900 people, about the size of our second largest city, Bismarck. Seventy percent of the uninsured are employed. They tend to have lower income and work in smaller firms of 10 or fewer employees. Approximately forty-one percent of the uninsured are 24 years old or younger and 21.9 percent of the uninsured are under 18 years of age. We have a significant Native American population in our state and 31.7 percent of them are uninsured compared to approximately seven percent of the Caucasian population. A report will be filed with the Secretary of HHS by the end of September 2004 with our research findings and our policy development at that time. We are applying for a one-year continuation grant of up to \$150,000.00 to continue policy development and consensus building around improving access to health care.//2005//

B. AGENCY CAPACITY

The State Health Officer of the ND Department of Health (DoH) is responsible for the administration of programs carried out with allotments made to the state by Title V. The Governor appoints the Health Officer. The ND Department of Human Services (DHS) administers the portion of funds allotted for children with special health care needs. The Governor appoints the Executive Director of this department.

Local public health departments are autonomous and not part of the DoH. Their relationship is cooperative and contractual. In the DHS, county social service boards work cooperatively with the state agency in administering programs and services. A state map and contact information for each county social service office can be found via the following link:

/2005/ <http://www.state.nd.us/humanservices/locations/countysocialserv/index.html> //2005//

The DoH functions in compliance with Chapter 28-32, Administrative Agencies Practice Act, ND Century Code (NDCC). The MCH Division of the DoH has statutory authority to accept and administer funds for the following programs: MCH/Title V, WIC, Family Planning/Title X and Domestic Violence (both state general and marriage license surcharge). The Governor named the DoH the lead agency for the STOP Violence Against Women Program contained in the federal crime bill. The MCH Division administers the STOP Program. The NDCC mandates newborn metabolic screening (23-01-03.1 and 25-17- 01 to 25-17-05) and SIDS reporting (11-19.1).

//2005/ The DoH functions in compliance with Chapter 28-32, Administrative Agencies Practice Act, ND Century Code (NDCC). The Divisions of Family Health, Injury Prevention and Control and Nutrition and Physical Activity, within the Community Health Section of the DoH, have statutory authority to accept and administer funds for the following programs: MCH/Title V, WIC, Family Planning/Title X and Domestic Violence (both state general and marriage license surcharge). The MCH/Title V and Family Planning/Title X are administered within the Division of Family Health. The WIC Program is administered within the Division of Nutrition and Physical Activity. The Domestic Violence Program is administered within the Division of Injury Prevention and Control. The Governor named the DoH the lead agency for the STOP Violence Against Women Program contained in the federal crime bill. The Division of Injury Prevention and Control administers the STOP Program. The NDCC mandates newborn metabolic screening (23-01-03.1 and 25-17- 01 to 25-17-05) and SIDS reporting (11-19.1). Metabolic screening is located in the Division of Nutrition and Physical Activity. The SIDS program is located in the Division of Family Health.//2005//

The DHS through the Children's Special Health Services (CSHS) Division administers programs for children with special health care needs. Administrative duties of state and county agencies and confidential birth reports for newborns with visible congenital deformities are addressed in NDCC Chapter 50-10.

//2002/ Required by the fifty-seventh Legislative Assembly, effective 7/1/01, CSHS became a unit within the Medical Services Division; part of the Economic Assistance Subdivision of the DHS.

//2003/ Provision of medical food and low-protein modified food products by CSHS is addressed in NDCC 25-17-03.

Various programs within the two departments and divisions contribute to the health of the maternal and child health population. The Optimal Pregnancy Outcome Program (OPOP) provides nursing, nutrition and social services to at-risk pregnant women that augments the care women receive from their primary health care provider. The program targets pregnant women who are adolescent, single or married women who are abused, developmentally delayed, emotionally impaired or of low income, and those women who may have a high-risk pregnancy or other risk factors. Services are available at nine local sites within the state's eight regions.

//2005/ OPOP continues to grow. In 2003, the program saw 497 clients.//2005//

Local public health departments provide grass roots primary preventive services to women and infants such as prenatal classes, immunizations and other health related programs. Part of the funding used to provide these services are Title V MCH grant funds. Two Native American Reservations receive funds to augment Healthy Start Programs.

//2005/ For tables depicting uses of Title V funds at the local level proposed for FY 2005, refer to the following URL: <http://www.ndmch.com/UseOfTitleVFunds.doc> //2005//

The MCH Domestic Violence/Rape Crisis Program grants federal and state funds to domestic violence/rape crisis, prosecution, law enforcement and other community agencies to address the issues of domestic violence and sexual assault through collaborative and coordinated efforts. The program provides technical assistance to the contracted agencies and maintains statewide domestic

violence and sexual assault data through a grant to the ND Council on Abused Women's Services.

/2003/ Domestic violence data is collected from city, county and tribal law enforcement agencies statewide. The report, Domestic Violence in ND, is printed and distributed to legislators, emergency room physicians, tribal leaders, victim witness advocates, law enforcement, prosecution, social services and other professional agencies addressing the issue of violence against women.

The Birth Review Program is a collaborative program between CSHS and DoH; the purpose of which is to identify at-risk newborns through information from the birth record, provide parents with information on risks and related health care concerns, and link families to early intervention and other support programs. It is part of a larger effort known as ChildFIND, whose purpose is to identify all children with disabilities.

/2003/ The Program provides all parents of newborns the opportunity to request information to assist them with their concerns or questions on infant care.

The MCH Nurse Consultant (maternal and infant) is involved in women and infant programs and issues, such as the Fetal Alcohol Syndrome Task Force, March of Dimes, Infant Massage, Birth Defects, and Newborn Home Visiting.

/2002/ The nurse consultant facilitates the updating of the MCH Child Health Manual and chairs the Newborn Home Visiting Committee.

/2003/ Leadership for the Birth Defect Surveillance Committee has been assumed by the State Systems Development Initiative Coordinator.

/2005/ "Parenting The First Year" newsletters were updated and continue to be distributed to 79 percent of new parents within ND. The nurse consultant is involved in the American College of Obstetricians and Gynecologists chapter on perinatal depression.//2005//

The state's Sudden Infant Death Syndrome (SIDS) Management Program provides support, education and follow-up services to parents/caregivers, family and childcare providers suffering a sudden infant death. The program coordinator collaborates closely with the ND SIDS Chapter affiliate.

/2002/ The Program promotes the "Back to Sleep" campaign.

/2003/ The Program and the ND SIDS Chapter affiliate are developing a plan to educate mothers in hospital maternity wards on the importance of positioning babies on their back while sleeping.

/2005/ The Program was awarded a \$3,000.00 grant from the CJ Foundation. The money was used to create a SIDS risk reduction brochure geared towards the Native American population.//2005//

The Newborn Metabolic Screening Program currently screens newborns for phenylketonuria (PKU), hypothyroidism, galactosemia and congenital adrenal hyperplasia through the University of Iowa's Hygienic Laboratory. The Chief Medical Officer and MCH staff does follow-up of positive and borderline cases. Iowa provides free monitoring of PKU levels for children. Special metabolic formulas are provided to children with PKU and MSUD and some low protein foods are provided to Medicaid and uninsured children.

/2002/ MCH staff does follow-up of positive and borderline cases. Iowa provides free monitoring of phenylalanine levels for children with PKU.

/2005/ The Newborn Screening Program is now located in the Division of Nutrition and Physical Activity. The Newborn Metabolic Screening Program has expanded testing to include: phenylketonuria (PKU), hypothyroidism, galactosemia, congenital adrenal hyperplasia, sickle

cell anemia and other hemoglobinopathies, biotinidase deficiency, and several additional amino acid, fatty acid oxidation and organic acid disorders identified using tandem mass spectrometry, including medium-chain acyl-coA dehydrogenase deficiency. ND's testing continues to be performed by the University of Iowa's Hygienic Laboratory in Des Moines. The MCH nutritionist and a nurse from the Division of Family Health provide follow-up services for positive and borderline cases. CSHS provides special metabolic formulas for children and women with PKU and MSUD and provides low protein foods to Medicaid clients with these same conditions. CSHS funds a quarterly metabolic clinic and provides state-level care coordination services.//2005//

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

/2002/ The Program now has seven Title V funded regional dental health consultants.

/2003/ The Program oversees a Donated Dental Services Program and a Dentists' Loan Repayment Program.

/2004/ The Program has added a 0.25 percent time research analyst and a 0.5 percent time oral health educator. These positions were the result of a CDC grant award to build capacity/infrastructure.

/2004/ The MCH Lead Program conducts blood lead screening surveillance and monitors blood lead levels reported to the department.

/2004/ The MCH Injury Prevention Program's mission is to reduce the number and severity of injuries to North Dakotans, with special emphasis on injuries to children. A full-time director, half-time health educator and a quarter-time secretary staff the program. Program staff provide training, technical assistance, educational materials, and safety products to local entities to implement community-based intervention projects. Injury-specific topics include child passenger safety, product safety, bike safety, poison prevention, suicide prevention, shaken baby syndrome awareness and playground safety. The program director and health educator are certified child passenger safety instructors, and the director is commissioned with the US Consumer Product Safety Commission to conduct recall effectiveness checks, product injury investigations and other assignments.

/2002/ The Shaken Baby Syndrome Task Force is no longer funded. Additional responsibilities of program staff include participation on the EMSC Advisory Council Task Force and the United Tribes Injury Prevention Program Advisory Committee.

The MCH School Nurse Program is staffed by a 45 percent RN director that promotes and supports school nursing as part of the comprehensive school health program. The program assists in the coordination of statewide school nurses meetings, provides technical assistance for school health services including scoliosis, vision and hearing, and safety issues for students, teachers and support staff.

/2002/ The School Nurse position has been incorporated into the Adolescent Health Program.

/2005/ In 2003, the first School Nurse of the Year award was given to a school nurse who demonstrated excellence in school nursing practice./2005/

/2005/ Legislation was introduced by the ND School Nurses Organization. SB No. 2307: A Bill for an Act to create and enact a new section to chapter 57-36 of the ND Century Code, relating to matching grants for public health agencies for school health services projects; to amend and reenact section 57-36-32 of the ND Century Code, relating to the rate of tax on the sale of cigarettes; to provide a continuing appropriation. Passed both the Senate Tax and Finance Committee and State Appropriations Committee. SB No. 2307 did not pass on the Senate floor (23-23, with one absent and not voting) ./2005/

/2005/ ND received the Coordinated School Health Programs (CSHP) and Reduction of Chronic Diseases Infrastructure Agreement from CDC in March 2003. The goal of this program is to build state education and health agency partnership and capacity to implement and coordinate school health programs across agencies and within schools. Full-time senior staff positions have been hired in the state education agency and the state health agency. The Coordinated School Health Program is located within the Division of Family Health. The expected outcome of this effort is to help schools reduce priority health risks among youth, especially those risks that contribute to chronic diseases. Eleven school districts have been selected as demonstration sites to implement CSHP. A School Health Interagency Workgroup (SHIW) made up of staff from the Department of Public Instruction and DoH meets quarterly to collaborate and coordinate issues pertaining to coordinated school health./2005/

The ND Abstinence Education Grant Project grants federal funds to Regional and Tribal Children's Services Coordinating Committees (R/TCSCCs) to carry out abstinence-only education activities at the local level. The project coordinator provides technical assistance to local agencies and maintains statewide data for annual reporting purposes.

/2002/ If the R/TCSCCs decline administration of the funds, local Public Health units within the region are given the opportunity to carry out the abstinence activities. A 30 percent Registered Nurse Project Coordinator directs the program.

/2005/ Grantees include two CSCCs, four regional tribes, one community action program, and five public health units. Grantees activities include the purchase of abstinence-only education materials and utilizing abstinence-only education speakers. These speakers target the middle school and high school population. A multi-region public health unit consortium has engaged in a media campaign targeting teens./2005/

The MCH Women's Health Coordinator's responsibility is to disseminate information regarding women's health and to facilitate the collaboration of programs, which enhance women's health. The goal is to develop a broader perspective of what contributes to the health and welfare of women and provide information to researchers, policy makers and the health care providers.

MCH Title V provides supplemental funding to the Title X Program. The goal of the overall program is to provide individuals with the information and means to exercise personal choice in determining the number and spacing of their children. Program staff assures that individuals have access to a broad range of acceptable and effective family planning methods. Technical assistance, training and materials are provided to contracting agencies to accomplish this goal.

/2004/ The Program contracts with 9 local public health and not-for profit agencies to serve 16,000 women and men annually.

The MCH Nutrition Program funds nutritionists to promote nutrition through emphasis on the ten essential public health functions adapted to nutrition activities. Emphasis is placed on population-based interventions such as the 5 + 5 Program, school-based interventions such as teacher in-services, and breastfeeding promotion. Working with school-aged children and adolescents to

promote healthy eating and exercising behaviors is a top priority. MCH nutrition staff coordinate meetings with other state nutrition program staff and local nutritionists for the purposes of program updates and sharing of ideas and materials.

/2002/ MCH staff coordinate the activities of the ND Obesity Prevention Work Group.

/2005/ MCH nutrition services are now located in the Division of Nutrition and Physical Activity. The MCH nutritionists serves as the Department's liaison to the Healthy ND Initiative's Healthy Weight Nutrition Committees (Breastfeeding, Fruit & Vegetables, Healthy School Nutrition Environment) and coordinates the activities of the Healthy Weight Council (formerly called the ND Obesity Prevention Workgroup)./2005//

The Nutrition Program for Women, Infants and Children or WIC Program was created to promote and maintain the health and well being of nutritionally at-risk women, infants and young children. This is accomplished through the provision of supplemental foods, nutrition education and counseling and referrals to health and social support programs. Pregnant, breastfeeding and recently delivered non-breastfeeding women, their infants and children up to age five are eligible if they meet income guidelines and have a nutritional need. The ND WIC Program contracts with 28 local public and private not-for-profit health agencies to serve 14,000 ND residents each month.

/2005/ Now located in the Nutrition and Physical Activity Division, the Nutrition Program for Women, Infants and Children (WIC) Program was created to promote and maintain the health and well being of nutritionally at-risk women, infants and young children. This is accomplished through the provision of supplemental foods, nutrition education and counseling and referrals to health and social support programs. Pregnant, breastfeeding and recently delivered non-breastfeeding women, their infants and children up to age five are eligible if they meet income guidelines and have a nutritional need. The ND WIC Program contracts with 27 local public and private not-for-profit health agencies to serve 13,500 ND residents each month./2005//

The MCH Nurse Consultant for children and adolescents participates and collaborates in a number of health related issues. Consultation is provided on a number of topics such as scoliosis, pediculosis, health and safety issues related to childcare, growth and development, and discipline.

Local agencies including public health agencies conduct primary preventive health services for the child and adolescent populations. Injury prevention, nutrition and oral health issues are some of the health issues addressed. Funding from Title V MCH assist them in these efforts. One school nurse program is funded at the Standing Rock Indian Reservation.

Payment for authorized services to qualified providers serving eligible children with special health care needs is provided through the Specialty Care Program in order to increase access to pediatric specialty care. Through this program, CSHS supports both diagnostic and treatment services. CSHS promotes early diagnosis of over 100 medical conditions. Families must complete an application for diagnostic services at their county social service office, but financial eligibility is not required. The CSHS Medical Director determines medical eligibility and other state-level staff provides technical assistance to county social service staff in the application process and authorizes payments for care. CSHS also pays for a variety of services needed to treat a child's eligible medical condition. Families apply for treatment services at their county social service office. Both medical and financial eligibility is required. The CSHS Medical Director determines medical eligibility at the central office. Other state-level staff develops policy and procedures, provide technical assistance in the application process and training of county social service staff, and authorize payments for care. Income eligibility has recently been raised to 185 percent of the federal poverty level and assets are no longer considered. CSHS maintains a list of approved health care providers who have agreed to participate in the program.

/2002/ As a result of the past legislative session, eligibility criteria for treatment services through CSHS was mandated at 185 percent of the poverty line, except for criteria relating to PKU or MSUD treatment services for which income is not to be considered when determining eligibility. Effective

8/1/01, CSHS must provide medical food and low protein food products to certain individuals with PKU or MSUD. Males under age 22 and females under age 45 receive formula at no cost and others receive formula at cost. Low protein modified food products must also be provided at no cost to males under age 22 and females under age 45 who are receiving medical assistance. Medical benefits coverage for medical food or low protein modified food products is not required to the extent those benefits are available under a DoH or DHS program.

/2003/ CSHS medical eligibility is reviewed annually at the CSHS Medical Advisory Council meeting. Expansions that have been recommended include coverage for seizure disorders and conditions discovered through expanded newborn metabolic screening.

/2004/ CSHS staff participates on HIPAA workgroups that deal with electronic transactions and privacy. Since CSHS utilizes the Medicaid Management Information System to process claims for children with special health care needs served by CSHS, the claims and eligibility administrator is heavily involved in planning necessary system changes to assure accurate claims processing and payment for Medicaid, as well as other payers that utilize the system.

Comprehensive pediatric evaluations and coordinated care recommendations for children with special health care needs are provided through the Multidisciplinary Clinic Program in order to help families effectively manage their child's chronic health condition. Clinics are available for children whose chronic health conditions are best managed through a team approach. CSHS directly administers or sponsors the following eight types of clinics: Cleft Lip and Palate Clinics, Scoliosis/Orthopedic Clinics, Cardiac Care for Children Program, Metabolic Disorders Clinics, Cerebral Palsy Clinics, Developmental Assessment Clinics, Myelodysplasia Clinics, and Diabetes Clinics. Over 80 clinics are held each year across the state; half of which are coordinated by CSHS. The other half is funded through contracts with hospitals, health systems and universities. Families are not billed for clinic services; however, third-party payers may be used, if available. State-level nursing staff provides clinic coordination services for programs directly administered by CSHS, carries out technical assistance, training and quality assurance activities. A network of public and private health care providers across the state participates in the program and local county social workers affiliated with CSHS staff many of the clinics. The Multidisciplinary Clinic Program provides a secondary benefit as an avenue for pre-service training, particularly for nursing and speech/language students.

/2003/ About ninety clinics were held in 2001. Proposals for neurorehabilitation clinics and an asthma education program have been submitted and will be pursued. An increase to 100-110 clinics is projected for the next fiscal year. CSHS staff will directly administer about one-third of these clinics.

/2004/ CSHS supported 96 clinics in 2002. In 2004, CSHS anticipates supporting ten different types of clinics, including neurorehabilitation and asthma programs.

/2004/ For tables depicting uses of Title V funds at the local level proposed for FY 2004, refer to the following URL: <http://www.ndmch.com/UseOfTitleVFunds.doc>

/2005/ For tables depicting uses of Title V funds at the local level proposed for FY 2005, refer to the following URL: <http://www.ndmch.com/UseOfTitleVFunds.doc> //2005//

Community-based case management services for children with special health care needs and their families are provided through the Care Coordination Program in order to assure access to necessary, comprehensive services. Public health nurses provide care coordination services to a broad population of children with physical, developmental, behavioral or emotional conditions in five eastern counties of the state. Care coordination responsibilities of county social service staff in all 53 counties were recently expanded to better serve children eligible for treatment services through CSHS. State-level staff provides technical assistance, training and quality assurance activities to support this program and work to align service coordination activities throughout the DHS.

/2003/ 140 children received community-based care coordination services through public health

nursing and county social service staff in FY 2001. Since no new proposals for public health care coordination programs were submitted for funding this fiscal year, expansion to other geographic areas of the state is unlikely.

/2004/ 287 children received community-based care coordination services through public health nursing and county social service staff in FY 2002.

Through CSHS Administration, leadership and support is provided to state and local partners for implementation of health service system improvements. Primary partners include families, county social service staff, health care providers and related program administrators. In addition to direct services for children with special health care needs and their families, CSHS provides the following public health services to promote maternal and child health:

- * Public information services - CSHS functions as a family resource center and conducts a variety of outreach and public education activities.
- * Training, consultation and technical assistance - CSHS provides technical assistance, training and consultation to county social service and public health nursing staff.
- * Planning and policy development - CSHS works with others to address identified needs of CSHCN and their families (e.g.) Medicaid, state legislature, etc.
- * Needs assessment, performance monitoring and quality assurance - The State Systems Development Grant supports these critical Title V efforts.
- * Coordination and collaboration - CSHS staff participate on a number of committees, advisory boards, workgroups and task forces (e.g.) Family and Medical Advisory Councils.

/2004/ CSHS continues to work to ensure a statewide system of services for children with special health care needs and their families. State-level staff participates in nearly 30 interagency committees, thus assuring collaboration on issues of importance to CSHCNs and their families. State support for communities is addressed through funding of multidisciplinary clinics and community-based care coordination programs, partnerships with county social service staff that work with the CSHS program at the local level, and activities to enhance local level data capacity addressed through the SSDI grant. Multidisciplinary clinics and care coordination activities are the primary mechanisms by which comprehensive health components are successfully coordinated with one another. Infrastructure that supports coordination of health and other services at the community level is found in the regional/tribal children's services coordinating committees which focus on children at risk and the regional interagency coordinating councils which focus on children birth to three in early intervention.

/2004/ Efforts to enhance family-centered care include support of a CSHS Family Advisory Council; contracts with two family organizations in the state that provide emotional support, information, and training for families; and active staff participation with a Family Support grant in both planning and program implementation.

/2004/ State-level staff attended cultural competency training and are planning to incorporate cultural competency training and skill-building into the next annual training event for local partners serving children with special health care needs and their families.

/2005/ CSHS has organized services it provides into the following framework. Updates in each area follow:

**** CSHS Administration - Leadership and support is provided to state and local partners to implement health service system improvements. Primary partners include families, county social service staff, health care providers and related program administrators. Efforts to enhance family-centered care include support of a CSHS Family Advisory Council; contracts with two family organizations in the state that provide emotional support, information, and training for families; and active staff participation with a Family Support grant in both planning and program implementation. Other projects within CSHS have focused on early hearing detection and intervention and asthma. Rehabilitation services for SSI recipients are provided,***

including outreach activities to assure families receive information about program benefits or services.

*** Specialty Care Program - CSHS medical eligibility for this program is reviewed annually at the CSHS Medical Advisory Council meeting. Effective 10/1/2003, seizure disorders and conditions discovered through expanded newborn metabolic screening were added to the list of CSHS eligible conditions. February 2004, Mucopolysaccharidosis (MPS) I (including variants) was added as an eligible condition. CSHS initiated a new policy for the Specialty Care Program whereby the amount of reimbursement paid for all diagnostic and/or treatment services in a one-year period cannot exceed \$20,000.00 per child regardless of the number of eligible conditions.**

*** Multidisciplinary Clinic Program - CSHS supported 109 clinics in 2003. In 2005, CSHS anticipates continued support of ten different types of clinics. A monthly, multidisciplinary clinic for children with asthma was the newest addition.**

*** Care Coordination Program - 272 children received community-based care coordination services through public health nursing and county social service staff in FY 2003. Continued services through current county social service and public health nursing staff is anticipated in 2005.**

*** Metabolic Food Program - 21 individuals with PKU and MSUD were served through the metabolic food program in FY 2003. Services for a similar number of individuals is expected in 2005.**

*** Information Resource Center - Services include a toll-free telephone number, targeted outreach, information and referral efforts, a resource library, education and consultative services, and other public information activities.**

*** Data Systems Development - Major activities include SSDI grant administration, birth defects monitoring, needs assessment, performance and outcome monitoring, chronic disease prevalence, utilization, cost estimates, and publications.//2005//**

/2005/ CSHS continues to work to ensure a statewide system of services for children with special health care needs and their families. State-level staff participated on over 30 interagency committees thus assuring collaboration on issues of importance to CSHCNs and their families. State support for communities is addressed through funding of multidisciplinary clinics and community-based care coordination programs, partnerships with county social service staff that work with the CSHS program at the local level, and activities to enhance local level data capacity addressed through the SSDI grant. Multidisciplinary clinics and care coordination activities are the primary mechanisms by which comprehensive health components are successfully coordinated. Infrastructure that supports coordination of health and other services at the community level is found in the regional/tribal children's services coordinating committees which focus on children at risk and the regional interagency coordinating councils which focus on children birth to three in early intervention. State-level staff attended cultural competency training and have incorporated skill-building sessions into the annual training event for local partners serving children with special health care needs and their families. Staff plan to attend the 2004 ND Immigrant Access Forum this August.//2005//

/2005/ DHS supports an American Indian Cultural Awareness Project which CSHS staff have recently been asked to join.//2005//

C. ORGANIZATIONAL STRUCTURE

Information on location of organizational charts is listed below. The two departments mesh in a variety of ways, both formal and informal, through the Title V programs. Examples include: quarterly meetings held for the Divisions of Family Health, Injury Prevention and Control and Nutrition and Physical Activity/CSHS staff, representation of the State Health Officer on the CSHS Medical Advisory Council, representation from the Division of Family Health on the CSHS Family Advisory Council, and other committees or workgroups that utilize representation from both departments to work on issues held in common.

The following organizational charts can be found in the attached Word document (1) State of North Dakota Title V; (2) North Dakota Department of Human Services; and, (3) North Dakota Medical Services Division.

The organizational chart for the North Dakota Department of Health can be accessed at the following URL: <http://www.health.state.nd.us/ndhd/contact.htm>

The organizational chart for the Community Health Section can be accessed at the following URL: <http://www.ndmch.com/MCHOrganizationalChart.pdf>

D. OTHER MCH CAPACITY

/2003/ Effective June 1, 2002 the divisions of MCH and Health Promotion are now the Community Health Section (previously the Preventive Health Section). Dr. Joyce was named as Section Chief. Dr. Joyce graduated from the UND School of Medicine and Health Sciences. He has been affiliated with the West River Medical Center in Hettinger since 1981, where he is a family practice physician. In addition, Dr. Joyce serves as a clinical assistant professor for the UND School of Medicine and Health Sciences.

/2004/ In June 2003, Sandra Anseth was named as the Executive Administrator of the Community Health Section. The goal of this position is to assist with the section reorganization and then be eliminated after one year. Sandra has a bachelor's degree in nursing with twelve years experience with the DoH, the last six as MCH Division Director. Sandra has 13 years experience as a public health nurse. Mary Dasovick took over as Acting Director for the MCH Division in June 2003 (until the reorganization is complete). Mary has past work experience in public health, elderly, and forensic nursing.

/2005/ In June 2003, reorganization of the Community Health Section was initiated. By September, six divisions had been formed to replace the previous two (MCH and Health Promotion). The new divisions are: Cancer Prevention and Control, Chronic Disease, Family Health, Injury Prevention and Control, Nutrition and Physical Activity and Tobacco Prevention and Control. Three of the six divisions receive funds from the Title V MCH Grant; Family Health, Injury Prevention and Control, and Nutrition and Physical Activity. The Division of Family Health will take the leadership for administering the block grant with assistance from the directors of the Divisions of Injury Prevention and Control and Nutrition and Physical Activity.

Family Health: Kim Senn is the Director for the Division of Family Health. Kim joined the NDDoH in 2000 as a nurse consultant and became Director of the Division of Family Health in September 2003. She is also responsible for administrating the Coordinated School Health Program grant. Kim earned a bachelor's degree in nursing from Medcenter One College of Nursing. Kim has twenty years experience in health care, including acute care, management and public health. The Division of Family Health administers state and federal programs designed to improve the health of ND families. The division provides funding, technical assistance, training, needs assessments, educational materials and other resources to local public health units and other public and private entities that offer health services in ND communities.

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

The Division of Injury Prevention and Control is dedicated to reducing the frequency and severity of intentional and unintentional injuries to North Dakotans.

Nutrition and Physical Activity: Colleen Pearce is the Director for the Division of Nutrition and Physical Activity. Colleen joined the NDDoH in 1978 and has worked as the program coordinator and director of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) since 1979. She became the Director of the Division of Nutrition and Physical Activity in September 2003. Colleen earned a bachelor's degree in food and nutrition from ND State University and a master's degree in public health from the University of Minnesota. The Division of Nutrition and Physical Activity promotes healthy eating and physical activity in order to prevent and reduce overweight, obesity and related chronic diseases in ND.

As planned, the Executive Administrator position was eliminated on May 31, 2004.

DoH Divisions/Staff funded and not funded by Title V

Family Health (funded)

Director 0.1 BNSc

Nurse Consultants 1.7 BSN

Dental Hygienists 1.1 RDH

Support Staff 1.05 Admin Assistant I

Data Processing Coor 1.0 BS Computer Science

**** Total Funded by Title V 4.95***

Family Health (not funded)

Director 0.9 (CSHP) BNSc

Nurse Consultants 1.2 (ECCS, Title X, Abstinence)BSN

Dental Hygienist 0.5 (CDC, HRSA) RDH

Support Staff 0.8 (Title X, CSHP) Admin Assistant I

**** Total Not Funded by Title V 3.4***

Injury Prevention and Control (funded)

Program Admin 1.0 BS Business Admin

Health Educator 1.0 BA Health

**** Total Funded by Title V 2.0***

Injury Prevention and Control (not funded)

Director 1.0 (STOP and FVPS) BSN

Program Admin 1.0 (State Injury Surv) BA Business Admin

**** Total Not Funded by Title V 2.0***

Nutrition and Physical Activity (funded)

Nutritionist 0.9 MPH, LR

Nutritionist 0.1 LRD

**** Total Funded by Title V 1.0***

Nutrition and Physical Activity (not funded)

Director 1.0 (WIC) MPH, LN

Nutritionist 2.0 (WIC) LRD

Support Staff 1.0 (WIC) Office Assistant II

**** Total Not Funded by Title V 4.0***

//2005//

/2003/ Terry Dwelle, M.D., was appointed to the office of state health officer by Governor John Hoeven in October 2001. Dr. Dwelle earned his medical degree from St. Louis University School of Medicine, graduating cum laude. He later received a master's degree in public health and tropical medicine from Tulane University. A Garrison, N.D. native, Dr. Dwelle has worked with the University of North Dakota School of Medicine, the Centers for Disease Control and Prevention and the Indian

Health Service. In addition, he practiced pediatrics in Bismarck, N.D., for many years. Arvy Smith was appointed as the Deputy Health Officer in October 2001. Arvy is a certified public accountant and a certified manager who has 22 years experience in state government. Previously, she was a budget analyst for the Office of Management and Budget, where her portfolio included the DoH and the DHS.

/2005/ Two new positions have been added to the Office of the State Health Officer: Healthy ND and Organizational Performance and Practice. These two positions support and work closely with the Community Health Section. Healthy ND is a statewide initiative whose goal is to improve the health of every North Dakotan by inspiring people to establish personal behaviors and support policies that improve health and reduce the burden of health-care costs. Melissa Olson was named coordinator of the Healthy ND Program in 2003. She has a bachelor's degrees in food and nutrition and corporate and community fitness from ND State University. Melissa has worked in state government since 2000, managing both the school health and tobacco programs. The Office of Organizational Performance and Practice works to improve the performance of the DoH by facilitating the adoption and practice of quality management initiatives throughout the department. Sandra Adams was named director of the Office of Organizational Performance and Practice in 2003. She received a bachelor's degree in food and nutrition education from ND State University and a master's degree in allied health education from Indiana University. Sandra has worked in state government since 1985. //2005//

/2005/ Dr. Joyce completed his Masters in Public Health through the University of Wisconsin. Dr. Dwelle has been accepted for postgraduate directed research studies in cross-cultural communication at the Assemblies of God Theological Seminary in Springfield, Missouri.//2005//

The Director of the CSHS Division has a Master of Science degree in social work and a long history of service at the state and regional levels within state government. Professional experiences include two years as director of a regional field office, three years as administrator of Program Operations in the State Capitol, and 20 years experience in his current position. Mr. Nelson is a member of the Program and Policy Management Team, which reports directly to the executive Director of the DHS.

/2002/ The position of program director for the CSHS Division was eliminated by legislative action effective 7/1/01.

Tammy Gallup-Millner, Deputy Director of the CSHS Division, is a licensed, registered nurse with a Master of Public Administration degree. Professional experiences include four years as a hospital staff nurse and 16 years of experience within state government. Tammy is a member of several professional organizations and serves on many committees, advisory boards and task forces.

/2002/ Tammy Gallup-Millner became CSHS Unit Director effective 7/1/01. The CSHS Unit is housed within the Medical Services Division.

/2005/ Tammy Gallup-Millner continues as CSHS Unit Director and has 20 years of experience within state government. //2005//

/2002/ David J. Zentner has been Director of the Medical Services Division since 1993. His responsibilities include administration of the Medicaid Program and the State Children's Health Insurance Program. CSHS was added as part of his administrative responsibilities effective 7/1/01. Previously, he served as Assistant Director of Medical Services and was involved in the development of the Comprehensive Child Welfare Information and Payment System. David is a member of the National Association of State Medicaid Directors, the ND Conference of Social Welfare, and is part of the Management Team that reports directly to the Executive Director of the DHS. In 1969, he graduated from the University of ND with a degree in Business Administration with an emphasis in accounting.

/2005/ CSHS Staff funded by Title V MCH Block Grant Unit Director 1.0 MPA (RN)

Administrators 2.0 BNSC and HSPA I
Nurse 1.0 BSN
Support Staff 3.0 Admin Assist I & Office Assist III
*** Total Funded by Title V 7.0**
CSHS Staff not funded by Title VV MCH Block Grant
Coordinator 1.0 MSA
*** Total Not Funded by Title V 1.0**
//2005//

/2003/ One CSHS administrative position is vacant. When two staff members retired during the last year, position duties were evaluated. One position was filled after being reclassified. Current CSHS staff absorbed job duties for the second position. There are no plans to fill the vacant position.

/2004/ A previously vacant position was eliminated. The CSHS unit is comprised of eight full-time staff.

CSHS contracts for the services of a part-time Medical Director, Dr. Robert Wentz. In addition to his medical degree, Dr. Wentz received a graduate degree in Public Health from the University of California in 1980. Dr. Wentz has worked in the DoH as MCH Director, Section Chief and State Health Officer. Currently, Dr. Wentz is a practicing pediatrician in Bismarck, ND. He became CSHS Medical Director in September of 1999.

/2004/ Dr. Wentz continues as part-time CSHS Medical Director. Parents of special needs children have not been hired within CSHS. However, the Division does support a nine-member Family Advisory Council. Members are reimbursed mileage, meals and lodging and are paid a \$75.00 consultation fee for each quarterly meeting they attend. CSHS has access to various management support personnel within the DHS. Of particular importance are staff within the Research & Statistics Unit who provide critical support in data analysis for CSHS surveys.

/2003/ A finance liaison, housed in Fiscal Administration, is assigned to CSHS. CSHS increasingly collaborates with staff from Legal Services and the Information Technology Division, especially for work stemming from HIPAA transactions and privacy rules.

/2005/ The CSHS Unit has maintained eight full-time staff. Dr. Wentz, the part-time Medical Director for CSHS, has discontinued his private pediatric practice. CSHS benefits from a ten member Medical Advisory Council that meets on an annual basis and nine-member Family Advisory Council that meets on a quarterly basis. Changes in physical location have occurred in DHS. The SSDI coordinator, previously housed in the DoH, moved to the CSHS Unit in December 2003 to alleviate space issues in the DoH. Two DHS Research and Statistics staff moved into the CSHS Unit space. These two Research and Statistics employees are supervised by the Director of the Human Resource Division. Staff changes have occurred within DHS Senior Management. Directors of the Division of Information Technology and the Mental Health and Substance Abuse Division resigned. The Research and Statistics Division is undergoing change and will be renamed the Office of Applied Research. A leadership position is planned to coordinate research activities and develop a program evaluation/quality assurance system for DHS. Staff within the greater Medical Services and Economic Assistance Policy Divisions is available to CSHS on a consultative basis. Included are medical and dental consultants, coding specialists, prior authorization nurses and eligibility staff.//2005//

E. STATE AGENCY COORDINATION

ND Title V Collaboration with Other State and Local Agencies

In ND, the Title V CSHNC and MCH Programs are located in two different departments within state government, the Department of Human Services (DHS) and the Department of Health (DoH). The two

programs are physically located on the same floor of the state capitol and communicate frequently. Quarterly meetings are scheduled for all staff from both programs for discussion of pertinent issues. Interaction between staff also occurs with unscheduled, more informal meetings. The SSDI Program also serves as a link between the two programs. SSDI staff is employed by one department and physically located in the other with emphasis on data issues in both programs.

//2005/ In December 2003, the SSDI Coordinator's physical location changed from the DoH to the CSHS Unit. This last year, Title V and SSDI staff also worked together through a Needs Assessment and Retreat Planning Workgroup.//2005//

The WIC, Family Planning and Domestic Violence Programs are all housed within the Division of Maternal and Child Health so collaboration with these programs and Title V is closely integrated. In DHS, the Medical Services Division houses Medicaid, SCHIP and Children's Special Health Services programs. Division staff meetings are held twice each month.

//2005/ In addition to Medical Services Division Administrative Staff meetings, CSHS staff consistently participate in Medicaid Claims Policy meetings, Claims staff meetings, and Medicaid Management Information System meetings.//2005//

//2005/ In mid-June 2003, reorganization of the Community Health Section was initiated. By September, six divisions had been formed to replace the previous two (MCH and Health Promotion) with directors hired for each. The new divisions are: Cancer Prevention and Control, Chronic Disease, Family Health, Injury Prevention and Control, Nutrition and Physical Activity and Tobacco Prevention and Control. Three of the six divisions receive funds from the Title V MCH Grant. These include Family Health, Injury Prevention and Control, and Nutrition and Physical Activity. WIC is located in the Division of Nutrition and Physical Activity. Family Planning is located in the Division of Family Health. The Domestic Violence Programs are located in the Division of Injury Prevention and Control.//2005//

There has been a Cooperative Agreement between the ND DHS and the DoH for several years. The programs included in this agreement have grown over the years. It now includes the Community Health Care Association (Primary Care Association in ND).

Programs included in the Cooperative Agreement within DHS include:

- * Title XIX Medicaid
- * Children's Special Health Services
- * EPSDT Program (Health Tracks)
- * Developmental Disabilities Unit
- * ND's Head Start-State Collaboration Office

Programs included in the Cooperative Agreement within the DoH include:

- * Title V Maternal and Child Health (MCH)
- * Optimal Pregnancy Outcome Program (OPOP)
- * Title X Family Planning Program
- * WIC
- * Diabetes Program
- * Immunization Program
- * Vital Statistics Division
- * Primary Care Organization

The agreement also alludes to cooperation between these same programs at the local level.

//2005/ The cooperative agreement was last updated July 1, 2003 and remains in effect until further review is required. Designated representatives meet not less than biannually to review, change or reaffirm the agreement.//2005//

/2005/ Other formal agreements are in place to address the children with special health care needs population. Examples include an interagency agreement to assure SSI recipients and cessations receive information about program benefits or services; a memorandum of understanding concerning cooperation and collaboration in providing services to young children ages birth through five in ND; and a cooperative agreement to seek funding for, establish, operate, and manage a statewide program to provide universal newborn hearing screening./2005//

Both the MCH Advisory Committee and the PRAMS Steering Committee involve individuals outside the department for input into programs and advocacy for the MCH population. Members represent multi-agency, multi-discipline groups interested in health issues related to the MCH population from across the state. Both state and community members are involved. The CSHS Medical Advisory Council includes representation of various specialists serving children with special health care needs and their families from health systems across the state. A state Family Advisory Council assures family input into policies and programs for the CSHCN population.

/2005/ In mid-June 2003, reorganization of the Community Health Section was initiated. By September, six divisions had been formed to replace the previous two (MCH and Health Promotion). The MCH Advisory Committee was reorganized and renamed the Community Health Section Advisory Committee to reflect this change. The mission of the Community Health Section Advisory Committee is to: promote the health and wellness of ND citizens through the programs and collaborative efforts of the Community Health Section; serve as advocates for ND's family care; review assessments of the health status of the state's population and advise Director's on health issues related to the state population; and make recommendations for the development and implementation of the Preventive and Health Services state plan./2005//

There continues to be collaboration between programs within the DoH and DHS, usually specific to particular MCH or CSHS Programs, such as:

- * School nursing, nutrition and physical exercise activities
 - * Oral health with the Primary Care Association
 - * Family planning with microbiology lab, HIV, Women's Way and STD Program
 - * Fluoridation and lead screening with the Environmental Health Section
 - * CSHS with emergency health services for EMSC, BELSS ***/2005/ and Special Needs Population Emergency Planning/2005//***
 - * CSHS, MCH, Environmental Health and others as part of the asthma workgroup
- /2005/***
- * ***Coordinated School Health Programs***
 - * ***Early Childhood Comprehensive Systems/2005//***

With reorganization within the DoH, the MCH Division became part of the Community Health Section along with the Health Promotion Division. Collaboration between programs in the Community Health Section has increased with the Healthy ND Initiative. As part of strategic planning within the Section, quarterly meetings will be held with all staff. They will also participate in quarterly meeting addressing data and public health training.

The Healthy Weight Council, coordinated by the MCH nutritionist, provided an opportunity for over 40 public and private agencies and organizations to discuss issues and coordinated activities related to healthy eating and increased physical activity. This group functions as a coordinating body for the Healthy ND Nutrition and Physical Activity Working Groups: Breastfeeding; Fruits and Vegetables; Healthy School Nutrition Environment; PA for Adults; PA for Youth.

Other departments within state government are also partners in many MCH endeavors. Close partners include the Department of Transportation with the Injury Prevention Program, Department of Public Instruction with school health, and numerous programs within the DHS in addition to Medicaid,

especially the Division of Child and Family Services. The Healthy Child Care America project has established ties with child care organizations and Head Start at both the state and community level.

//2005/ Funding for Healthy Child Care America is in its last year. Partnerships that have been formed as a result of this continue. The Early Childhood Comprehensive Systems (ECCS) program manager is working closely with Human Services and the Healthy ND Initiative (Healthy ND Early Childhood Alliance). The ECCS grant is managed within the Division of Family Health.//2005//

Various programs also work with their professional organizations and boards. This includes nutritionists, nurses, oral hygienists, etc.

Title V programs have strong ties to various family organizations within the state including the Family-to-Family Support Network and Family Voices.

Federal partners include HRSA, CDC and the Justice Department. HRSA partners hold monthly conference calls and provide technical assistance and training for grantees. CDC provides training specific to grants, i.e. oral health and PRAMS.

The Regional and Tribal Children Services Coordinating Committees and Regional Interagency Coordinating Councils continue to be a link to community efforts. The director of the OPOP Program has established ties with the private medical community on the maternal depression workgroup. Programs work closely with local public health departments, family planning delegate agencies, reservations, etc.

//2005/ Changes with the state and regional/tribal Children's Services Coordinating Committees (CSCC) are expected. DHS plans to discontinue the "refinancing" initiative with the CSCC effective June 30, 2004. Agencies that claim administrative reimbursement such as juvenile courts, schools and public health units will no longer be reimbursable under federal Title IV-E foster care because they are not supervised by the DHS or involved in the placement and care of children.

Staff within the state CSCC, which in 1989 was made a permanent agency in statute, will likely be gone after December 2004. How the state CSCC functions after that time is being determined. Tribal CSCCs are currently not active and regional CSCCs are evolving. Carry-over and refinancing dollars are available through November 1 to support regional CSCC collaboration and local grants. Six of the regions have retained part-time or full time coordinators that support coordination and collaboration efforts. Two of the regions are expected to focus only on grants administration with their remaining funds. Whether this infrastructure will survive in future at the state or regional level is questionable. //2005//

Other committees, task forces include

- * FAS Task Force/Advisory Group
- * Birth Defects Surveillance
- * Child Fatality Review Panel
- * Genetics Task Force
- * Birth Review
- * Interagency Coordinating Council
- * First Sounds (early hearing detection and intervention)
- * Clinic Coordinator Meetings
- * Social Security Administration/DDS
- * Diabetes Youth Outreach
- * Family Support Grant Advisory Committee
- * Care Coordination Workgroup
- * March of Dimes

* Data Advisory Group

/2005/

* **School Health Interagency Workgroup**

* **Covering Kids and Families**

* **Healthy ND Subcommittees (worksites wellness, third party payers, healthy weight/physical activity, healthy weight/breastfeeding, healthy weight/school nutrition environment, healthy weight/fruit and vegetables, community engagement, tobacco, mental health and substance abuse, health disparities)**

* **Community Engagement/Assessment**

* **Chronic Disease Workgroup**

* **Natural Allies**

* **Healthy People 2010**

* **Newborn Screening Advisory Committee**

* **CATCH grant**

* **ND Oral Health Coalition//2005//**

The Division of Maternal and Child Health and the CSHS Unit include minority populations in their respective programs. In addition, there are some grants to American Indian Health Programs. The DHS has a Tribal Liaison as resource staff and the DoH has recently started a Disparities Work Group associated with the Healthy ND Initiative; MCH staff will be monitoring this.

//2005/ In mid-June 2003, reorganization of the Community Health Section was initiated. By September, six divisions had been formed to replace the previous two (MCH and Health Promotion). Staff from the Community Health Section, and those working with the MCH population, are involved in the Health Disparities Workgroup. The State Health Disparities Work Group exists to provide leadership in identifying and positively impacting disparities affecting ND citizens. The workgroups Vision is "Health equity for all North Dakotans." Health disparities in ND are defined as inequalities in health status, utilization or access due to structural, financial, personal or cultural barriers. Population categories affected include, but are not limited to, those identified by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation.//2005//

F. HEALTH SYSTEMS CAPACITY INDICATORS

01: Due to the unavailability of hospital discharge claims data for individuals with private insurance, the most recent asthma hospitalization discharge rates are from 2000. That year the rate per 100,000 children under age 4 was 15.0.

02: The percent of Medicaid enrollees under age 1 with an initial or periodic screen has increased steadily from 44.7 percent in 1995 to 74.1 percent in 2003.

03: Since the ND SCHIP plan was initiated in 1999, approximately 80 percent of enrollees under age 1 received an initial or periodic screen.

04: In 2002, 87.7 percent of ND women received adequate prenatal care as measured by the Kotelchuck index. The percent has changed little in the last 5 years.

05: ND women on Medicaid are more likely than non-Medicaid women to have a LBW baby, a baby die during infancy, and are less likely to have received first trimester or adequate prenatal care.

06: ND's poverty eligibility levels for Medicaid and SCHIP for all age groups has not changed over the past 7 years.

07: Less than half of all children age 6-89 in the Medicaid EPSDT program receive dental services each year.

08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs (CSHCN) Program remained at about 9 percent each of the past 6 years.

09A: ANNUAL DATA LINKAGES

Annual linkage of infant birth and infant death certificates. Birth and infant death certificates have been linked and made available electronically to Title V staff since 1994.

These linked files have been analyzed for program planning purposes.

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files. Birth certificate files and Medicaid eligibility and claims files have been linked on several occasions for specific analytic projects. Title V staff have direct access to the electronic Medicaid records.

Annual linkage of birth certificates and WIC eligibility files. To date, birth certificate and WIC files have not been linked. The ND WIC program is currently designing a new client data system. Upon completion, linkage of these two data sets is planned.

Annual linkage of birth certificates and newborn screening files. Birth certificate and newborn screening files have been linked since 1996. This linkage has helped us to identify the characteristics of infants not screened as well as assess the characteristics of women who breastfeed at hospital discharge.

09A: REGISTRIES AND SURVEYS

Hospital discharge survey for at least 90 percent of in-State discharges. Title V staff have electronic access to hospital discharge data. This data has been analyzed by program staff for a number of programmatic purposes.

Annual birth defects surveillance system. During the last year, the state developed a passive birth defects monitoring system. Title V staff manage the database and data is available electronically for program planning purposes.

Survey of recent mothers at least every two years (like PRAMS). ND recently completed a Point-In-Time PRAMS Survey. In the near future, Title V staff will be able to obtain the data for program purposes, but at this time, it is not known if we will have access to the electronic database.

09B: ADOLESCENT TOBACCO USE

ND participates in the Youth Risk Behavior Survey and has access to the database for analysis. The percent of ND high school students considered current cigarette smokers has decreased from 40.6 percent in 1999 to 30.2 percent in 2003.

09C: OVERWEIGHT/OBESITY

ND participates in the Youth Risk Behavior Survey, the Pediatric Nutrition Surveillance System (PedNSS), and has WIC Program Data. We have direct access to the databases for analysis.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

Upon completion of the five-year needs assessment, a retreat was held with Title V stakeholders to identify priority needs for the MCH population. Twenty-six initial priority needs were established for the maternal and child health population. This represented four to six priorities for each of the five population groups identified. The priority needs identified for each population group were:

Women (of childbearing age):

- * Healthy weight and nutritional status
- * The need for pre-pregnancy vitamin intake
- * Domestic violence
- * The early initiation of prenatal care
- * Unplanned or unintended pregnancies
- * The need for pre-conception counseling

Infants (age birth to one):

- * Promotion of the importance of breast feeding
- * The effects of prenatal and maternal smoking on infant health
- * Behaviors associated with SIDS deaths
- * Infant mortality rates

Children (age one through 10):

- * Immunization rates
- * Access to health care and other services
- * Child abuse and neglect
- * The number and causes of child deaths
- * Overweight and the lack of physical activity
- * The causes of pediatric hospitalization

Children with Special Health Care Needs (age birth to 21):

- * The impact of chronic health conditions and congenital anomalies on children and their families
- * The degree of coordinated care
- * Financial access to specialty care and related services
- * The availability of specialty care and related service providers

Adolescents (age 11 through 21):

- * Tobacco and alcohol usage
- * The number of deaths due to suicide
- * Eating disorders and nutritional behavior
- * The number of deaths due to motor vehicle crashes
- * The rate of sexually transmitted diseases
- * Racial disparities in the teen birth rate

The priorities were ranked as to level of importance within each population group. Each priority was reviewed to determine if the needs could be addressed through activities related to an existing federal performance measure, MCH and CSHS collaboration with other DoH programs (i.e., health promotion, disease control) or other state agencies, or through separate interventions requiring a state negotiated performance measure.

It was determined that a few of the identified priority needs could best be addressed through collaborative activities with other State agencies and public and private organizations. Many of priorities will be addressed through workplan activities around existing federal performance measures. Following are the ten state priorities that were not addressed through existing federal measures and required state negotiated measures, organized by the four levels of the pyramid.

Direct Health Care Services:

1. For children to receive necessary health care services in school.

Enabling Services:

2. To increase the percentage of Medicaid eligible children who receive dental services.

Population Based Services:

3. To reduce the rate of abuse and neglect in infants and children.
4. To increase the percent of young adults who are of normal weight.
5. To increase the number of pregnancies that are intended.
6. The effects of prenatal and maternal smoking on infant health.
7. For women of childbearing age to use folic acid.
8. To reduce the number of deaths due to unintentional injuries to children and adolescents.

Infrastructure Building Services:

9. To reduce the impact of congenital anomalies and chronic health conditions on children and their families.
10. For children with special health care needs to receive necessary specialty care and related services.

All 10 state priorities continue to appropriately represent the needs of the MCH population identified during the five-year needs assessment.

B. STATE PRIORITIES

Upon completion of the five-year needs assessment, a retreat was held with Title V stakeholders to identify priority needs for the MCH population. Twenty-six initial priority needs were established for the maternal and child health population. This represented four to six priorities for each of the five population groups identified. Title V staff then grouped the priority need into three categories: 1) the priority need could be incorporated into existing national performance measures, 2) state performance measures should be developed to address the priority need, and 3) the priority need is addressed through another program/agency.

Following is a list of the priority needs and the associated national performance measure:

The early initiation of prenatal care FPM #18
The need for pre-conception counseling FPM #18
Promotion of the importance of breast feeding FPM #11
Behaviors associated with SIDS deaths FPM #18
Immunization rates FPM #7
The degree of coordinated care FPM #2
Financial access to specialty care and related services FPM #2
The number of deaths due to suicide FPM #16
The number of deaths due to motor vehicle crashes FPM #10
Racial disparities in the teen birth rate FPM #8

Following is a list of priority needs for which a state performance measure was developed:

Healthy weight and nutritional status SPM #4
The need for pre-pregnancy vitamin intake SPM #12
Unplanned or unintended pregnancies SPM #8
The effects of prenatal and maternal smoking on infant health SPM #9
The impact of chronic health conditions and congenital anomalies on children and their families SPM #10
The availability of specialty care and related service providers SPM #11
Eating disorders and nutritional behavior SPM #4

Child abuse and neglect SPM #3
The causes of pediatric hospitalization SPM #10
The number and causes of child deaths SPM #13
Overweight and the lack of physical activity SPM #4

Following are the priority needs that were determined to be addressed through other state programs or agencies:

Domestic violence
Access to health care and other services
The rate of sexually transmitted diseases
Tobacco and alcohol usage
Infant mortality rates

After the selection of the state's 10 priority needs and development of state negotiated performance measures, a joint meeting was held with North Dakota's two Title V programs; the Children's Special Health Services (CSHS) program in the Department of Human Services and the Maternal and Child Health (MCH) program in the Department of Health. Individual staff persons from the MCH program were assigned primary responsibility for each national and state performance measure that closely related to their programmatic area of expertise. CSHS program staff opted to work on CSHCN related performance measures as a group. The SSDI coordinator, who works with both Title V programs, was responsible for the collection and reporting of data for each measure and for monitoring the overall process.

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

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

Federal Performance Measures

North Dakota has adequate capacity and resources to address most federal performance measures. Although the program has relatively small numbers of staff persons, MCH has experienced, qualified individuals administering injury prevention, oral health, nutrition, family planning, adolescent health, and MCH nursing programs. The injury prevention program coordinates much of the programmatic activity for performance measures related to reduction of mortality and injury. The adolescent health coordinator, who administers the state's abstinence grant, has responsibility for the measure related to teen birth rate. In addition to the newborn screening measure, the MCH nutrition program has responsibility for the breastfeeding measure and staff from the MCH nursing program monitor the measures related to very low birth weight birth and prenatal care.

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

CSHS program staff have responsibility for the six federal measures for CSHCN in addition to the

measure for newborn hearing screening. For national performance measure #1, CSHS has programmatic responsibility for treatment of eligible individuals with metabolic diseases. For the past year, CSHS has been providing metabolic food to eligible individuals with PKU and MSUD. CSHS also has direct responsibility for the newborn hearing screening performance measure.

CSHS has developed program plan to impact the five other new national performance measures for CSHCN (family partnership and satisfaction, medical home, insurance, community-based service system organization, and transition). However, the state CSHCN program directly serves only a fraction of all CSHCN in the state, therefore making direct impact on any of the measures difficult.

State Performance Measures

Title V staff have the capacity and resources to carry out activities that are expected to impact each of the state selected performance measures. MCH works with staff from the Department of Human Services on programs to prevent abuse and neglect in young children. Newborn home visiting programs carried out by local public health departments are also expected to reduce child abuse and neglect in infants. The MCH nutritionist, along with local public health nutritionists, administer a number of programs to encourage healthy diet and exercise practices which help to promote healthy weight in children and young adults. The MCH oral health director, in collaboration with local oral health professionals, help to increase access to dental care for children in Medicaid.

MCH nursing staff work with local school health and nursing networks across the state to promote increased school nursing services. The ND Family Planning Program, located in the MCH Division, works to reduce the number of unwanted and mistimed pregnancies in the state. Primarily through the Optimum Pregnancy Outcome Program (OPOP), MCH and local nursing staff work educate high-risk young mothers about the risks of smoking during pregnancy.

Pediatric nurses with the CSHS program work collaboratively with a number of entities to reduce the effects of childhood asthma. CSHS staff also work to assist eligible children with special health care needs to access specialty care physicians as needed. MCH staff work with the ND March of Dimes chapter to encourage adequate folic acid consumption for women of reproductive age. The injury prevention program in MCH work collaboratively with other stakeholders, including the Department of Transportation, to reduce unintentional injuries among children.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

Rules to expand the number of tests and clarify screening procedures were promulgated. Final rules were presented to the Legislative Rules Committee on July 15, 2003. Effective March 1, 2003, the mandated tests in North Dakota are: PKU, congenital hypothyroidism, congenital adrenal hyperplasia, galactosemia, sickle cell disease and other hemoglobinopathies, biotinidase deficiency, MCAD and 32 other conditions that can be identified by Tandem Mass Spectrometry testing (i.e. amino acid disorders, fatty acid disorders and organic acid disorders).

Screening records were matched with resident births to identify missing records.

CSHS purchased and provided metabolic food for individuals with PKU and MSUD. CSHS maintains an inventory and processes orders for eligible individuals. In FFY 2003, 21 individuals were served.

CSHS provided state level care coordination for individuals with PKU and MSUD served through the metabolic food program. State-level staff attended metabolic clinics, offered follow-up support to individuals when needed for diet compliance, provided information and referral services, and met monthly to review program activities.

Changes to the CSHS Policy and Procedure manual were drafted to reflect administration of the metabolic food program. Metabolic diseases found with expanded metabolic screenings were added to the list of CSHS eligible conditions effective 10/01/2003. A metabolic program procedure manual was drafted.

CSHS supported multidisciplinary clinics for children and women of childbearing age with metabolic disorders. Four clinics were conducted during the year. Twelve individuals were served in 17 separate clinic visits.

Effective March 1, 2003, the mandated tests in North Dakota are: PKU, congenital hypothyroidism, congenital adrenal hyperplasia, galactosemia, sickle cell disease and other hemoglobinopathies, biotinidase deficiency, MCAD and 32 other conditions that can be identified by Tandem Mass Spectrometry testing (i.e. amino acid disorders, fatty acid disorders and organic acid disorders).

b. Current Activities

Rules to expand the number of tests and clarify screening procedures will be drafted with input from the Newborn Screening Advisory Council, the CSHS Medical Advisory Council, NDAAP and other interested parties. Rules will be open for public input and will be presented to the Legislative Rules Committee.

In February 2003, the 2002 screening records will be matched with 2002 resident births to identify missing records.

CSHS will purchase and provide metabolic food for individuals with PKU and MSUD.

CSHS will provide state level care coordination for individuals with PKU and MSUD served through the metabolic food program.

The CSHS Policy and Procedure manual will be updated to reflect administration of the metabolic food program.

CSHS will support multidisciplinary clinics for children and women of childbearing age with metabolic disorders.

c. Plan for the Coming Year

CSHS will support multidisciplinary clinics for children and women of childbearing age with metabolic disorders.

CSHS will provide metabolic food to eligible individuals with PKU and MSUD.

CSHS will provide state level care coordination to eligible individuals with PKU and MSUD.

CSHS staff will participate on the newborn screening advisory committee.

The Newborn Screening Program follow-up policies and procedures will be revised and updated, including the expanded MS/MS screening follow-up.

The Newborn Screening Program Advisory Group will meet by conference call at least four times during 05.

Transitioning the Newborn Screening Program from the Division of Nutrition & Physical Activity to the Division of Family Health will be investigated.

Bring the new Iowa Biochemical Geneticist, Dr. Sara Copeland, to North Dakota to meet with Newborn Screening Program, CSHS Staff and Advisory Committee members, and if possible, to speak at the 2005 meeting of the North Dakota Academy of Pediatrics.

Performance Measure 02: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

a. Last Year's Accomplishments

CSHS offered financial support and reimbursement to Family Advisory Council members to support participation. Four meetings were held during the year. Members were paid a consultant fee and were reimbursed for travel, food, and lodging expenses. CSHS made application for a scholarship for a family member to attend AMCHP, provided financial support for family members to participate in county training, birth defects workgroup, clinic coordinator, and SSI meetings.

CSHS Family Advisory Council members assisted in the development of training topics and agenda for CSHS county social service training. A family member also participated in the training.

CSHS explored RFP development for CSHCN parent training. CSHS contracted with two family organizations to provide information, training and support on behalf of families with CSHCNs.

CSHS funded two family organizations that address CSHCN issues in the state, participated in a statewide family support initiative, provided in-kind support to a family organization through targeted outreach mailings, and distributed public information materials such as family support packets upon request.

b. Current Activities

Collect and input data on CSHCNs served by CSHS and the medical home status of Medicaid-eligible children.

Participate in CompCare technical assistance activities with Health Systems Research, Inc. Provide public information services to improve access to and appropriate use of a medical home by CSHCNs and their families.

Explore e-mail and web site resources on the medical home.

CSHS staff will attend or facilitate a meeting on the medical home.

Promote the care coordination program to local public health departments.

Monitor status and quality of service plans written by county social service and public health nursing staff for children receiving care coordination services through CSHS.

c. Plan for the Coming Year

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

CSHS will support the activities of family organizations in the state by providing financial

assistance through contracts and serving on advisory boards as requested.
CSHS will continue to include client satisfaction assessments as part of overall quality assurance efforts in CSHS service contracts.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

a. Last Year's Accomplishments

CSHS collected information on the medical home status of children served through the state CSHCN program. 76% were found to have a medical home. Data were not collected on Medicaid-eligible children due to the inability to measure components of a medical home using claims data.

CompCare technical assistance has ended in the state. No activities were done during the last year.

Information about medical homes was provided to families through distribution of well child/immunization packets.

CSHS staff participated in a list serv related to medical homes for children.

CSHS staff and other state partners participated in a Tri-Regional meeting that focused on planning around 2010 objectives. Information about medical homes was addressed. As a result of that meeting, the state has applied for a CATCH grant, which will focus on medical homes for CSHCN.

CSHS provided financial support to two local public health units to provide care coordination services to CSHCN. An RFP was sent to two additional public health units but they did not apply for a grant to develop a care coordination program.

CSHS monitored the status and quality of service plans written by county social service and public health nursing staff for children receiving care coordination services through CSHS. 98% of children were found to have a service plan and 91% had a current service plan - defined as a plan that was reviewed and revised during the year.

b. Current Activities

Collect and input data on CSHCNs served by CSHS and the medical home status of Medicaid-eligible children.

Participate in CompCare technical assistance activities with Health Systems Research, Inc.

Provide public information services to improve access to and appropriate use of a medical home by CSHCNs and their families.

Explore e-mail and web site resources on the medical home.

CSHS staff will attend or facilitate a meeting on the medical home.

Promote the care coordination program to local public health departments.

Monitor status and quality of service plans written by county social service and public health nursing staff for children receiving care coordination services through CSHS.

c. Plan for the Coming Year

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

CSHS will collaborate with partners to further the medical home concept and practice in North Dakota. Partners could include Indian Health Service, ND Chapter of the American Academy of Pediatrics, family organizations, providers, Early Childhood Comprehensive Systems, Medicaid PCP Program, Early Hearing Detection and Intervention, etc.

CSHS will monitor the medical home status of children receiving care coordination services through CSHS and Medicaid-eligible children.

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

Performance Measure 04: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

a. Last Year's Accomplishments

A report summarizing the health insurance status of children served through the state CSHCN program was completed. 94% were found to have a source of coverage.

Policy manual changes were made to require exploration of eligibility for public health insurance programs for uninsured children applying for CSHS services in order to link families to available sources of health care coverage. Uninsured children currently enrolled in the program were sent an outreach mailing informing them of coverage sources. Family organizations also assisted in linking families to services.

CSHS contracted for services of a Medical Director who determined medical eligibility of applicants, reviewed qualifications of participating providers, and facilitated an annual Medical Advisory Council meeting.

CSHS staff determined financial eligibility and coordinated benefits with providers and payers for services paid through the Specialty Care program. During the year, 312 children were served, 1,450 visits were paid, and 3,266 claims were processed.

Revised forms and financial eligibility guidelines were provided to county staff. Other manual changes are in process of being updated and will be completed during the next year.

b. Current Activities

CSHS staff will collect, compile, analyze and summarize data on insurance status for CSHCNs served by CSHS.

Uninsured CSHCNs served by CSHS will be linked to Medicaid, CHIP and Caring programs.

State and local staff as well as family organizations, will support families in completing applications when needed.

CSHS Medical Director will determine medical eligibility, review qualifications of providers serving CSHCNs and conduct the annual Medical Advisory Council meeting.

CSHS staff will determine financial eligibility and coordinate benefits with providers and payers.

CSHS staff will develop or revise policies and procedures needed for administration of CSHS programs.

c. Plan for the Coming Year

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

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

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

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

CSHS staff will monitor the developments of the state Covering Kids grant.
CSHS will disseminate results from the CSHCN SLAITS and CSHS Family Surveys that pertain to health insurance coverage.

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

CSHS will explore collaboration with Medicaid to explore models of chronic disease management.

Performance Measure 05: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

a. Last Year's Accomplishments

Technical assistance was provided to county and public health staff in the following areas: service planning/care coordination, financial and medical eligibility, covered services, claims payments, clinics, and information and referral.

The annual training for CSHS county social service workers and local public health care coordinators was conducted in October 2002. Topics covered included care coordination, medical conditions, CSHS policy and procedure update, and a family presentation.

During the year, 12 site visits were conducted by CSHS staff to county social service offices,

public health units, and contracted clinic service providers.

CSHS staff and the CSHS Family Advisory Council drafted a Family Handbook. The handbook will be finalized and distributed during the next year.

b. Current Activities

Provide ongoing technical assistance for county social service staff and public health nurses who provide services for CSHS.

Provide an annual training opportunity for county social service staff and public health nurses who provide services for CSHS.

Conduct 5-10 site visits per year.

c. Plan for the Coming Year

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

CSHS will provide public information services to improve access to care including operation of a family resource center.

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

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

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

Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

a. Last Year's Accomplishments

Data was collected electronically on children receiving SSI and Medicaid in the state. The data were linked with CSHS program data and a report was generated and distributed.

CSHS continued to receive referrals from Disability Determination Services and provided information and referral services directly to 91 families.

An SSI meeting was held by CSHS that included representatives from a family organization, the Social Security Administration, Medicaid, and Disability Determination Services.

A transition outreach mailing targeting 283 families served by CSHS with youth ages 16-21 was conducted.

b. Current Activities

CSHS will monitor the status of the SSI population.

CSHS will provide information and referral services for the SSI population.

CSHS will collaborate with other stakeholders involved with children's SSI.

c. Plan for the Coming Year

CSHS will collaborate with state and local entities and family organizations to promote health care transitions for CSHCN.

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

CSHS will explore the inclusion of youth or young adults with special health care needs on the Family Advisory Council when recruiting members.

CSHS will monitor the status and provide information and referral services to the SSI population and collaborate with other stakeholders involved with children's SSI.

CSHS will explore development and dissemination of "health" transition resources.

Performance Measure 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

a. Last Year's Accomplishments

Twenty-one local public health departments and three tribal health agencies used funding to provide immunizations.

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

Memorandum of Agreement signed June 1, 2003. In effective through May 31, 2005.

b. Current Activities

Provide funding to local public health units to fund immunization administration. This is a population-based service for the child population group.

Continued collaboration with the Immunization Program through the Memorandum of Agreement.

Collaborate with the Immunization Program to provide trainings/updates to public health, school nurses, childcare and head start on immunizations, especially the new varicella vaccine recommendations.

c. Plan for the Coming Year

Continue to collaborate with the Immunization Program through the Memorandum of

Agreement.

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

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

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

a. Last Year's Accomplishments

There were four Children's Services Coordinating Committees (CSCCs), one Tribal Children's Services Coordinating Committee (TCSCC), four local health units and St. Ann's Parish on the Turtle Mountain Reservation who received grant funds for the abstinence only education grant.

Regions II, III, IV, V, VI and VII abstinence only education grantees collaborated to implement a unified media awareness campaign targeting the entire central and eastern part of North Dakota. The message, "Abstinence. The Choice is Yours." was used on print materials, billboards, radio and television ads in the counties.

The abstinence only education coordinator and family planning nurse consultant were combined into one position. This has led to increased collaboration efforts between the two grants to decrease the number of births in teens.

b. Current Activities

Contract with R/TCSCC's and local health units to support local projects related to abstinence only education.

Collaborate with five of the twelve R/TCSCC's and local health units to provide an abstinence media campaign (media, billboards, newspaper ads, ect.) to those regions.

Collaborate with MCH Nurse Consultant for adolescent health and family planning to support the efforts of family planning in reducing teen births.

c. Plan for the Coming Year

There are 2 CSCC'S, 4 Regional Tribes, 1 Community Action Program, and 5 Public Health Units that have applied for the Abstinence Education Only Grant.

Regions 3, 4 and 6 continue to collaborate to provide an Abstinence Education Only Media Campaign targeting the teen population.

Communicate and collaborate with the local grantees to assist them in utilizing quality speakers and appropriate abstinence education only educational materials.

Continue to collaborate with appropriate partners, such as Family Planning and Adolescent Health, to support the efforts in reducing teen births.

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

a. Last Year's Accomplishments

ND Department of Health oral health consultants reached 3,250 elementary school students with oral health education.

312 third grade students were reached with sealant information.

ND Department of Health Oral Health Consultants worked with local agencies to acquire sealant information.

Held trainings in Grand Forks and Minot to train/refresh Health Tracks nurses in screening procedures.

Working with Research Analyst to redesign Health Tracks Screening forms.

Analyzed some of the available data, specifically related to workforce issues.

Outdated oral health materials purged.

Project Will Show remarketed to Health Tracks Nurses, Social Workers, Medicaid Case workers. A separate mailing announcing the changes sent to the dental providers.

A list of invitees determined and invited to the first Oral Health Coalition meeting on Nov 13, 2003. CDC sent two evaluation experts to help with this first important meeting.

The oral health program added a 65% time Oral Health Educator and a 25% time Research Analyst. CDC did not allow the Donated Dental Services Contract this new grant period. The funding for this program was moved to the MCH Block grant. Eighty-four dentists and 15 dental laboratories agreed to donate comprehensive services for one or two disabled or aged people each year - people who cannot afford treatment and are not eligible for public assistance. As of September 2003, there have been 55 completed cases, for a total of \$105,192.00 worth of donated dental care. Of the 55 individuals helped, the average cost of the donated care was \$1,913.00.

Provided technical assistance to the Red River Valley Dental Access Project (RRVDAP), as well as letters of support for grants. RRVDAP shared some of their recently developed educational materials for the Oral Health Program to use.

Provided technical assistance to the Bridging the Dental Gap Coalition (BDG) as well as grant assistance and letters of support. The BDG Coalition received notification that they had received a Bush Foundation Grant to start work on the clinic. Target date for opening the clinic is June 2004.

b. Current Activities

With CDC funds, plan for another 3rd Grade Survey. This survey is done once every five years.

With CDC funds, identify gaps in data collection for the Oral Health Program.

With CDC funds, create directed educational materials from baseline data.

c. Plan for the Coming Year

Third grade survey to be conducted in August 2004, with analysis completed by December 2004.

Continue coalition building and meeting of the Oral Health Coalition to identify strategies to work towards school based sealant programs.

Form and convene workgroups from the Oral Health Coalition.

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

a. Last Year's Accomplishments

Continued car seat distribution program throughout the state by providing car seats, guidelines, training and technical assistance to local agencies. Provided car seats and technical assistance to five Indian reservation programs.

Assisted local agencies in conducting car seat check-ups through specific events or through on-site "fitting stations," by providing instructors, technicians, car seats and check-up supplies.

Continued educational efforts to increase use of car seats through use of pamphlets, posters, displays, etc.

Sponsored Child Passenger Safety Awareness Week in February 2003, emphasizing the 20th anniversary of the state's child passenger safety law.

Provided booster seats to local distribution programs, along with guidelines and training.

Continued "Boost, Then Buckle" Campaign targeting health care providers, child care providers and parents.

Continued educational efforts and support enforcement efforts to encourage older children to use seat belts.

Provided funding to 10-15 local agencies to implement education and incentive programs in specific elementary, junior high, or senior high schools.

Provided funding to ND Nurses Association to continue the "Think First" and "Forever A Child" Projects in 200 schools.

Conducted three four-day National Highway Traffic Safety Administration (NHTSA) Standardized Child Passenger Safety Courses.

Conducted two one-day refresher courses for current technicians.

On an ongoing basis, provided technical assistance and updated information to technicians to maintain technical knowledge.

Conducted six regional child passenger safety two to eight hour workshops for specific audiences, i.e., law enforcement, child care providers, etc.

Provided technical assistance, training, educational materials, bike helmets, and incentives to local agencies.

b. Current Activities

Continue car seat distribution program throughout the state by providing car seats, guidelines, training and technical assistance to local agencies. Provide car seats and technical assistance to five Indian reservation programs. Assess the status of current programs, i.e., number and type of seats distributed annually, training status, fees, etc.

Assist local agencies in conducting car seat check-ups through specific events or through on-site "fitting stations," by providing instructors, technicians, car seats and check-up supplies.

Continue educational efforts to increase use of car seats through use of pamphlets, posters, displays, etc.

Sponsor Child Passenger Safety Awareness Week in February 2004.

Provide booster seats to local distribution programs, along with guidelines and training.

Continue "Boost, Then Buckle" Campaign targeting health care providers, child care providers and parents.

Continue educational efforts and support enforcement efforts to encourage older children to use seat belts.

Provide funding to 10-15 local agencies to implement education and incentive programs in specific elementary, junior high, or senior high schools.

Conduct two to three four-day NHTSA Standardized Child Passenger Safety Courses.

Conduct one to two one-day refresher courses for current child passenger safety technicians.

On an ongoing basis, provide technical assistance and updated information to technicians to maintain technical knowledge.

Conduct four to six regional child passenger safety two to eight hour workshops for specific audiences, i.e., law enforcement, child care providers, etc.

Coordinate a bike safety project by providing technical assistance, training, educational materials, bike helmets, and incentives to local agencies. Expand public information and education activities on bike safety.

c. Plan for the Coming Year

Re-apply for ND Department of Transportation funds to administer the state's child passenger safety program; monitor expenditures, complete reports as required.

Continue educational efforts to increase the proper use of car seats through use of pamphlets, posters, displays, etc. Sponsor Child Passenger Safety Week in February 2005.

Continue car seat distribution program throughout the state by providing car seats, policies/procedures, and training/technical assistance to local agencies. Provide car seats and training to five Indian reservations.

Assist local agencies in conducting car seat check-ups by providing certified instructors, technicians, car seats, and checkup supplies.

Continue coordinating the "Boost, Then Buckle" Campaign to encourage the use of booster

seats by children from 40 to 80 pounds. Provide booster seats to local agencies to enhance the campaign.

Promote use of "Buckle Up With Bucky" video-tape, curriculum and other materials for grades K-2.

Continue educational efforts to encourage the use of seat belt by children 3-6 through development of a video-tape, curriculum and other educational materials.

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

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

Coordinate a bike safety project by providing technical assistance, training, educational materials, and bike helmets to local agencies. Continue to expand public information and education activities relating to bike helmet use.

Monitor child safety legislation during the 2005 Legislative session. Provide information as requested/appropriate.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

The 5th Biennial ND Breastfeeding Conference was held in October 2002. About 240 persons attended the program, which featured "Promoting Breastfeeding Success Through Evidence-Based Practice" by Marsha Walker, RN, IBCLC. A committee was formed to begin planning the 6th biennial conference, which will be held in Bismarck, ND on July 20, 2004.

Thirty-seven persons participated in the Center for Breastfeeding's Lactation Counselor Training Program, which was held March 2003. Over 180 persons have been trained through this program over the last five years.

WIC staff continue working on a video-streaming presentation featuring Cathy Breedon, PhD, LRD, as a way to reach physicians with continuing education on breastfeeding. The Healthy ND Breastfeeding Committee met in February 2003 for a strategic planning meeting. A strategic plan for breastfeeding promotion and support was drafted. The Early Head Start Program provided the funding for the strategic planning meeting.

A presentation on breastfeeding statistics, along with a resource packet, was developed for the Health North Dakota (HND) Breastfeeding Strategic Planning meeting. Breastfeeding data from newborn screening records and WIC Pregnancy Nutrition Surveillance System (PNSS) data continue to be tracked. Tobacco use and its relationship to initiation of breastfeeding were investigated through a linkage of the newborn screening records and vital records.

During the summer of 2003, a graduate student conducted a survey of Baby Friendly Hospital Practices in ND as part of her MCH Certificate program requirements. Results available in late 2003.

The WIC Program held four regional breastfeeding training in summer 2003. WIC, Tribal WIC programs, public health nurses, hospital and clinic staff participated.

New versions of the La Leche League Answer Books were distributed to all WIC Agencies in May 2003.

b. Current Activities

The Healthy North Dakota Breastfeeding Work Group's strategic plan will be finalized and activities begun.

Reviewing the findings of and disseminate the Baby Friendly Hospital survey information utilizing conferences, newsletters, e-mail lists, etc.

Develop one on more media pieces (fact sheets, PowerPoint) on breastfeeding, which can be used at the local for policy and environmental change in hospitals and worksites.

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

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

Breastfeeding data will be put on the new MCH website -- <http://www.ndmch.com>

WIC/MCH staff will help in planning the 6th Biennial ND Breastfeeding Conference, to be held in Bismarck in 2004.

Planning will be done for holding the Breastfeeding Lactation Counselor training again in North Dakota either in fall of 2004 or spring of 2005.

Training will be provided to one or more of these groups on how to accommodate mothers that breastfeed and how to support infants and children who are breastfed: Head Start, Child and Adult Care Food Program Sponsors, childcare providers.

c. Plan for the Coming Year

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

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

MCH Nutritionist or other members of the HNDBC will work with the North Dakota Workforce Safety and Insurance Program to include a breastfeeding component into a Worksite Wellness Incentive Program, which is under development.

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

MCH Nutritionist or other members of the HNDBC explore the possibility of "Right to Breastfeed" legislation for the 2005 legislative session.

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

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

Promote the Breastfeeding Lactation Counselor training which will be held November 8-12, 2004 in Grand Forks. WIC will financially support the attendance of about six WIC and Public Health Nursing personnel at the course.

Provide a breakout session on breastfeeding support in a child care setting at the Region VIII Head Start Early Childhood Professional Institute October 13-16, 2004.

Provide training on breastfeeding support in a childcare setting to the Child and Adult Care Food Program (CACFP) Sponsors.

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

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

WIC staff will investigate the appropriate ways to implement a WIC Peer Counseling Program.

Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.

a. Last Year's Accomplishments

Staff continued to serve on the grant management team of the state's Early Hearing Detection and Intervention (EHDI) program. Staff has attended the annual national EHDI meetings that supports continued education regarding EHDI programs, as well as collaboration and idea sharing with other states. An article on what makes a standard of care was also disseminated to EHDI stakeholders.

An annual survey is conducted each spring. In the survey mailed out in 2003 for 2002 births, the percent of newborns screened was 91%. The EHDI tracking program does not have complete and accurate data, which makes the use of the annual paper survey a necessity.

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

The grants management team has looked at possible ways to sustain the EHDI program after the grant is done. CSHS hosted a technical assistance visit with an EHDI Regional Consultant to discuss possible options to improve and sustain the program. Various agencies indicated their willingness to assist in the continuation of the First Sounds Program. A variety of funding resources are also being explored. EHDI legislation that was introduced did not pass during the 2003 session.

b. Current Activities

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

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

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

CSHS will explore sustainability and transition of EHDl grant activities through technical assistance and legislation.

c. Plan for the Coming Year

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

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

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

CSHS will analyze newborn hearing screening data and conduct short-term follow-up when EHDl grant activities are completed.

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

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

a. Last Year's Accomplishments

Title V staff participated in CHIP and Medicaid outreach activities through a Robert Wood Johnson Family Foundation "Covering Kids and Families" grant awarded to Dakota Medical Foundation.

Title V staff monitored enrollment levels in CHIP and Medicaid.

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

b. Current Activities

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

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

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

c. Plan for the Coming Year

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

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

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

Performance Measure 14: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

a. Last Year's Accomplishments

The SSDI Coordinator analyzed utilization and cost trend data for children enrolled in the ND Health Tracks program and distributed results to Medicaid staff and other stakeholders.

b. Current Activities

MCH and CSHS will continue to meet regularly with Medicaid and ND Health Track staff. Title V staff will analyze utilization and cost trend data for children enrolled in the ND Health Tracks program.

c. Plan for the Coming Year

MCH and CSHS will continue to meet regularly with Medicaid and ND Health Track staff. Title V staff will analyze utilization and cost trend data for children enrolled in the ND Health Tracks program.

Performance Measure 15: The percent of very low birth weight infants among all live births.

a. Last Year's Accomplishments

MCH and CSHS staff participated in the activities of the Fetal Alcohol Syndrome (FAS) Task Force and encouraged primary prevention activities by the task force.

Provided partial funding of Optimal Pregnancy Outcome Program (OPOP) programs activities.

Coordinated statewide meetings of OPOP coordinators and staff.

Gathered data on birth outcomes and associated risks using OPOP computer data program.

Report on FY 2002 comparison data between OPOP and Vital Records.

OPOP staff provided nutrition education for OPOP clients.

WIC provided nutrition education to women receiving WIC services.

b. Current Activities

MCH staff will participate in the activities of the FAS Task Force and encourage primary prevention activities by the task force.

MCH provides partial funding to nine OPOP sites within the state.

State OPOP meeting will be held at least once a year.

Gather data on birth outcomes and associated risk factors using the OPOP computer data program.

OPOP will provide nutritional education for OPOP clients.

WIC will provide nutritional education to women receiving WIC services.

A resource guide entitled, "Services Offered to Women and Children by Public and Private Agencies Statewide" will be posted on the MCH website.

c. Plan for the Coming Year

WIC will provide nutritional education to women receiving WIC services.

Provide partial funding to the nine public health units that administer OPOP.

MCH staff will participate in the activities of the FAS Task Force and encourage primary prevention activities by the task force.

Collaborate with appropriate partners to support the efforts in reducing VLBW babies.

Coordinate statewide meetings of OPOP coordinators and staff.

Gather data on birth outcomes and associated risk factors using the OPOP computer data program.

A resource guide entitled, "Services Offered to Women and Children by Public and Private Agencies Statewide" will be posted on the MCH website.

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

a. Last Year's Accomplishments

Continued coordinating and chairing the State Adolescent Suicide Prevention Task Force.

Coordinated suicide prevention activities with the Mental Health Association of ND to conduct suicide prevention awareness and prevention workshops.

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

b. Current Activities

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

Coordinate suicide prevention activities with the Mental Health Association of ND to conduct suicide prevention awareness and prevention workshops.

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

c. Plan for the Coming Year

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

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

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

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

a. Last Year's Accomplishments

Continued to monitor the measure.

b. Current Activities

Continue to monitor the measure.

c. Plan for the Coming Year

Continue to monitor the measure.

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

a. Last Year's Accomplishments

Optimal Pregnancy Outcome Program (OPOP) staff provided education to pregnant women at local public health units.

Supported Healthy Start through MCH participation on Healthy Start Board.

Supported the March of Dimes activities by participating on the Program Services Committee (PSC) and the State PSC Board.

Provided funding for Spirit Lake Sioux Program at Fort Totten to provide prenatal care, infant care and immunizations; Trenton Indian Health Center to support Healthy Start and Indian Health Center coordination; Three Affiliated Tribes WIC Program to coordinate WIC and Healthy Start and Indian Health Services prenatal activities.

Carried out functions of the second year of Pregnancy Risk Assessment Monitoring System (PRAMS) Point-in-Time proposal.

b. Current Activities

Distribute PRAMS data when available.

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

OPOP sites will provide educational material to clients.

MCH staff will attend March of Dimes meetings as scheduled.

OPOP information available on the MCH website.

OPOP data will be distributed statewide on prenatal care.

Provide funding for Spirit Lake Sioux program at Fort Totten to provide prenatal care, infant care and immunizations, Trenton Indian Health Center to support Healthy Start and Indian Health Center coordination, Three Affiliated Tribes WIC program to coordinate WIC, Healthy Start and Indian Health Services Prenatal activities.

c. Plan for the Coming Year

Distribute PRAMS data when available.

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

OPOP sites will provide educational material to clients.

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

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

Provide funding for Spirit Lake Sioux program at Fort Totten to provide prenatal care, infant care and immunizations, Trenton Indian Health Center to support Healthy Start and Indian Health Center coordination, Three Affiliated Tribes WIC program to coordinate WIC, Healthy Start and Indian Health Services Prenatal activities.

Coordinate statewide meetings of OPOP coordinators and staff.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				

1. The MCH Newborn Screening Program follow-up policies and procedures will be revised and updated, including the expanded MS/MS screening follow-up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. The Newborn Screening Program Advisory Group will meet by conference call at least four times during FY '05.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Transitioning the Newborn Screening Program from the Division of Nutrition & Physical Activity to the Division of Family Health will be investigated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Bring the new Iowa Biochemical Geneticist, Dr. Sara Copeland, to North Dakota to meet with Newborn Screening Program, CSHS Staff and Advisory Committee members and if possible to speak at the 2005 meeting of the North Dakota Academy of Pediatrics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. CSHS will support multidisciplinary clinics for children and women of childbearing age with metabolic disorders.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. CSHS will provide metabolic food to eligible individuals with PKU and MSUD.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. CSHS will provide state level care coordination to eligible individuals with PKU and MSUD.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. CSHS staff will participate on the newborn screening advisory committee.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. CSHS will continue to include family advice and recommendations from a Family Advisory Council when making program and policy decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. CSHS will support the activities of family organizations in the state by providing financial assistance through contracts and serving on advisory boards as requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. CSHS will continue to include client satisfaction assessments as part of overall quality assurance efforts in CSHS service contracts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0				

to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. CSHS will provide information on medical homes for CSHCNs to providers and families.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. CSHS will collaborate with partners to further the medical home concept and practice in North Dakota.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. CSHS will monitor the medical home status of children receiving care coordination services through CSHS and Medicaid-eligible children.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Increase percentage of children receiving care coordination services with a written service plan.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. CSHS will monitor the number of CSHCN?s served by CSHS with a source of health care coverage and assess underinsurance issues for special demographic characteristics of CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. CSHS will conduct activities to refer and link families that have CSHCN to available sources of health care coverage such as Medicaid, CHIP and Caring programs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. CSHS will provide diagnostic and treatment services to eligible uninsured and underinsured CSHCN.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. CSHS staff will participate in meetings within Medical Services related to claims payment, Medicaid policy, or services to CSHCN and their families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. CSHS staff will monitor the developments of the state Covering Kids grant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. CSHS will disseminate results from the CSHCN SLAITS and CSHS Family Surveys that pertain to health insurance coverage.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. CSHS staff will monitor any health care legislation that impacts children as well as policy changes that affect Medicaid eligibility or covered services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. CSHS will explore collaboration with Medicaid to explore models of chronic disease management.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. CSHS will enhance capacity of local staff to implement CSHS programs by providing technical assistance and an annual training opportunity for county social service staff and public health nurses.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. CSHS will provide public information services to improve access to care including operation of a family resource center.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. CSHS staff will participate in interagency workgroups and committees whose focus is improved access to services for CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCNs and their families.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. CSHS will collaborate with other stakeholders to enhance the multidisciplinary clinic infrastructure in the state by conducting a clinic coordinator meeting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. CSHS will collaborate with state and local entities and family organizations to promote health care transitions for CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. CSHS will monitor the level of transition service planning for children ages 14-21 for CSHCN?s served by CSHS with written service plans.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. CSHS will explore the inclusion of youth or young adults with special health care needs on the Family Advisory Council when recruiting members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. CSHS will monitor the status and provide information and referral services to the SSI population and collaborate with other stakeholders involved with children?s SSI.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. CSHS will explore development and dissemination of ?health? transition resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Continued to collaborate with the Immunization Program through the Memorandum of Agreement.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborate with the Immunization Program to provide trainings/updates to public health, school nurses, childcare and head start on immunization recommendations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide funding to local public health units to fund immunization administration.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. There are 2 CSCC?S, 4 Regional Tribes, 1 Community Action Program, and 5 Public Health Units that have applied for the Abstinence Education Only Grant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Regions 3, 4 and 6 continue to collaborate to provide an Abstinence Education Only Media Campaign targeting the teen population.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Communicate and collaborate with the local grantees to assist them in utilizing quality speakers and appropriate Abstinence Education Only educational materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to collaborate with appropriate partners such as Family Planning and Adolescent Health to support the efforts in reducing teen births.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
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1. Third grade survey to be conducted in August 2004, with analysis completed by December 2004.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue coalition building and meeting of the Oral Health Coalition to identify strategies to work towards school based sealant programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Form and convene workgroups from the Oral Health Coalition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Re-apply for ND Department of Transportation funds to administer the state's child passenger safety program; monitor expenditures, complete reports as required.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continue educational efforts to increase the proper use of car seats through use of pamphlets, posters, displays, etc. Sponsor Child Passenger Safety Week in February 2005.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Continue car seat distribution program throughout the state by providing car seats, policies/procedures, and training/technical assistance to local agencies. Provide car seats and training to five Indian reservations.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Assist local agencies in conducting car seat check-ups by providing certified instructors, technicians, car seats, and checkup supplies.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Continue coordinating the "Boost, Then Buckle" Campaign to encourage the use of booster seats by children from 40 to 80 pounds. Provide booster seats to local agencies to enhance the campaign.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Promote use of "Buckle Up With Bucky" videotape, curriculum and other materials for grades K-2.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Continue educational efforts to encourage the use of seat belt by children 3-6 through development of videotape, curriculum and other educational materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Conduct 2-3 four-day National Highway Traffic Safety Administration (NHTSA) Standardized Child Passenger Safety Courses to certify new child passenger safety technicians.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Provide technical assistance and updated information to technicians to maintain technical knowledge on child passenger safety issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Coordinate a bike safety project by providing technical assistance, training, educational materials, and bike helmets to local agencies. Continue to expand public information and education activities relating to bike helmet use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. MCH Nutritionist will continue as the Department's liaison to the Healthy North Dakota Breastfeeding Committee (HNDBC).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. MCH nutritionist and other members of the HNDBC will work to assure that breastfeeding support is a component of worksite wellness initiatives of the Healthy North Dakota Worksite Wellness Committee.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. MCH Nutritionist or other members of the HNDBC will work with the North Dakota Workforce Safety and Insurance Program to include a breastfeeding component into a Worksite Wellness Incentive Program, which is under development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. MCH Nutritionist or other members of the HNDBC will work with the HND Third Party Payer Committee to promote reimbursement for lactation consultant services and electric breast pumps.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. MCH Nutritionist or other members of the HNDBC explore the possibility of "Right to Breastfeed" legislation for the 2005 legislative session.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. MCH Nutritionist or other members of the HNDBC will promote the implementation of Breastfeeding Friendly Hospital procedure in North Dakota hospitals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. The state WIC Program will provide local agencies with resources for promotion of World Breastfeeding Week.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Promote the Breastfeeding Lactation Counselor training which will be held November 8-12, 2004 in Grand Forks. WIC will financially support the attendance of about six WIC and public health nursing personnel at the course.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Provide a breakout session on breastfeeding support in a child care setting at the Region VIII Head Start Early Childhood Professional Institute October 13-16, 2004.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Provide training on breastfeeding support in a childcare setting to the Child and Adult Care Food Program (CACFP) Sponsors.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. A CSHS staff member will serve on the grant management team and function as the state implementation coordinator for the EHDI Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. If needed for monitoring purposes, CSHS will administer an annual newborn hearing screening survey to all birthing hospitals in the state.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. A CSHS staff member will serve as the Title V state EHDI contact.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. CSHS will analyze newborn hearing screening data and conduct short-term follow-up when EHDI grant activities are completed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. CSHS will monitor other early screening and detection systems for young children (e.g.) Health Tracks.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
NATIONAL PERFORMANCE MEASURE				Pyramid Level of Service			
				DHC	ES	PBS	IB
13) Percent of children without health insurance.							
1. Title V staff will continue to participate in CHIP and Medicaid outreach activities.							
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
2. Title V staff will monitor enrollment levels in CHIP and Medicaid.							
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
3. MCH and CSHS staff will provide information to county social service staff and local public health.							
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

NATIONAL PERFORMANCE MEASURE				Pyramid Level of Service			
				DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.							
1. MCH and CSHS will continue to meet regularly with Medicaid and ND Health Tracks staff.							
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2. Title V staff will analyze utilization and cost trend data for children enrolled in Medicaid.							
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

NATIONAL PERFORMANCE MEASURE				Pyramid Level of Service			
				DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.							
1. WIC will provide nutritional education to women receiving WIC services.							
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2. Provide partial funding to the nine public health units that administer OPOP.							
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

3. MCH staff will participate in the activities of the FAS Task Force and to encourage primary prevention activities by the task force.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collaborate with appropriate partners to support the efforts in reducing VLBW babies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Coordinate statewide meetings of OPOP coordinators and staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Gather data on birth outcomes and associated risk factors using the OPOP computer data program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. A resource guide entitled, "Services Offered to Women and Children by Public and Private Agencies Statewide" will be posted on the MCH website.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Continue coordinating and chairing the State Adolescent Suicide Prevention Task Force.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Assist the Mental Health Association of ND in identifying funding to continue its suicide prevention efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Update the "State Plan for Adolescent Suicide Prevention" to include information on suicides for all ages.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. MCH will continue to monitor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Distribute PRAMS data when available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. MCH will provide partial funding to the nine OPOP sites within the state.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. OPOP sites will provide educational material to clients.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. OPOP contact information and a resource guide entitled, "Services Offered to Women and Children by Public and Private Agencies Statewide" are posted on the MCH website.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. OPOP data will be distributed statewide on prenatal care and birth outcomes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide funding to provide prenatal care, infant care and immunizations, to support Healthy Start and Indian Health Center coordination, to coordinate WIC, Healthy Start and Indian Health Services Prenatal activities.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Coordinate statewide meetings of OPOP coordinators and staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The rate of abuse and neglect in infants and children from birth to age five.*

a. Last Year's Accomplishments

Provided technical assistance and consultation to home visiting agencies. Maintained resource inventory for home visiting.

Provided technical assistance to the Head Start Health Coordinators. Worked with the Head Start Health Coordinators to develop an organized meeting structure.

Provided technical assistance to Childcare Health Consultants (CCHC). Offered resources and information related to early childhood care and education. Worked with the CCHCs in the development of a framework that includes role definition, goals, objectives and outcomes. Facilitated quarterly meeting or conference calls.

Participated in scheduled QUILT (Quality in Linking Together) meetings.

Provided technical assistance to those trained in Infant Massage. Held a Network meeting on June 19, 2003. Distributed meeting minutes and infant massage related information to infant massage instructors as appropriate.

Continued to distribute Parenting the First Year Newsletter to parents of newborns. Updated

and printed the newsletter for distribution.

The Forms Committee met regularly to update the Pediatric Assessment section of the Child Health Services Manual.

b. Current Activities

The newborn home visiting committee will meet as needed.

Develop and distribute the Parenting the First Year Newsletter to parents of newborns within North Dakota.

Update and distribute the North Dakota Directory for Infant and Early Childhood Home Visiting Programs.

The Forms Committee will meet regularly to update the Child Health Services Manual. The Committee will develop any New Mother or Baby Fact Sheets as needed.

MCH will host a yearly Infant Massage meeting to share current information on infant massage.

MCH will continue to work with CCHC as needed.

Sixteen Local Health Departments use funds for a Newborn Home Visiting Program.

c. Plan for the Coming Year

The newborn home visiting committee will meet as needed.

Update and distribute the Parenting the First Year Newsletter to parents of newborns within North Dakota.

Distribute the North Dakota Directory for Infant and Early Childhood Home Visiting Programs.

The Forms Committee will meet regularly to update the Child Health Services Manual. The Committee will develop any New Mother or Baby Fact Sheets as needed.

MCH will host a yearly Infant Massage meeting to share current information on infant massage.

MCH will continue to work with CCHC as needed.

Sixteen Local Health Departments use funds for a Newborn Home Visiting Program.

State Performance Measure 2: *Incidence of normal weight among young adults 18-24 years of age.*

a. Last Year's Accomplishments

The MCH nutritionist continues to coordinate the activities of the Obesity Prevention Work Group, which has changed its name to Healthy Weight Council. E-mail was used extensively to communicate between the Healthy Weight Council members and the Healthy North Dakota Nutrition and Physical Activity Work Groups.

Nutrition staff participate in the Governor's Healthy ND Initiative. The MCH nutritionist is the Department's liaison for the Nutrition Priority, which has three work groups: breastfeeding; fruit and vegetable promotion; healthy school nutrition environment.

The MCH nutritionist coordinated periodic meetings with local MCH nutritionists and staff from Child Nutrition Programs, Prevention Block Grant Programs, 5-A-Day, 5 + 5 Communities, ND Healthy Heart Council, Midwest Dairy Council, March of Dimes, etc. A face-to-face meeting was held in fall 2002, a conference call was held in January 2003, a face to face meeting in June 2003.

MCH Nutrition staff met regularly with nutrition/physical activity staff from Division of Health Promotion, DPI Child Nutrition Programs and the Coordinated School Health staff to coordinate activities. MCH staff helped the staff from the Division of Health Promotion write an application for a CDC nutrition/physical activity/obesity grant. WIC received USDA funding for an obesity research study on effectiveness of motivational interviewing in a WIC setting to change dietary and physical activity behaviors.

MCH Nutrition, Child Nutrition Programs, WIC, Health Promotion Prevention Block Grant Programs, etc. have compiled nutrition and physical activity statistics to update/develop fact sheets.

MCH nutrition staff coordinated the activities of the YRBSS Nutrition subcommittee to disseminate YRBSS nutrition/physical activity data. MCH staff led the nutrition sub-committee in updating diet, physical activity and body image page for the YRBS brochure.

The Healthy Weight Council conducted a survey of North Dakota school policies related to assessment of students' weight status.

The Obesity Prevention Working Group's Medicaid sub-committee explored ways to extend prevention and treatment services to Medicaid clients. This resulted in revision of Medicaid reimbursement guidelines for nutrition counseling. Medical Nutrition Therapy is now available for those with a BMI of 30 or above rather than 40 or above.

WIC recently finished a video for families, which promotes healthy eating and increased physical activity. This was disseminated in the summer of 2003 to WIC and Head Start Programs.

b. Current Activities

MCH nutritionist will continue as Department liaison for the Promoting Healthy Weight -- Nutrition Priority area of the Healthy North Dakota Initiative. Strategic plans for all three workgroups will be developed: breastfeeding; fruit & vegetable; healthy school nutrition environment. The Healthy North Dakota Third Party Payer Work Group and Worksite Wellness Work Group will be involved in discussions with the Nutrition and Physical Activity Work Groups.

MCH nutritionist will facilitate meetings and projects of the Healthy Weight Council, and help to coordinate the activities of both the Nutrition and Physical Activity Work Groups of Healthy North Dakota Initiative.

Recommendations for ND school weighing and measuring practices will be written and disseminated in by the spring of 2004.

MCH staff will hold two face-to-face meetings and one conference call with local MCH nutritionists. Staff from Child Nutrition Programs, Prevention Block Grant Programs, 5 A Day, 5

+ 5 Communities, ND Healthy Heart Council, Midwest Dairy Council, ND Extension Service, etc. will be participants in the meetings/calls.

MCH nutritionist will help plan 5 + 5 Community Coalitions training for the fall of 2003.

If funded, the WIC program will implement a research study of the use of motivational interviewing to change dietary and physical activity behaviors from fall 2003-fall 2006.

c. Plan for the Coming Year

MCH nutritionist will continue coordinating meetings of the Healthy Weight Council and distributing nutrition, physical activity and obesity related e-mails to the group.

MCH nutritionist will continue as Department liaison for the Promoting Healthy Weight -- Nutrition Priority areas of the Healthy North Dakota Initiative (HND). Strategic plans for all three workgroups will be developed: breastfeeding; fruit & vegetable; healthy school nutrition environment.

MCH nutritionists and other HND nutrition committee members will work with the North Dakota Workforce Safety and Insurance staff to develop criteria for a worksite wellness incentive program.

The MCH nutritionist and members of the HND nutrition committees will work with the HND Third Party Payer Work Group to develop reimbursement for nutrition and physical prevention interventions, as well as for related Medical Nutrition Therapy that are not currently covered.

State and local MCH nutritionists will work with 5 A Day consultant and ND Cooperative Extension Service to implement a nutrition wellness initiative for participants of the ND Public Employees Retirement System (PERS) -- Note: PERS includes all state employees, not just those that are retired.

State and local MCH nutritionists will work with Cardiovascular Healthy Program, 5 A Day consultant and ND Cooperative Extension Service to support and expand activities of the local 5 + 5 Community Coalitions.

The ND WIC Program will implement a USDA research project on motivational interviewing that includes several obesity related behaviors as evaluation components (i.e. decreasing TV viewing, increasing consumption of skim/1% milk, etc.).

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

The state MCH and local public health nutritionists will work with the MCH Oral Health Program on the weighting and measuring component in the Oral Health Survey of 1st -3rd graders in the fall of 2004.

State Performance Measure 3: Percent of Medicaid-eligible children who receive dental services as part of their comprehensive services.

a. Last Year's Accomplishments

Head Start/Early Head Start Oral Health Forum was held in April 2003.

The Tri-state dental taskforce, now called the Dakota Initiatives group continued to meet quarterly. Discussed plans to draft a grant to the Bremer Foundation to start a satellite dental school in the Dakotas. Analysis has been completed on the 2000 and 2002 workforce surveys.

Continued to serve on both the Red River Valley Dental Access Project and Bridging the Dental Gap Boards of trustees. Red River Valley Dental Access Project wrote continuation grants for the HRSA Healthy Tomorrows grant. Bridging the Dental Gap just submitted a HRSA Health Tomorrows grant.

Drafted a letter and fact sheet with the PCO office to the Dental Association that can be used for recruitment.

Worked with UND to develop a practice opportunities booklet. This booklet contains a listing of dental practices in the state that are looking to sell or associate with new graduates.

Hired a research analyst to analyze data for the oral health program, as well as help to devise a surveillance system.

Hired an oral health educator to create outreach materials, help plan meetings, etc.

b. Current Activities

The following will be done with funding through a CDC Cooperative Agreement:

Plan for another 3rd Grade Survey. This survey is done once every 5 years. This is an infrastructure building service for the child population group.

Identify gaps in data collection for the Oral Health Program. This is an infrastructure building service for the child population group.

Create directed educational materials from baseline data. This is an infrastructure building service for the child population group.

Update "Project Will Show", an educational tool to help decrease missed appointments by Medicaid recipients. This is an infrastructure building service for the child population group.

c. Plan for the Coming Year

Use information gathered from the Head Start Oral Health Forum to develop or acquire educational materials and integrate into current curriculums.

Market Project Will Show to public health providers, social workers, hospitals, clinics, etc.

Work with Bridging the Dental Gap to market the clinic and to make sure patient data is collected so outcomes can be measured.

State Performance Measure 4: *Ratio of school nurses to students in ND.*

a. Last Year's Accomplishments

North Dakota School Nurse's Organization (NDSNO) meetings held in October 2002, March, June and August 2003.

The NDSNO retained a lobbyist to assist with legislative issues. SB 2307 was introduced, which provided for the rate of tax on cigarettes to provide a continuous appropriation for school health service grants. The bill did not pass.

The state school nurse consultant developed a fact sheet "Frequently Asked Questions about School Nursing Services" that was used by NDSNO for education and advocacy.

Chalkboard on Health school nurse newsletter was completed and distributed in March 2003.

School Nurse of the Year criteria developed and the first ND School Nurse of the Year was honored at the annual Roughrider Health Promotion Conference in June 2003.

Numerous resources were shared via the school nurse list serve. In addition, various resources were shared at the NDSNO quarterly meetings.

School Health Services survey conducted in January 2003 and data analyzed. School nurse to student ratio is 1:4,717 with 23.8 FTE. (2001 data - 1:4,482 with 18.1 FTE.) Much of the reduction in school nurse to student ratio and increase in FTE can be attributed to the Dakota Medical Foundation's model school nursing project which has contributed over 1 million dollars to develop a replicable, sustainable model school nurse program as part of its focus on children's access to healthcare services. The state school nurse consultant continued to act as liaison between the DMF and the project evaluator and gave an update on the project to the DMF Board in May 2003. The state school nurse consultant also acted as facilitator during the annual meeting/site visit from the project's evaluator, Judith Igoe.

School nursing represented on various state task forces/workgroups, i.e., State Asthma Workgroup, Healthy Weight Council, Basic Emergency Life Saving in Schools (BELSS).

Collaborated with the Department of Public Instruction and the Division of Health Promotion in writing a successful grant application for the Coordinated School Health Programs (CSHP) and Reduction of Chronic Diseases Infrastructure Agreement from CDC in March 2003.

b. Current Activities

Facilitate the planning for the quarterly North Dakota School Nurses Organizational (NDSNO) meetings.

Facilitate/co-chair the quarterly School Health Interagency Workgroup (SHIW) meetings.

Edit the bi-annual "Chalkboard on Health" school nursing newsletter.

Provide resources to the school nurses at the quarterly meetings and via the list serve.

Update school nursing information/resources as needed (i.e., ND school nursing fact sheet, scoliosis booklet).

Provide education to various state groups/agencies on the new Coordinated School Health Programs grant.

Continue to serve as liaison for the Model School Nursing Project between the Dakota Medical Foundation (project funder) and Judith Igoe (project evaluator).

Serve as the school nursing representative on various state task forces/workgroups (i.e., State Asthma Workgroup, Health Weight Council, BELSS).

c. Plan for the Coming Year

Facilitate the planning for the quarterly North Dakota School Nurses Organizational (NDSNO) meetings.

Provide resources to the school nurses at the quarterly meetings and via the list serve.

Attend the quarterly School Health Interagency Workgroup (SHIW) meetings.

Edit the "Chalkboard on Health" school nursing newsletter.

Update school nursing information/resources as needed (i.e., ND school nursing fact sheet, scoliosis booklet).

Continue to serve as liaison for the Model School Nursing Project between the Dakota Medical Foundation (project funder) and Judith Igoe (project evaluator).

Serve as the school nursing representative on various state task forces/workgroups (i.e., State Asthma Workgroup, Health Weight Council, BELSS).

Apply for non-profit status through the North Dakota Secretary of State and tax-exempt status through the IRS for the North Dakota School Nurse Organization.

State Performance Measure 5: *The proportion of pregnancies that are intended*

a. Last Year's Accomplishments

Title X funding distributed to delegate agencies based on formula.

ND Family Planning Program (NDFPP) distributed 39,000 brochures provided to the Regional Human Service Centers as well as county social service agencies.

Referral rate reviewed on an ongoing basis between programs.

In-service/updates provided to local county social service agencies by delegate agencies on a by request basis.

Services being provided on Standing Rock and Spirit Lake reservations. Work continued to coordinate service with IHS and Tribal Health on Three Affiliated Tribes and Turtle Mountain reservations.

Educational/informational materials profile assessed to assist in developing reservation-specific, culturally appropriate materials.

b. Current Activities

Provide federal grant dollars to the delegate agencies using the State funding formula.

Provide NDFPP outreach brochures to Regional Human Service Centers.

Expand services to the American Indian reservations within ND - Standing Rock, Three Affiliated Tribes, Spirit Lake and Turtle Mountain - by providing on-reservations medical and educational services.

Provide services to the women in correctional facilities.

c. Plan for the Coming Year

Provide Title X federal grant dollars to the delegate agencies using the State funding formula.

Provide NDFPP outreach brochures to Regional Human Service Centers.

Continue to expand services to the American Indian reservations within ND - Standing Rock, Three Affiliated Tribes, Spirit Lake and Turtle Mountain - by providing on-reservations medical and educational services.

Final report of focus group study on the four reservations and Indian Service Area will be reviewed and presentations made to staffs of the Family Planning delegate agencies. Strategic plans for implementation of recommendations will be developed over the next year.

Distribution of the final report from the PRAMS study with focus on unintended pregnancy will be presented to Family Planning delegate agencies, as well as public health.

Provide services to the women in correctional facilities -- James River Correctional Center and Stutsman County Correctional Center in Jamestown and Cass County Jail and Juvenile Detention Center in Fargo.

State Performance Measure 6: *The percent of women who use tobacco during pregnancy.*

a. Last Year's Accomplishments

OPOP sites distributed "A Pregnant Woman's Guide to Quit Smoking" guide.

Collaborated with the State Tobacco Prevention and Control program to provide smoking cessation information to OPOP, WIC, PHUs and Indian Health Services clients.

The OPOP Director distributed the statewide OPOP data report (includes smoking data) to the nine OPOP Coordinators.

Collaborated with the State Tobacco Program to distribute smoking cessation information to OPOP, WIC, PKU and Indian Health Services clients.

b. Current Activities

OPOP Director will distribute statewide OPOP data on smoking and pregnancy to OPOP Coordinators.

OPOP Director will provide educational materials to the OPOP sites on smoking and pregnancy.

Collaborate with the State Tobacco Prevention and Control program to provide smoking cessation information to OPOP, WIC, PHUs and Indian Health Services clients.

c. Plan for the Coming Year

Collaborate with the State Tobacco Prevention and Control program to provide smoking cessation information to OPOP, WIC, PHUs and Indian Health Services clients.

Share WIC PNSS data on prenatal smoking with State Tobacco Prevention and Control

program for distribution to local tobacco programs.

WIC staff will participate on the advisory committee for the tobacco quit line.

State Performance Measure 7: *The rate per 100,000 of pediatric hospitalization for asthma in children age 1 through age 17.*

a. Last Year's Accomplishments

During FY 2003, CSHS paid claims for 19 children with asthma through the Specialty Care program. CSHS provided support to an established asthma clinic on one of the state's Indian reservations and provided funding through a contract for a new child asthma clinic in the south central region of the state. CSHS staff explored submission of a CDC asthma grant, attended a national CDC-sponsored asthma meeting, developed asthma action plans and asthma action plan desk guides as tools to improve diagnosis and management, and planned an asthma web cast to promote use of NIH guidelines by providers.

CSHS staff facilitated a State Asthma Workgroup, which has four focus areas: data and surveillance, treatment, education, and collaboration. Three meetings were held during the year. Representatives from the School of Medicine at the University of North Dakota were added as new workgroup partners.

Estimated prevalence of childhood asthma in the state was conducted through a childhood asthma module in the BRFSS and analysis of health care claims for the Medicaid population. Based on these data sources, it is estimated between 8 and 10 percent of ND children have asthma. Rates are higher in males and American Indian children.

b. Current Activities

CSHS will continue to provide and/or pay for specialty care services for children with asthma. Continue to monitor the number of children eligible for CSHS with asthma, as well as related expenditures. Promote development of asthma clinic services. Promote use of quality standards by providers and/or families to improve asthma diagnosis and management.

CSHS will collaborate with other stakeholders involved with asthma. CSHS staff facilitated meetings with an established Children's Asthma Workgroup. CSHS will monitor prevalence of childhood asthma in the state and service utilization for Medicaid-eligible children. Identify available state and national data sources. Identify and utilize appropriate statistical methods of estimation.

c. Plan for the Coming Year

CSHS will continue to provide and/or pay for specialty care services for children with asthma.

CSHS will collaborate with other stakeholders involved with asthma (e.g.) workgroup participation, educational opportunities, legislation, etc.

CSHS will monitor prevalence of childhood asthma in the state and service utilization for Medicaid-eligible children.

CSHS will promote the distribution and utilization of asthma action plans.

State Performance Measure 8: *The percent of CSHCN served by CSHS with a specialty care visit*

a. Last Year's Accomplishments

During the year, CSHS supported 10 different types of multidisciplinary clinics, three that were directly administered and eight that were contracted through other providers. 236 children received contracted clinic services and 925 were served by clinics directly administered by CSHS. CSHS also developed and distributed 2,354 clinic schedules.

A statewide clinic coordinator meeting was held in September 2003. The focus of the meeting was on strategies to assure clinic quality. A family member participated in this meeting.

The CSHS Medical Director continued to determine medical eligibility, review qualifications of providers serving CSHCNs and conduct the annual Medical Advisory Council meeting. He also staffed some of the cleft lip/palate and asthma clinics.

CSHS staff continued to determine financial eligibility and coordinate benefits with providers and payers.

CSHS staff participated in department-wide meetings related to the implementation of health care transactions and privacy aspects of HIPAA and attended Medicaid claims and policy meetings.

Revised forms and financial eligibility guidelines were provided to county staff. Other manual changes were in process of being updated and due to be completed during the next year.

b. Current Activities

CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCNs and their families. Disseminate a clinic schedule. Administer and provide on-site clinic management for approximately three different types of multidisciplinary clinics. Write an annual clinic report. Initiate a request for proposal process for multidisciplinary clinic services. Develop and administer CSHS contracts for approximately six different types of multidisciplinary clinics. Write an annual contract report.

CSHS will collaborate with other stakeholders in order to enhance the multidisciplinary clinic infrastructure in the state. Conduct a clinic coordinator meeting that includes representation of family organizations.

CSHS Medical Director will determine medical eligibility, review qualifications of providers serving CSHCNs and conduct the annual Medical Advisory Council meeting.

CSHS staff will determine financial eligibility and coordinate benefits with providers and payers.

CSHS staff will develop or revise policies and procedures needed for administration of CSHS programs.

c. Plan for the Coming Year

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

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

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

State Performance Measure 9: *The percent of reproductive age women who use a multivitamin or folic acid containing supplement.*

a. Last Year's Accomplishments

MCH and WIC staff along with local public health nutritionists continued to work with the NDSU Cooperative Extension Service on folic acid promotion to replicate selected aspects of and earlier Folic Acid Project in the Fargo area. The following are accomplishments of this Task Force, funded by March of Dimes and coordinated by NDSU Extension Service:

- * Quarterly conference calls were held.
- * The CDC tested folic acid messages were used as the bases of the interventions. Other educational materials from the March of Dimes were also used.
- * For three years, wedding cards with the folic acid message have been disseminated with marriage licenses statewide through collaborations with clerks of court and local task force members.
- * News releases were developed for use in local newspapers.
- * Displays were developed and used at Health Fairs and a multitude of other locations.
- * Media spots were purchased and run during prime time and at appropriated places to reach the target population.
- * Indoor advertising (bathroom stalls) was purchased (estimated that this method reached 25,000 persons per month).
- * A commuter bus for the NDSU campus (Fargo) featured the folic acid message on the back. Three buses in Grand Forks carried a folic acid banner on the side.
- * The Governor proclaimed January as Folic Acid Awareness Month.
- * 2002 BRFSS data for North Dakota showed an increase in the number of females 25-34, who reported taking a multivitamin.
- * Labels for birth control pills "You may benefit from a folic acid containing supplement. Talk to your healthcare provider for more details" will be distributed statewide to pharmacies.
- * Statistics from the BRFSS folic acid questions were provided to the Extension Service for use in evaluating their project. Extension staff participated in the June 2003 local nutritionists meeting and discussed activities for FY 2004.

b. Current Activities

State and local MCH nutritionists will continue to work with ND Extension Service on the folic acid promotion. This is a population-based service for pregnant women, mothers, and infants.

Data from the 2003 PRAMS and 2002 BRFSS survey on pre-pregnancy vitamin consumption will be used to update the MCH Fact Sheet on Pre-Pregnancy Vitamins. This is a population-based service for pregnant women, mothers, and infants.

c. Plan for the Coming Year

State and local MCH nutritionists will continue to work with ND Extension Service their folic acid promotion project. This is a population-based service for pregnant women, mothers, and infants.

Data from the 2003 BRFSS survey on pre-pregnancy vitamin consumption will be shared with partners. This is an infrastructure building service for pregnant women, mothers, and infants.

State Performance Measure 10: *The rate of deaths to children aged 0-19 caused by unintentional injuries per 100,000 children.*

a. Last Year's Accomplishments

Provided technical assistance, training, data and materials to local entities on injury-specific topics.

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

Collaborated with Safe Kids Coalition, Emergency Medical Services for Children (EMSC), Native American Injury Prevention Coalition and others in developing injury prevention projects.

Conducted recall effectiveness checks and special projects as assigned.

Reviewed recommendations from the State and Territorial Injury Prevention Directors Association (STIPDA) State Technical Assessment Team (STAT) Report. Followed up on appropriate recommendations relating to the MCH Injury Prevention Program.

Participated in State Health Department Injury Prevention Coordinating Committee and Data Sub-Committee to develop an injury profile for North Dakotans.

Participated in ND Child Fatality Review Panel. Did a cursory review of all deaths to children under age 18 and conducted in-depth review on specific cases.

Arranged logistical details, scheduled speakers, sent conference flyers, handled registrations, etc. for the ND Conference on Injury Prevention and Traffic Safety.

Distributed educational materials and baby rattles to hospitals, public health and other local entities.

Established and promoted a Shaken Baby Syndrome (SBS) Prevention Week. Encouraged radio stations to play SBS public service announcements.

Monitored blood lead levels reported to MCH. Tracked and managed elevated levels through local public health agencies.

Oversaw sub-contracts to local agencies conducting lead screenings.

b. Current Activities

Provide technical assistance, training, data and materials to local entities on injury-specific topics.

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

Collaborate with Safe Kids Coalition, EMSC, Native American Injury Prevention Coalition and others in developing injury prevention projects.

Conduct recall effectiveness checks and special projects as assigned by the US Consumer Product Safety Commission.

Participate in ND Child Fatality Review Panel. Do a cursory review of all deaths to children under age 18 and conduct in-depth review on specific cases.

Establish and promote a Shaken Baby Syndrome Prevention Week. Encourage radio stations to play SBS public service announcements.

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

c. Plan for the Coming Year

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

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

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

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

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

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

Establish and promote a Shaken Baby Syndrome Prevention Week.

Coordinate the ND Conference on Injury Prevention and Traffic Safety in November 2004.

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

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The rate of abuse and neglect in infants and children from birth to age five.				
1. The newborn home visiting committee will meet as needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Update and distribute the Parenting the First Year Newsletter to parents of newborns within North Dakota.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Distribute the North Dakota Directory for Infant and Early Childhood				

Home Visiting Programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. The Forms Committee will meet regularly to update the Child Health Services Manual. The Committee will develop any New Mother or Baby Fact Sheets as needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. MCH will host a yearly Infant Massage meeting to share current information on infant massage.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Sixteen Local Health Departments use funds for a Newborn Home Visiting Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. MCH will continue to work with CCHC as needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Incidence of normal weight among young adults 18-24 years of age.				
1. MCH nutritionist will continue coordinating meetings of the Healthy Weight Council and distributing nutrition, physical activity and obesity related e-mails to the group.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. MCH nutritionist will continue as Department liaison for the Promoting Healthy Weight ? Nutrition Priority areas of the Healthy North Dakota Initiative (HND).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. MCH nutritionists and other HND nutrition committee members will work with the North Dakota Workforce Safety and Insurance staff to develop criteria for a worksite wellness incentive program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. The MCH nutritionist and members of the HND nutrition committees will work with the HND Third Party Payer Work Group to develop reimbursement for nutrition and physical prevention interventions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. State and local MCH nutritionists will work with 5 A Day consultant and ND Cooperative Extension Service to implement a nutrition wellness initiative for participants of the ND Public Employees Retirement System (PERS).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. State and local MCH nutritionists will work with Cardiovascular Healthy Program, 5 A Day consultant and ND Cooperative Extension Service to support and expand activities of the local 5 + 5 Community Coalitions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. The ND WIC Program will implement a USDA research project on motivational interviewing that includes several obesity related behaviors as evaluation components (i.e. decreasing TV viewing, increasing consumption of skim/1% milk, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. MCH nutritionist will hold two face-to-face meetings and one conference call with local public health nutritionists.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. The state MCH and local public health nutritionists will work with the MCH Oral Health Program on the weighting and measuring component in the Oral Health Survey of 1st -3rd graders in the fall of 2004.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

	DHC	ES	PBS	IB
3) Percent of Medicaid-eligible children who receive dental services as part of their comprehensive services.				
1. Use information gathered from the Head Start Oral Health Forum to develop or acquire educational materials. Integrate this information into current curriculums as well.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Market project will show to Public Health Providers as well as social workers, hospital clinics etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Work with Bridging the Dental Gap to market the clinic and to make sure patient data is collected so outcomes can be measured.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Ratio of school nurses to students in ND.				
1. Facilitate the planning for the quarterly North Dakota School Nurses Organizational (NDSNO) meetings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide resources to the school nurses at the quarterly meetings and via the list serve.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Attend the quarterly School Health Interagency Workgroup (SHIW) meetings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Edit the ?Chalkboard on Health? school nursing newsletter.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Update school nursing information/resources as needed (i.e., ND school nursing fact sheet, scoliosis booklet).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continue to serve as liaison for the Model School Nursing Project between the Dakota Medical Foundation (project funder) and Judith Igoe (project evaluator).	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Serve as the school nursing representative on various state task forces/workgroups (i.e., State Asthma Workgroup, Healthy Weight Council, BELSS).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Serve as the school nursing representative on various state task forces/workgroups.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Apply for non-profit status through the North Dakota Secretary of State and tax-exempt status through the IRS for the North Dakota School Nurse Organization.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) The proportion of pregnancies that are intended				

1. Provide federal grant dollars to the delegate agencies using the State funding formula.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide NDFPP outreach brochures to Regional Human Service Centers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue to expand services to the American Indian reservations within ND - Standing Rock, Three Affiliated Tribes, Spirit Lake and Turtle Mountain - by providing on-reservations medical and educational services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Final report of focus group study on the four reservations and Indian Service Area reviewed and presentations made to staffs of the Family Planning delegate agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Distribution of the final report from the PRAMS study with focus on unintended pregnancy will be presented to Family Planning delegate agencies as well as public health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide services to the women in correctional facilities ? James River Correctional Center and Stutsman County Correctional Center in Jamestown and Cass County Jail and Juvenile Detention Center in Fargo.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percent of women who use tobacco during pregnancy.				
1. Collaborate with the State Tobacco Prevention and Control program to provide smoking cessation information to OPOP, WIC, PHUs and Indian Health Services clients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Share WIC PNSS data on prenatal smoking with State Tobacco Prevention and Control program for distribution to local tobacco programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. WIC staff will participate on the advisory committee for the tobacco quit line.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. OPOP Director will distribute statewide OPOP data on smoking and pregnancy to OPOP Coordinators and Tobacco Prevention and Control program.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. OPOP Director will provide educational materials to the OPOP sites on smoking and pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) The rate per 100,000 of pediatric hospitalization for asthma in children age 1 through age 17.				

1. CSHS will continue to provide and/or pay for specialty care services for children with asthma.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. CSHS will collaborate with other stakeholders involved with asthma (e.g.) workgroup participation, educational opportunities, legislation, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. CSHS will monitor prevalence of childhood asthma in the state and service utilization for Medicaid-eligible children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. CSHS will promote the distribution and utilization of asthma action plans.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The percent of CSHCN served by CSHS with a specialty care visit				
1. CSHS will provide diagnostic and treatment services to eligible uninsured and underinsured CSHCN.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCNs and their families.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. CSHS will collaborate with other stakeholders to enhance the multidisciplinary clinic infrastructure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) The percent of reproductive age women who use a multivitamin or folic acid containing supplement.				
1. State and local MCH nutritionists will continue to work with ND Extension Service their folic acid promotion project.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Data from the 2003 BRFSS survey on pre-pregnancy vitamin consumption will be shared with partners.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STATE PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
10) The rate of deaths to children aged 0-19 caused by unintentional injuries per 100,000 children.					
1. Provide technical assistance, training, data, and materials to local entities on injury-specific topics, i.e., playground safety, product safety, etc.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Distribute media releases and produce a quarterly newsletter, "Building Blocks to Safety" with a "Buckle Update" section.		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Collaborate with state and local Safe Kids Coalitions, Emergency Medical Services for Children, Native American Injury Prevention Coalition and other private/public partners on injury prevention projects.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Coordinate/contract with the US Consumer Product Safety Commission to educate the public about product recalls, conduct recall effectiveness checks, and complete special projects as assigned.		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Participate in the ND Child Fatality Review Panel. Do a cursory review of all deaths to children under age 18, assign for further review as appropriate, and conduct in-depth review of all motor vehicle cases.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Do a cursory review of all deaths to children under age 18, assign for further review as appropriate, and conduct in-depth review of all motor vehicle cases.		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Coordinate North Dakota's Poison Prevention education campaign. Work with Hennepin County Poison Control Center in Minnesota to assure poison consultation coverage for North Dakota.		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Establish and promote a Shaken Baby Syndrome Prevention Week.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Coordinate the ND Conference on Injury Prevention and Traffic Safety in November 2004.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Monitor blood lead levels reported to MCH. Track and manage elevated levels through local public health agencies.		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

E. OTHER PROGRAM ACTIVITIES

Early Childhood Comprehensive Systems (ECCS) Grant: The purpose of the ECCS grant is to plan, develop and implement collaborations and partnerships to support families and communities in the development of children who are healthy and ready to learn at school entry. The five critical component areas for early childhood systems development include: 1. Access to health insurance and medical home; 2. Mental health and social-emotional development; 3. Early care and education/childcare; 4. Parent education; and 5. Family support.

North Dakota's plan to develop comprehensive systems of early childhood services are embedded into our state's Child Care Resource and Referral (CCR&R) agencies/system. CCR&R have expertise in early childhood issues, are experts are building local partnerships and have strong connections to each of the five critical component areas.

Coordinated School Health: North Dakota has received an Infrastructure Coordinated School Health grant. The expected outcome of this effort is to assist schools in the reduction of priority health risks among youth, especially those that contribute to chronic diseases, specifically to reduce tobacco use and addiction, improve eating patterns, increase physical activity, and reduce obesity among youth. The Department of Public Instruction and the Department of Health will be working cooperatively on this initiative.

CSHS provides a toll-free telephone line (1.800.755.2714) that supports access to care for CSHCNs and their families. This "Info-Line" is marketed in a variety of ways including printed media, promotional materials and CSHS web pages. 2,007 calls were received in 2002. The line is answered by administrative support staff and then routed as needed within the CSHS unit. Voice mail is available for coverage on weekends, holidays and after office hours during the week.

/2005/ 1,831 calls were received in FY 2003./2005//

The MCH Division also maintains a toll-free telephone line (1.800.472.2286) to facilitate access for clients, consumers and stakeholders. In 2002, 6,546 calls were received on the toll-free line. Calls received have decreased over the years, which may be related to declining population of women with children or improved knowledge of services available by the public and stakeholders. The toll-free number is included on various pamphlets and publications produced by the various programs within the division. MCH staff answer the toll-free line 7:00 a.m. to 5:00 p.m. Monday through Friday with voice mail available evenings and weekends.

/2005/ 6,104 calls were received in FY 2003./2005//

F. TECHNICAL ASSISTANCE

Technical assistance has been requested to:

- 1) Develop a State Adolescent Plan, and
- 2) Conduct a CSHCN Program evaluation.

V. BUDGET NARRATIVE

A. EXPENDITURES

Please refer to the attached Word document.

B. BUDGET

Please refer to the attached Word document.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.