NORTH DAKOTA MATERNAL & CHILD HEALTH NEEDS ASSESSMENT

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NDSU CENTER FOR SOCIAL RESEARCH

NORTH Dakota Be Legendary. | Health & Human Services

North Dakota Maternal & Child Health Needs Assessment

Prepared for: North Dakota Department of Health and Human Services

Title V Maternal and Child Health Services Block Grant

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Overview of North Dakota

North Dakota is located in the upper Midwest region of the United States (U.S.) and is bordered by Minnesota, South Dakota, and Montana, and to the north, the Canadian provinces of Saskatchewan and Manitoba. Identified as the 17th largest state by geographic area, North Dakota has a land area of 68,994 square miles and a water area of 1,705 square miles. According to the U.S. Census Bureau, North Dakota had an estimated 796,568 residents in July 2024, a 2.2 percent increase from April 2020. The state's population density also increased from 9.7 persons per square mile in 2010 to 11.3 persons per square mile in 2020. North Dakota has 53 counties and five-federally recognized Tribes and one Indian community located partially within North Dakota: Mandan, Hidatsa and Arikara Nation (Three Affiliated Tribes), the Spirit Lake Nation, the Standing Rock Sioux Tribe, the Turtle Mountain Band of Chippewa Indians, the Sisseton-Wahpeton Oyate Nation, and the Trenton Indian Service Area. Only eight North Dakota counties possess a population of over 20,000 residents and over two-thirds of the state's counties are considered "frontier" due to population densities of six residents per square mile or less. While geographically North Dakota is largely rural, since 2021 population growth has been concentrated in urban areas. According to the U.S. Census Bureau, 40 percent of North Dakotans live in rural areas, a decrease from 43 percent in 2021.

North Dakota has experienced robust economic conditions since 2010. The state's oil and gas and agriculture industries are the two largest industries in the state accounting for roughly half of the state's Gross Domestic Product (GDP) [Bangsund & Hodur, 2025(a); Bangsund & Hodur, 2025 (b)]. Economic growth in the state's urban centers combined with favorable conditions in the state's two largest industries has contributed to continued growth in the state's GDP. North Dakota had the highest annual change in real GDP in the nation from 2022-2023 at nearly 8 percent. North Dakota's economy grew an average of 3.5 percent annually based on 2010-2023 real compound annual growth rates of its GDP compared to the United States growth rate of 2.3 percent during the same time period (ND Compass).

As a result of a strong statewide economy, household incomes in North Dakota have risen substantially since 2010. In 2010, the median household income was $67,995 (in 2023 inflation adjusted dollars). In 2011, the median household income in the state exceeded the U.S. household income for the first time. North Dakota's median household income peaked in 2015 at $77,855, then declined to $76,525 in 2023, which is slightly below the U.S. median household income of $77,719 (ND Compass). Despite the rise in median income, there has been little overall change in the number of moderate-income households. Households earning from $75,000 to $99,000 represented about 14 percent of all households in the state in 2022 compared to 13 percent in 2021. North Dakota ranks 8th in the nation in terms of the lowest percentage of individuals living below the poverty level (9.8 percent).

Over the past 13 years, North Dakota has experienced significant population changes, largely driven by energy development. After a long period of modest growth, the state's population

rose sharply, by 16 percent, from 672,591 in 2010 to 779,094 people in 2020. Much of this increase occurred before 2015 and was fueled by an influx of adults ages 25 through 44 seeking employment opportunities, much of which was driven by energy development in western North Dakota. As a result, North Dakota was the only state in the nation to grow younger during this period, with its median age dropping from 37 in 2010 to 35.8 in 2022, which is a few years younger than the U.S. median age of 39 years.

The population growth in the state, especially among young adults, has strengthened North Dakota's workforce and revitalized the state's natural population increase through more births. The state's age structure has been shaped by a robust, diversified economy in the east and rapid energy-driven expansion in the west. This will have long-term implications for the state. The greatly expanding number of births will increase the number of children and youth in the state, thereby creating increased demand for child care and educational services. In 2023, 6 percent of the state's population was age 4 or younger (49,307 youth). Just over 20 percent of the state's population were children and adolescents ages 5 through 19 (160,327 youth) and 56 percent of North Dakotans were ages 20 through 64 (440,976 people). Approximately half of North Dakota's population was female (49 percent), therefore about a quarter of the state's population were women ages 20 through 64, many of which were of child bearing age. Despite the state becoming younger, the baby-boom generation (those born between 1946 and 1964) continues to age forward into the 65 and older age cohort. The 65 and older age cohort grew by 33 percent from 2010 to 2022 and the most significant change in population (expected to occur by 2027) is continued growth in the 65 and older age cohort. Statewide, from 2022 through 2027, the state's population age 65 and older is projected to increase by 22 percent (Hodur, Olson, & Bangsund, 2025).

Needs Assessment

Process Description

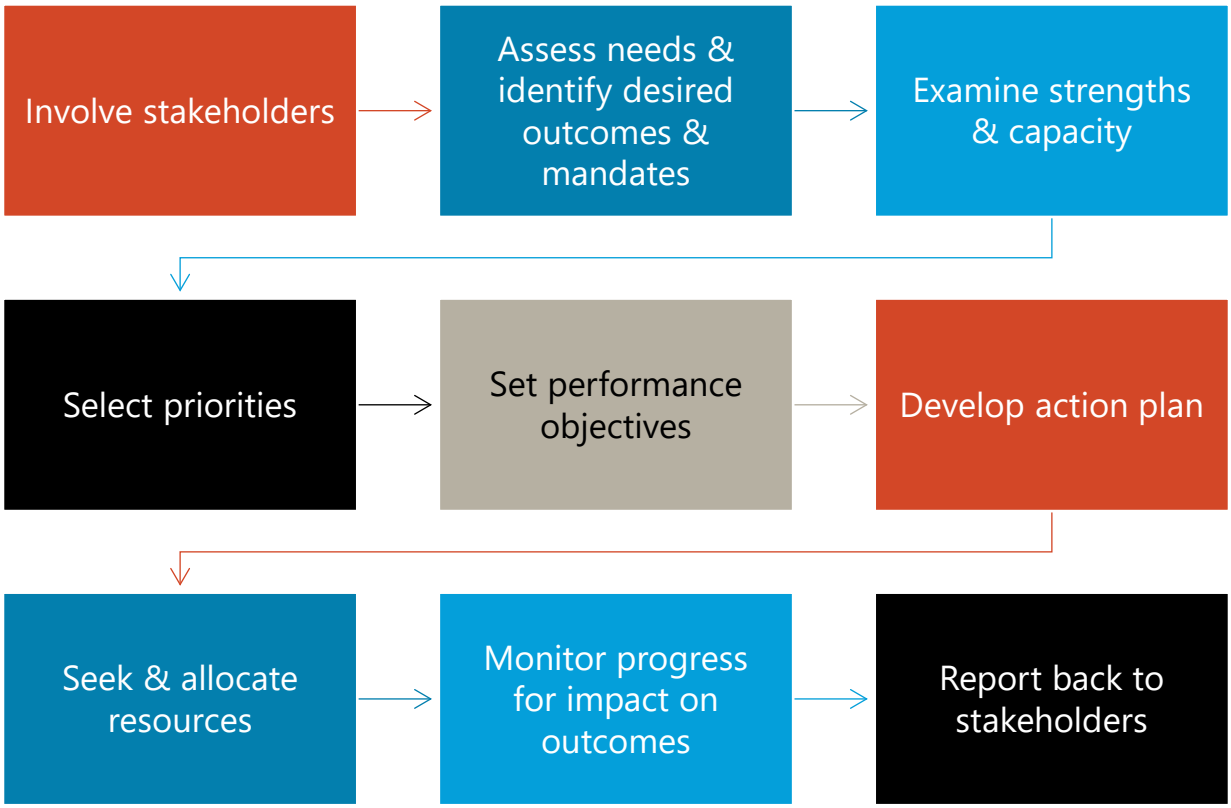
The North Dakota Department of Health and Human Services (HHS) and the North Dakota State University (NDSU) Center for Social Research (CSR) conducted a statewide Needs Assessment of Maternal and Child Health (MCH) populations across North Dakota to better understand potential needs and challenges associated with the health and well-being of women and children. The Needs Assessment is used to guide and inform decisions for program planning and development by describing both the strengths and needs of North Dakota MCH populations, prioritizing North Dakota programs and resources, and assessing the resources and assets of North Dakota communities.

Prior to the current Title V MCH Needs Assessment, the NDSU CSR partnered with HHS to complete the most recent State Health Assessment (2023). The 2023 State Health Assessment guided the development of the State Health Improvement Plan (SHIP) for 2024-2029. Based on the Center's work experience with the State Health Assessment and knowledge of the MCH

Needs Assessment process, North Dakota HHS again contracted with the Center for Social Research, to complete the MCH Needs Assessment. Findings from the State Health Assessment, as well as gaps in the assessment, served as a starting point for the 2025-2030 MCH Title V Block Grant 5-year Needs Assessment.

A requirement of the Block Grant is the selection of a minimum of five national performance measures to set as priority needs. North Dakota's selection of priority needs was guided by a survey of stakeholders and well-being profiles for each MCH Title V population domain. Findings from this process (Figure 1) informed discussions by MCH core leadership, resulting in the identification of nine MCH priority needs. The NDSU research team met with North Dakota HHS MCH Domain leads in July 2024 to guide development of a stakeholder survey. Individual interviews with leadership from Women and Maternal Health, Adolescent Health, Children with Special Health Care Needs, and the Crosscutting/Systems building population domains, and a joint interview with leadership from Perinatal and Infant Health and Child Health domains provided insight on issues and conditions relevant and unique to MCH in North Dakota, which guided development of the survey instrument. A stakeholder survey was drafted in the fall of 2024, finalized in December 2024, and disseminated in January 2025.

Figure 1. Overview of the Needs Assessment Process

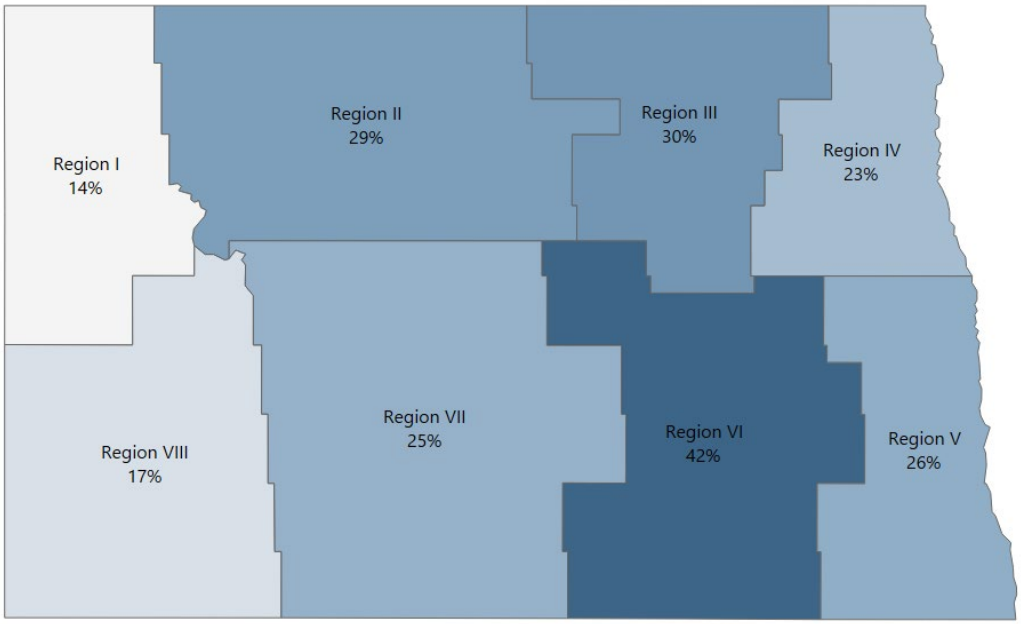


A list of key stakeholders was developed by HHS. The survey link was distributed to a total of 198 stakeholders via an email requesting participation and input through an online survey instrument using Qualtrics software. A snowball sampling technique was used for survey distribution. Stakeholders were asked to forward the survey link to colleagues and partners that could provide meaningful insight on MCH needs in North Dakota. The survey was well received with excellent participation from stakeholders. Although the survey received 196 total responses, participation was voluntary. As a result, the number of respondents (N) varies across questions. The specific N is noted for each to indicate how many participants provided a response.

Data were analyzed using widely accepted standard descriptive statistical analyses (Appendix C). Quantitative analysis such as mean, median, mode, and simple frequencies were used to measure the greatest level of consensus among survey respondents. In addition to quantitative analysis, the stakeholder survey had multiple open-ended questions. Content coding of the qualitative data revealed key themes and priorities identified by stakeholders' responses to open-ended questions.

The majority of survey respondents worked in the public sector in health, education, or government positions (Appendix C). There was representation across the state with at least one survey respondent from every county in North Dakota. When stakeholders were asked to indicate which North Dakota counties their organization served, approximately 27 percent of respondents indicated their work served the entire state. A majority of stakeholders' work served at least one county in Region VI and slightly fewer served counties in Region I and Region VIII (Figure 2).

Figure 2. Survey Respondents Area of Service, by North Dakota State Planning Region, MCH Stakeholder Survey, 2025 (N=132)*



*27 percent of survey respondents indicated their work serves all of North Dakota, not shown in Figure 2.

In addition to the stakeholder survey, five well-being profiles were created, each corresponding to one of the five MCH defined population domains: perinatal and infants, children, children with special health care needs, adolescents, and women and mothers. National performance measures (NPMs) are specific to each population with six to nine measures aligning with each of the domains. Performance measures are widely accepted indicators used to track conditions, gauge trends, and measure health outcomes. The North Dakota Well-Being Profiles provide a snapshot of current conditions, which were placed in context by comparing each performance measure to regional and national averages, where data were available. A resource glossary defining each of the NPMs can be found in Appendix A.

Data for the well-being profiles were compiled from numerous data sources. North Dakota Pregnancy Risk Assessment Monitoring System (ND PRAMS) was the data source for multiple performance measures across nearly every population domain. PRAMS is a population-based surveillance system designed to identify groups of women and infants at high risk for health problems, to monitor changes in health status, and to measure progress towards goals in improving the health of mothers and infants. ND PRAMS data are collected directly from North Dakota mothers and are some of the best available data to describe the health and well-being of infants and mothers across the state. The PRAMS Automated Research File (ARF) was used to collect the same data points for Health Resources and Services Administration (HRSA) Region 8 and nationally, to enable comparisons and provide further context of North Dakota's health status in the Midwest and within the United States. HRSA Region 8 encompasses North Dakota, Colorado, Montana, South Dakota, Utah, and Wyoming. Other data sources used for the North Dakota Well-Being Profiles were the Youth Risk Behavior Surveillance System (YRBSS), Maternal and Child Health Bureau Federally Available Data (FAD), the National Survey of Children's Health (NSCH), and North Dakota Immunization Information System (NDIIS). A full description of each data source can be found in the resource glossary (Appendix A). While each data set provides meaningful and insightful data, how the data are reported is not consistent across all performance measures and demographics. Some data sources provide single year estimates (i.e., 2022, 2023); other sources provide combined two-year estimates (i.e., 2021-2022, 2022-2023). The specific year(s) corresponding to each performance measure are also detailed in the resource glossary.

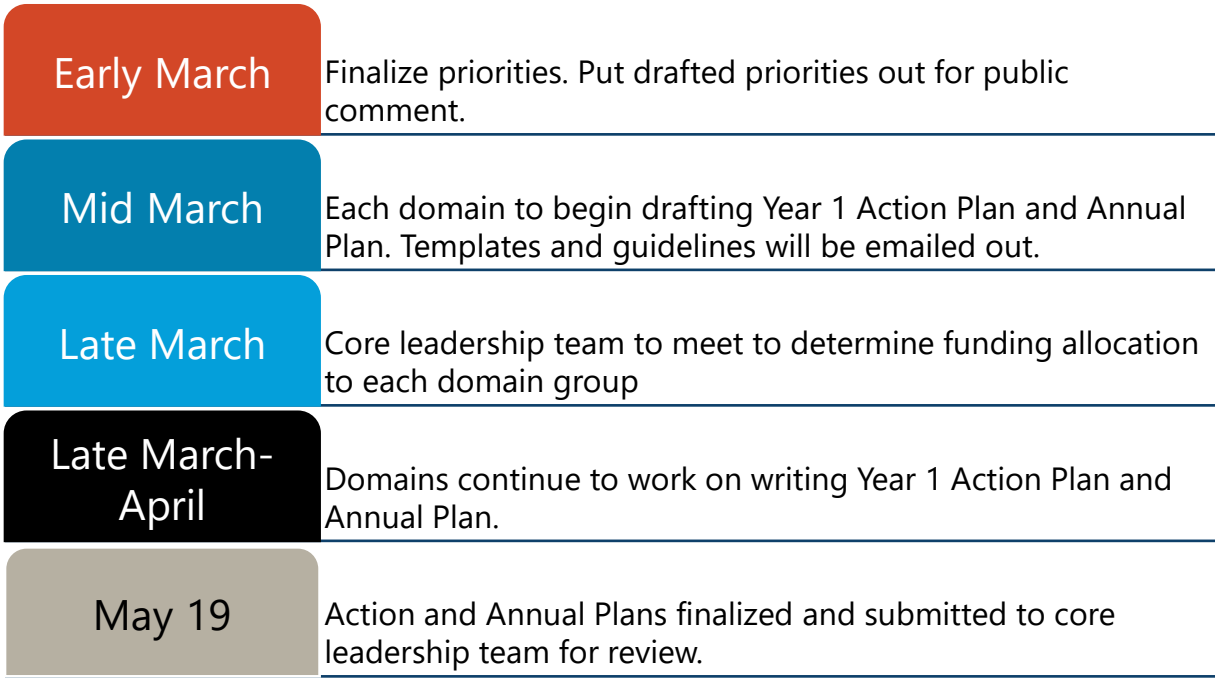
For each MCH population domain profile, the applicable NPMs were summarized in a one-page well-being profile or infographic (Appendix A). In addition to overall averages, metrics were reported by various demographic characteristics as available and appropriate. Demographic analyses consisted of measures such as marital status or family structure, educational attainment, age, race and ethnicity, household income, poverty level, and type of health care insurance. The Well-Being Profile metrics are presented for North Dakota and compared to HRSA Region 8 and United States averages where data were available. Summary data points are also color-coded. Metrics presented in white or blue indicate a performance measure where North Dakota is performing better than the national average. A data point highlighted in black

or grey indicates a performance measure in which North Dakota is performing worse than the United States average. Data that may be unreliable due to low counts or large standard error (SE) are highlighted with an asterisk (*). Some performance measures are in more than one MCH population domain and are featured in multiple Well-Being Profiles. For example, bullying is a performance measure in both the adolescent domain and the children with special health care needs (CSHCN) domain. A resource glossary defining the performance measures, the years of data presented and data sources for each Well-Being Profile can be found in Appendix A.

NDSU CSR researchers provided the MCH team with quantitative and qualitative analysis of the stakeholder survey (Appendix C), performance measure analysis (Appendix D), and five North Dakota population domain Well-Being Profiles (Appendix A). The three-person MCH Epidemiology Team reviewed stakeholder survey findings, performance measure data, and the Well-Being Profiles to inform the identification and selection of North Dakota's priority measures. In addition to holding these smaller workgroup meetings with MCH team members, the Microsoft Teams platform was used to keep version-controlled documents and recordings of various meetings. Real time updates supported clear communication of progress throughout the assessment process. MCH programmatic leaders also considered staff capacity, feasibility and other potential resource opportunities or constraints in identifying North Dakota's 2025-2030 priority measures. A multi-partner stakeholder meeting was held during the typical bi-monthly Title V meeting in March 2025, which reviewed results from the 2025 ND Title V MCH Survey to Stakeholders and draft priority measures, to ensure agreement with the rankings done by the MCH Core Leadership Team. A draft of MCH priorities were chosen and made available for public comment. A press release asking for public comment went out in March 2025 (Appendix B). Once public comment was received and reviewed, the MCH Priorities for 2025-2030 were finalized. Public comments largely reflected agreement that the correct priorities were chosen, and encouraged collaboration among stakeholders to address new priorities and health goals across the state.

Figure 3. 2025 North Dakota Title V/MCH Timeline

Establishing new priorities, completing Year 1 Action Plan, and completing Year 1 Annual Plan.



Findings

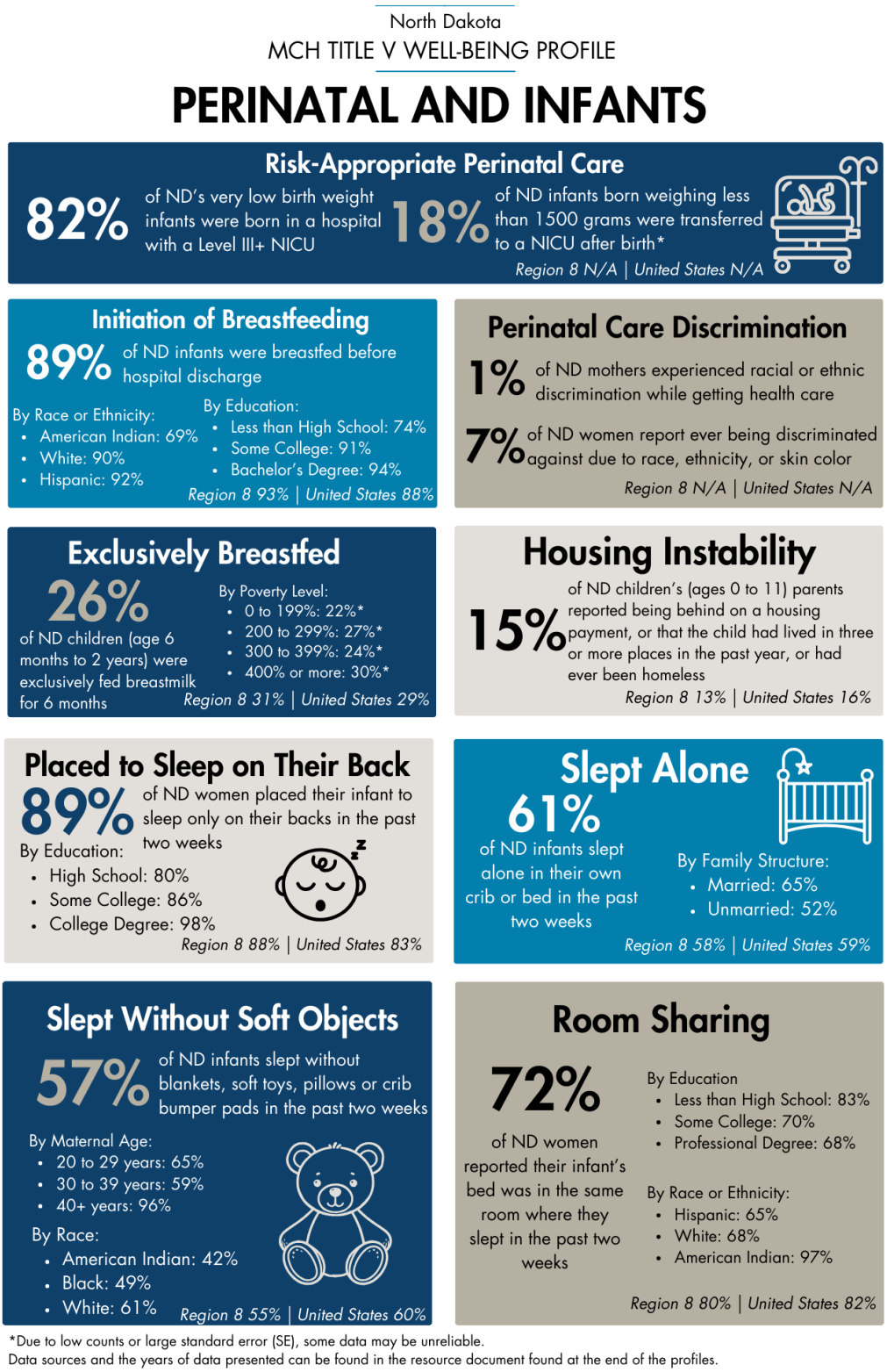
Well-Being Profiles

In support of North Dakota's Title V MCH Services Block Grant plan to address the health service's needs and promote the health of all mothers and children, including children with special health care needs (CSHCN) and their families, a Needs Assessment and five Well-Being Profiles were created. A total of 20 NPMs, as defined by the MCH Title V Block Grant to address key MCH priority areas within each population domain, were used to create domain profiles with performance measure data spanning from 2018 to 2024 when available. Results of this analysis are presented below by MCH population domain.

Perinatal and Infant Health

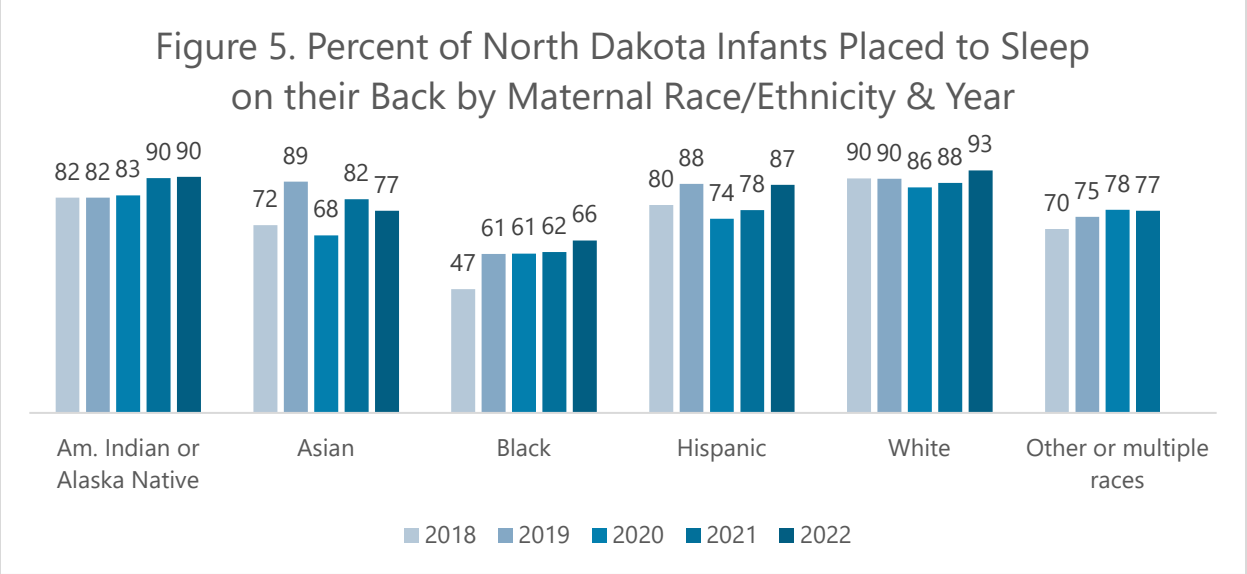
The NPMs used to track perinatal and infant health outcomes are breastfeeding, housing instability, perinatal care discrimination, risk-appropriate perinatal care, and safe sleep practices. The North Dakota Well-Being Profile for perinatal and infant health provides a snapshot of health and well-being among North Dakota's infants 24 months and younger (Figure 4). Detailed performance measure analysis for perinatal and infant health measures can be found in Appendix D.

Figure 4. North Dakota Perinatal and Infant's Well-Being Profile



*Due to low counts or large standard error (SE), some data may be unreliable.
Data sources and the years of data presented can be found in the resource document found at the end of the profiles.

For some indicators, North Dakota mothers' safe sleep practices were favorable compared to regional and national averages, and for others, less favorable. Overall, 89 percent of North Dakota mothers reported only placing their baby on their back to sleep (not stomach or side), which is similar to the regional average (88 percent) and slightly better than the national average (83 percent). An increased percentage of women now report placing their infants to sleep exclusively on their backs, as opposed to on their stomachs or sides, compared to previous years. Safe sleep practices vary by race and ethnicity. The percentage of White mothers that reported only placing their infant to sleep on their back increased from 90 percent in 2018 to 93 percent in 2022 (Figure 5). The lowest prevalence of exclusively placing their infant to sleep on their backs, also experienced the largest percentage increase from 2018 through 2022, was among Black mothers. The percentage of Black mothers who reported placing their infants only on their back to sleep increased by 19 percentage points, from 47 percent in 2018 to 66 percent in 2022.



For other safe sleep indicators, infants that slept alone in their own crib or bed, room sharing (infants' bed in the same room as another adult), and infants that slept without blankets, pillows or crib bumper pads, varied when compared to regional and national averages. Sixty-one percent of North Dakota mothers reported that their infant always slept alone in their own crib or bed which is consistent with Region 8 (58 percent) and the national (59 percent) average. The percentage of infants that slept without blankets, soft toys, pillows or crib bumper pads was slightly lower in North Dakota (57 percent) than nationally (60 percent). However, women with higher levels of education were more likely to report not placing their infant to sleep with comforters, quilts, blankets, non-fitted sheets, soft toys, cushions, pillows or crib bumper pads; 76 percent of mothers with a professional degree compared to 35 percent with less than a high school diploma. Further, room sharing was less prevalent in North Dakota than either regionally

or nationally. The infant's crib or bed was in the same room where they or another adult slept for 72 percent of North Dakota babies compared to 82 percent nationally (Figure 4, Appendix D).

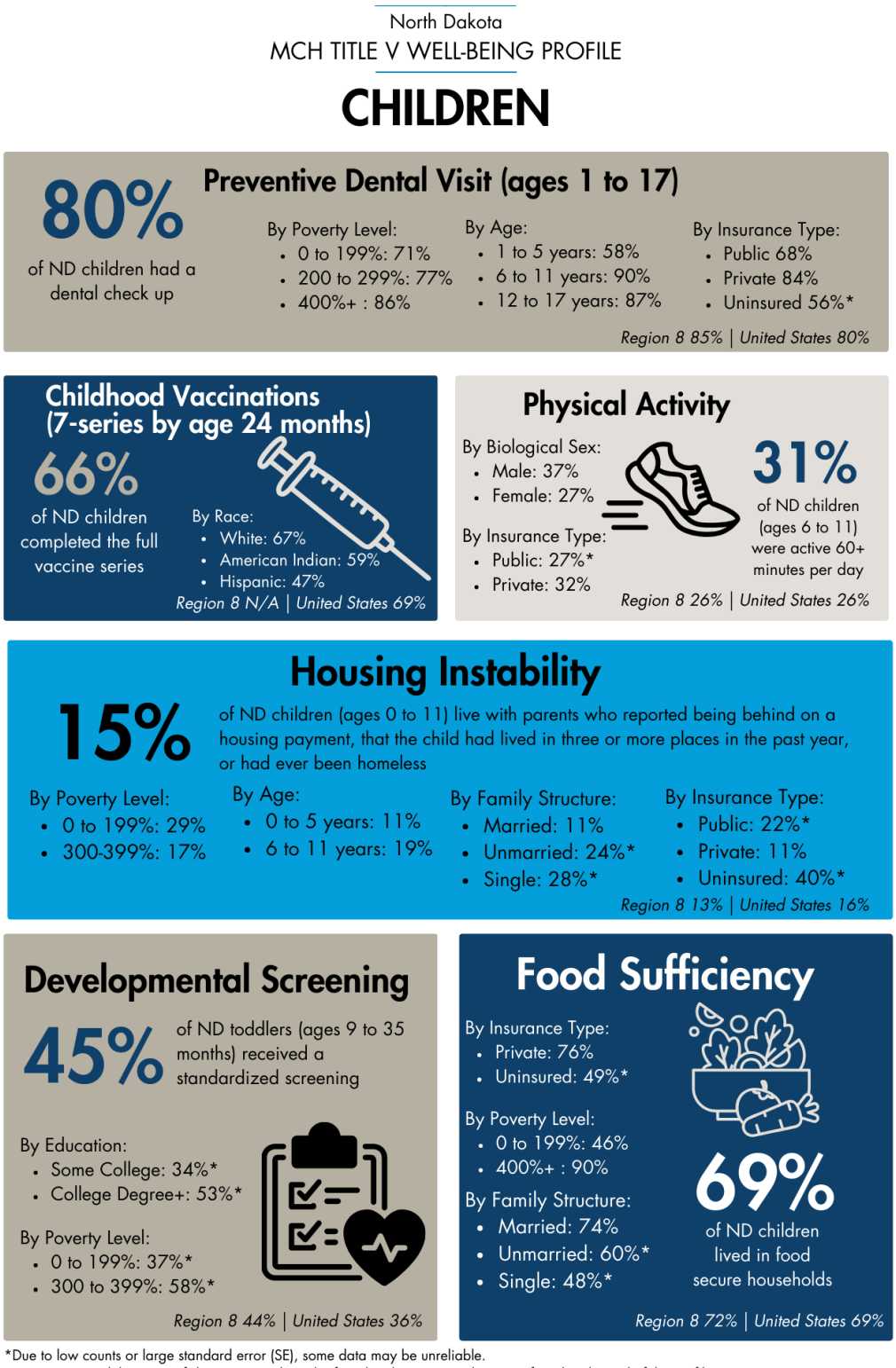
Other perinatal and infant indicators such as breastfeeding and housing instability also varied compared to regional and national averages. Breastfeeding was initiated prior to hospital discharge for 90 percent of North Dakota infants compared to 88 percent nationally and 93 percent regionally. Approximately 1 in 4 (26 percent) North Dakota children are exclusively breastfed until age 6 months, compared to 29 percent nationally and 31 percent regionally. Housing instability in North Dakota is comparable to regional and national averages. Fifteen percent of children ages 0 through 11 live with parents who reported they are behind on housing payments, have lived in three or more places in the past year, or that they have ever been homeless in North Dakota compared to 13 percent regionally 16 percent nationally.

When North Dakota perinatal and infant health indicators were compared to regional and national averages, for most indicators, behaviors were generally similar, varying plus or minus one to three percentage points, with two exceptions. The prevalence of infants only placed on their back to sleep was greater in North Dakota than nationally, 89 percent compared to 83 percent respectively. Room sharing was less prevalent in North Dakota, 72 percent compared to 82 percent nationally.

Children's Health

The NPMs used to track children's health outcomes are childhood vaccination, developmental screening, food sufficiency, housing instability, preventive dental visit, and physical activity. The North Dakota Well-Being Profile for children's health provides a snapshot of health and well-being among North Dakota's children ages 12 and younger (Figure 6). Detailed performance measure analysis for children's health measures can be found in Appendix D.

Figure 6. North Dakota Children's Well-Being Profile



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Data sources and the years of data presented can be found in the resource document found at the end of the profiles.

Health care providers completed standardized developmental screening questionnaires for nearly half of all North Dakota infants (45 percent), ages 9 through 35 months, which is higher than the national average of 36 percent, and similar to the regional average of 44 percent (Figure 6). The developmental screening rate has been increasing over the past 4 years. Thirty-one percent of married parents reported their child completed a developmental screening in 2019-20, a rate which increased to 47 percent in 2022-23 (Appendix D).

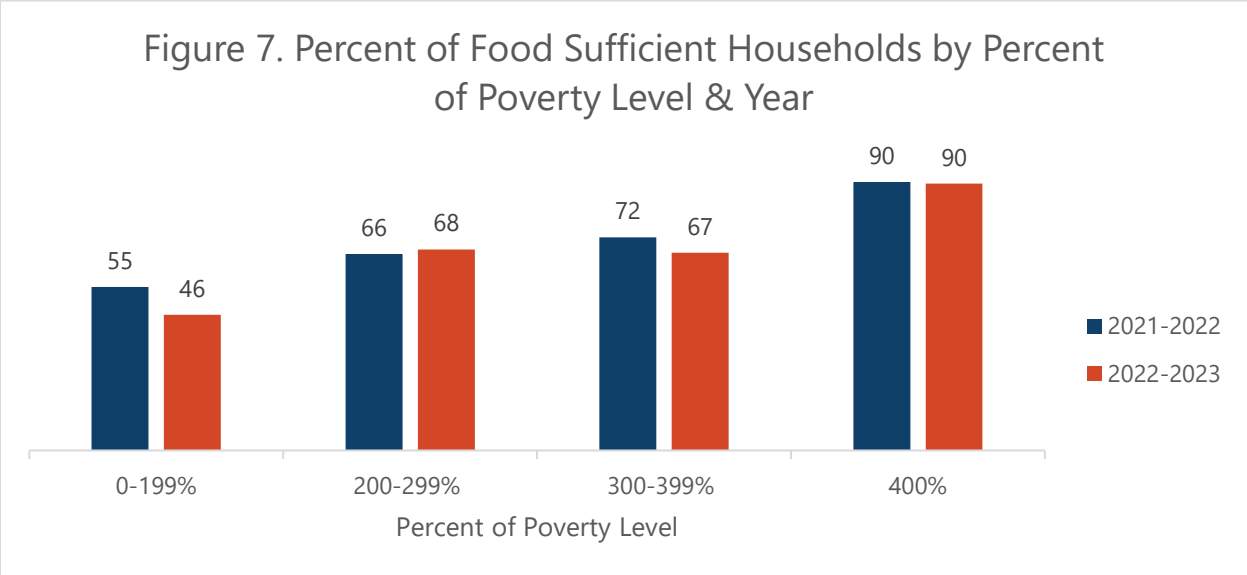
Nearly 66 percent of North Dakota children completed the combined 7-vaccine series by age 24 months in 2024. Hispanic children had the lowest prevalence of vaccine completion (47 percent) followed by Pacific Islanders (52 percent) and Black children (55 percent). The highest prevalence of vaccine completion before 24 months was among White children (67 percent) and Other or Multiple Races (68 percent) (Appendix D).

The prevalence of preventive dental visits among children in North Dakota was the same as nationally, 80 percent, but slightly lower than regionally, 85 percent. Preventive dental visits were reported more often for children ages 6 and older. Ninety percent of children ages 6 through 11 and 87 percent of children ages 12 through 17, saw a dentist for preventative care in the past year compared to 58 percent of children ages 1 through 5. From 2019-20 to 2022-23 the rate of children's dental visits increased across age, education level, poverty level, and insurance type (Appendix D).

Metrics that inform housing instability among children in North Dakota were similar to regional and national averages. Fifteen percent of children ages 0 through 11 live with parents who reported they are behind on housing payments, have lived in three or more places in the past year, or that they have ever been homeless. The prevalence of housing instability in North Dakota is similar to the national average of 16 percent and slightly higher than the regional average of 13 percent.

Reported food sufficiency among children is the same in North Dakota as nationally, 69 percent, but slightly less the regional average, 72 percent. Fewer married parents reported to have always been able to afford to eat good nutritious food compared to the previous two-year estimate, 77 percent in 2021-22 compared to 74 percent in 2022-23. Food sufficiency is lower for households under the poverty level and higher for children with married parents as compared to unmarried or single parents, and for those with health insurance as comparted to those uninsured (Appendix D).

Children in North Dakota are more likely to be physically active at least 60 minutes per day than the regional or United States average. Approximately one-third of North Dakota children, ages 6 through 11, are physically active at least 60 minutes per day compared to 26 percent regionally and nationally.



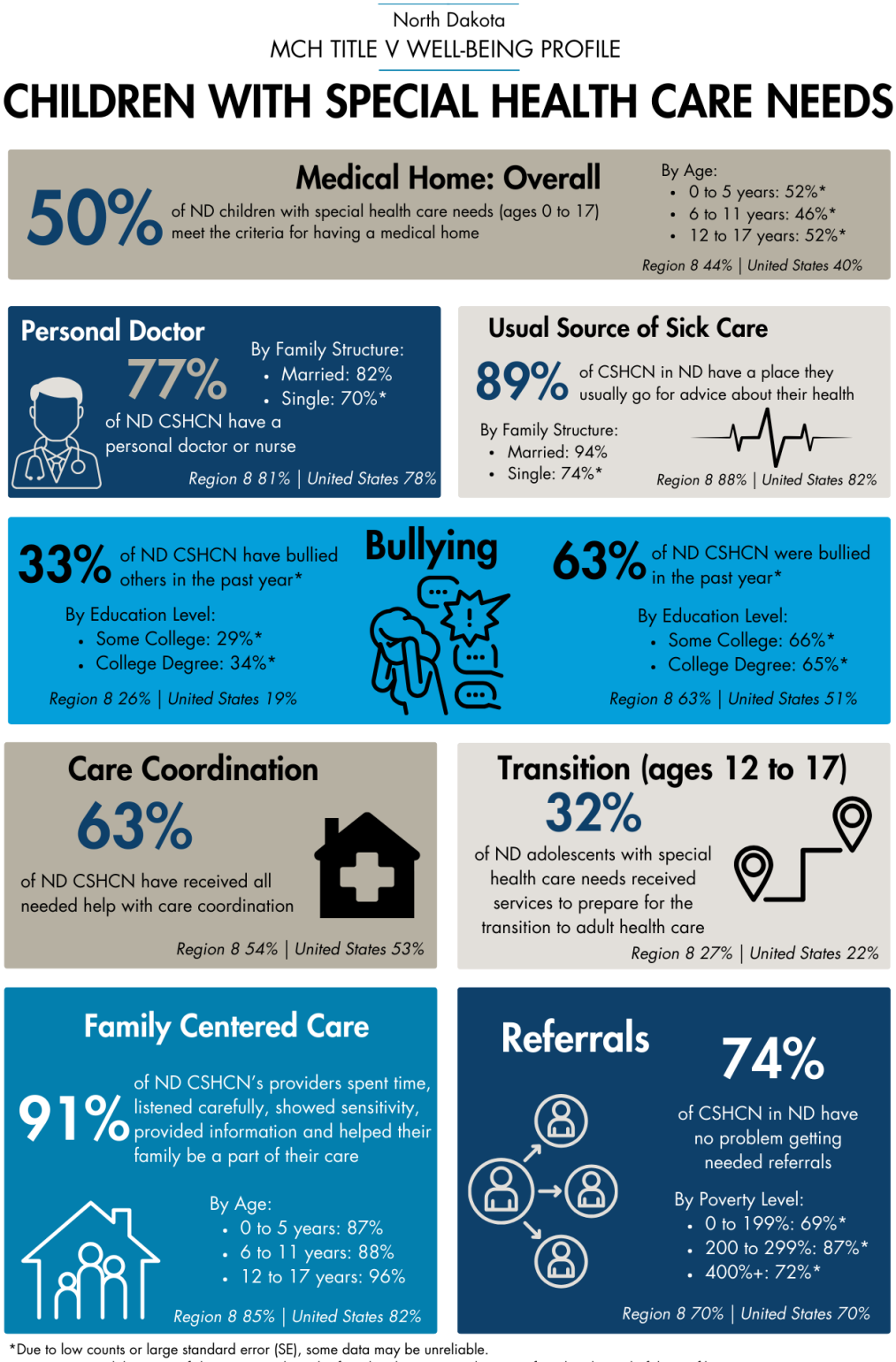
Three quarters (75 percent) of North Dakota children ages 0 through 17 with and without special health care needs were reported by a parent to have received all needed help with care coordination, compared to the United States average of 67 percent (Appendix D).

When North Dakota indicators for children were compared to regional and national averages, the prevalence of developmental screenings was comparable to the regional average and higher than the national average, while preventive dental visits among children was the same as the national average but lower than the regional. Food sufficiency and housing instability in North Dakota were also similar to regional and national averages. However, the prevalence of children ages 6 through 11 who are physically active 60 minutes or more per day was higher in North Dakota than regionally or nationally.

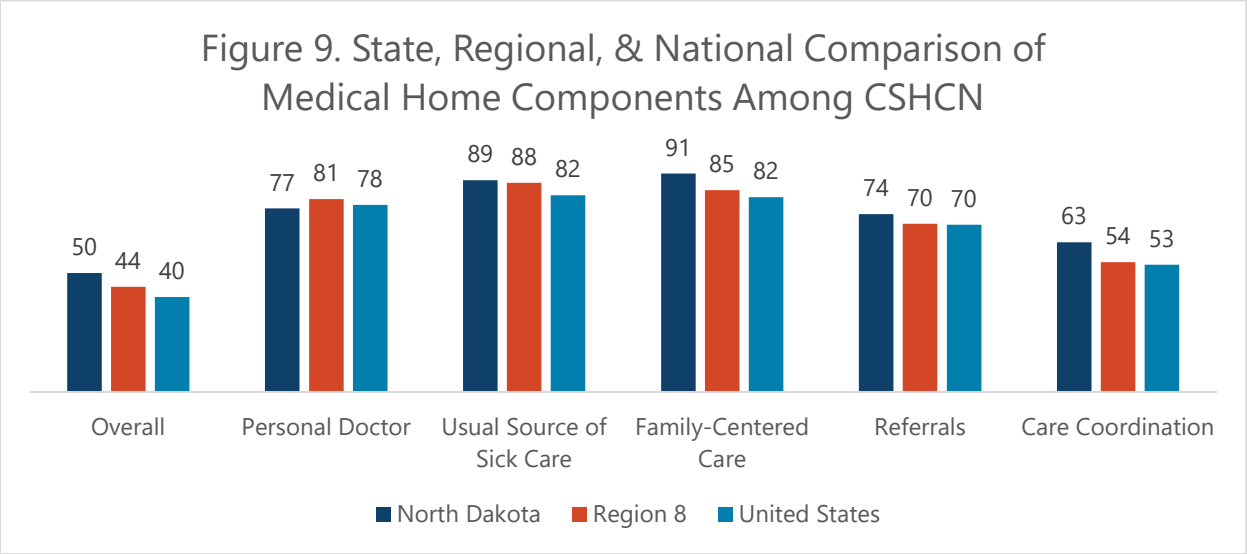
Children with Special Health Care Needs' (CSHCN) Health

The NPMs used to track CSHCNs' health outcomes are bullying, health care transition, medical home overall, care coordination, family-centered care, personal doctor, referrals, and usual source of sick care. The North Dakota Well-Being Profile for CSHCN provides a snapshot of health and well-being among North Dakota's CSHCN ages 0 through 17 (Figure 8). Detailed performance measure analysis for children with special health care needs measures can be found in Appendix D.

Figure 8. North Dakota Children with Special Health Care Needs' Well-Being Profile



A comparison of NPMs for CSHCN suggests for most indicators, North Dakota is performing similarly or better than regionally or nationally. Indicators related to access to care and care coordination are generally better than national averages, however, the prevalence of both bullying others and being the victim of bullying, among CSHCN, is higher in North Dakota than both regionally and nationally.



Half of North Dakota CSHCN, ages 0 through 17, were reported by a parent to meet the criteria for having a medical home (Figure 9), compared to 44 percent regionally and 40 percent nationally. Further, 89 percent of CSHCN have a place they usually go for health care advice, compared to 88 percent regionally and 82 percent nationally. While only approximately one-third of ND adolescents, ages 12 through 17, with special health care needs received services to prepare for the transition to adult health care (Figure 8), North Dakota performs slightly better in transitional service than regionally (27 percent) and substantially better than nationally (22 percent). A vast majority (91 percent) of CSHCN were reported by a parent to have received family-centered care, which is better than both regionally (85 percent) and nationally (82 percent) — and nearly 75 percent had no problem getting needed referrals, which is slightly better than regionally and nationally (70 percent). The prevalence of adequate care coordination was also higher in North Dakota (63 percent) compared to regional and national averages, 54 and 53 percent, respectively. The prevalence of CSHCN that have a personal doctor or nurse (77 percent) is slightly less than regionally (81 percent) and approximately the same as nationally (78 percent).

However, the prevalence of CSHCN that have bullied others and who have been bullied is higher in North Dakota than nationally for both indicators. Over 63* percent of ND adolescents, ages 12 through 17, with special health care needs are reported by a parent to have been bullied in

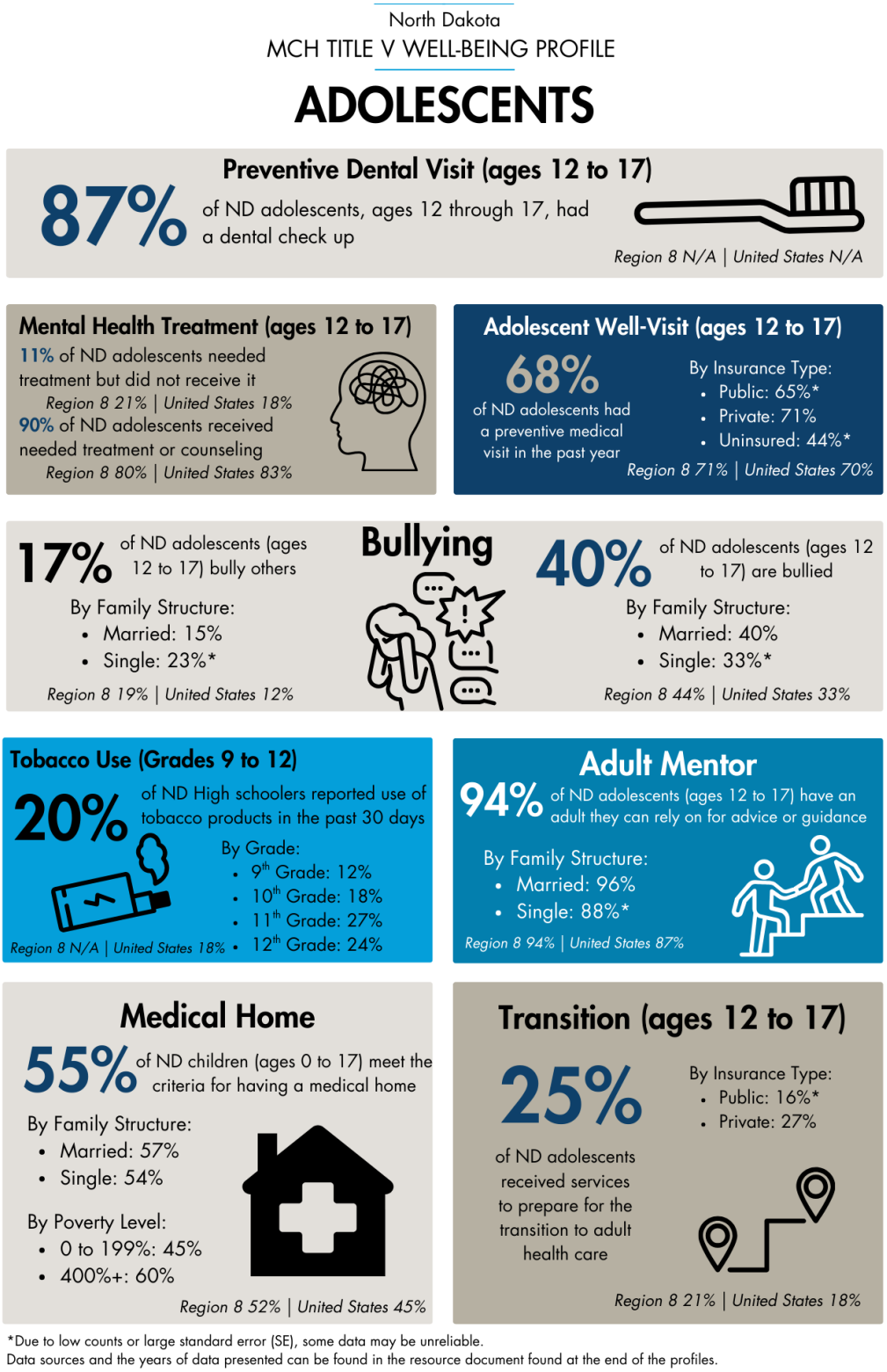
the past year compared to 51 percent nationally. Nearly 33* percent of CSHCN in North Dakota bullied others in the past year compared to 19 percent nationally. However, caution should be used when interpreting metrics related to bullying due to reliability and large margins of error (*).

Adolescent Health

The NPMs used to track adolescent health outcomes are adult mentor, adolescent well-visit, bullying, health care transition, medical home, mental health treatment, preventive dental visit, and tobacco use. The North Dakota Well-Being Profile for adolescent health provides a snapshot of health and well-being among North Dakota's teenagers, ages 12 through 17 (Figure 10). Detailed performance measure analysis for adolescent health measures can be found in Appendix D.

When examining adolescent indicators related to access to and delivery of health services (dental care, mental health care, well-visit, and medical home), North Dakota performance measures were generally slightly better than regionally or nationally with the exception of adolescent well-visits, where North Dakota averages were slightly lower than regionally and nationally. Preventive dental visits among ND adolescents was the same as nationally but slightly lower than regionally. The prevalence of bullying or being bullied in North Dakota was slightly higher than regionally, but lower than nationally, as was the prevalence of teen tobacco use.

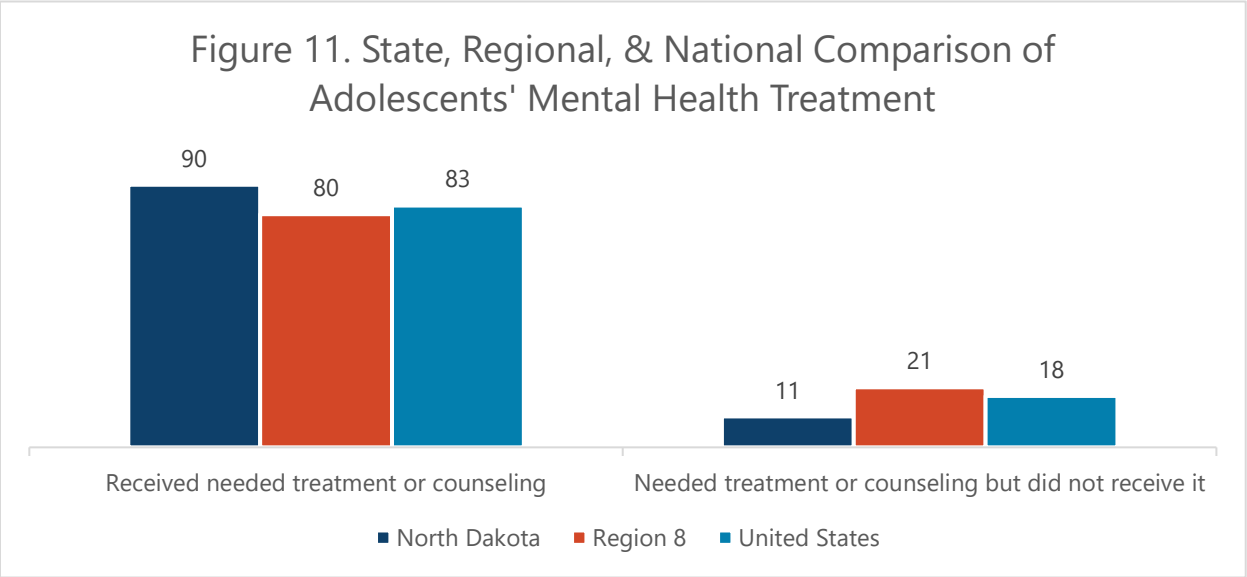
Figure 10. North Dakota Adolescents' Well-Being Profile



*Due to low counts or large standard error (SE), some data may be unreliable.
Data sources and the years of data presented can be found in the resource document found at the end of the profiles.

Nearly 68 percent of North Dakota adolescents, age 12 through 17, had a wellness visit with a health care provider in the past year, which is slightly lower than regionally (71 percent), and nationally (70 percent). Eighty-seven percent of children ages 12 through 17 had a visit to a dentist, which is higher than the national and regional average of all children ages 1 through 17 who had a visit to the dentist (80 percent and 85 percent, respectively). A slight increase in the rate of dental visits can be seen from 2019-20 to 2022-23 across age, education level, poverty level, and insurance type. For example, 77 percent of children with two parents, currently married, had a preventive dental visit in 2019-20, a rate which increased to 83 percent of North Dakota children with married parents going to the dentist in 2022-23 (Appendix D).

The prevalence of access to mental health care and adolescents with a medical home was greater in North Dakota than regionally or nationally. Ninety percent of North Dakota adolescents that needed mental health care received treatment (Figure 11) compared to 80 percent regionally and 83 percent nationally. Fifty-five percent of children ages 0 through 17 meet the criteria for having a medical home in North Dakota, which is slightly greater than regionally (52 percent) and somewhat higher than nationally (45 percent). The percentage of North Dakota teens who received services to prepare for the transition to adult health care was 25 percent, which is higher than the regional and national average (21 percent and 18 percent, respectively).



Overall, tobacco use among high school students, grades 9th through 12th, in North Dakota has been trending downward over the past few years. In 2017, 27 percent of high school students used tobacco products, a rate which increased to 35 percent in 2019 before dropping substantially to 20 percent in 2023. Tobacco use among North Dakota high schoolers was slightly higher than the national average, 20 percent in North Dakota compared to 18 percent in the United States.

The majority of adolescents, ages 12 through 17, have at least one other adult in their school, neighborhood, or community who knows them well and who they can rely on for advice or guidance. In 2022-23, 94 percent of both North Dakota and Region 8 adolescents had an adult mentor compared to 87 percent nationally.

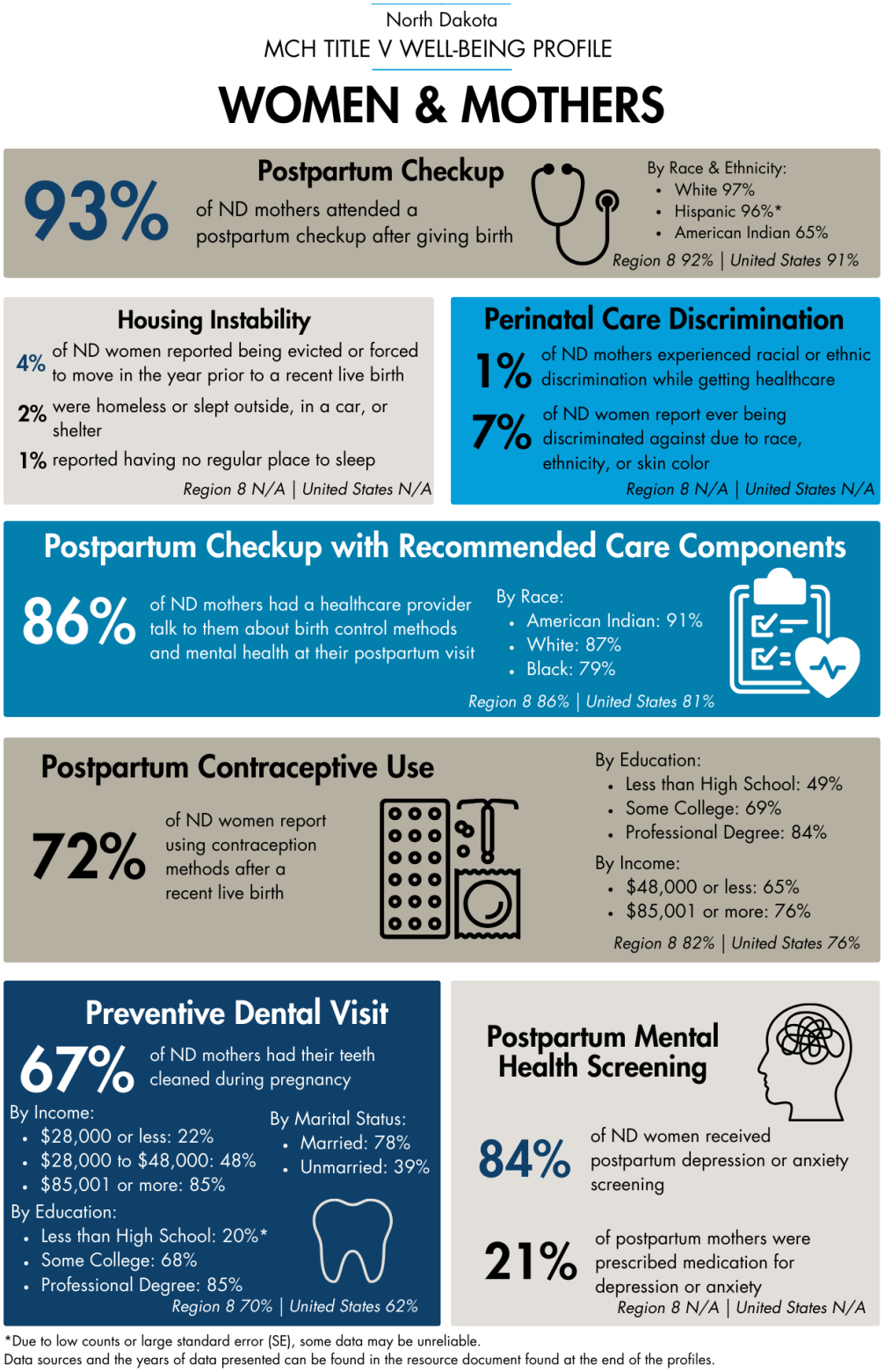
The prevalence of both North Dakota adolescents that bullied or were bullied was slightly higher than regionally and slightly lower than nationally. Seventeen percent of North Dakota adolescents have bullied others in the past year compared to 19 percent regionally and 12 percent nationally, while almost 40 percent of North Dakota teens were a victim of bullying compared to 44 percent regionally and 33 percent nationally (2022-23).

Women and Maternal Health

The NPMs used to track women and mothers' health outcomes are housing instability, perinatal care discrimination, postpartum contraceptive use, postpartum mental health screening, postpartum visit, and preventive dental visit. The North Dakota Well-Being Profile for women and maternal health provides a snapshot of health and well-being among North Dakota's women and mothers (Figure 12). Detailed performance measure analysis for women and maternal health measures can be found in Appendix D.

North Dakota indicators related to postpartum check-up and recommended care were generally similar to regional averages and somewhat higher than national averages. Prevalence of preventive dental visits for women during pregnancy in North Dakota was slightly lower than regionally but higher than nationally. Contraceptive use among North Dakota mothers was lower than the regional and national average.

Figure 12. North Dakota Women and Mothers' Well-Being Profile



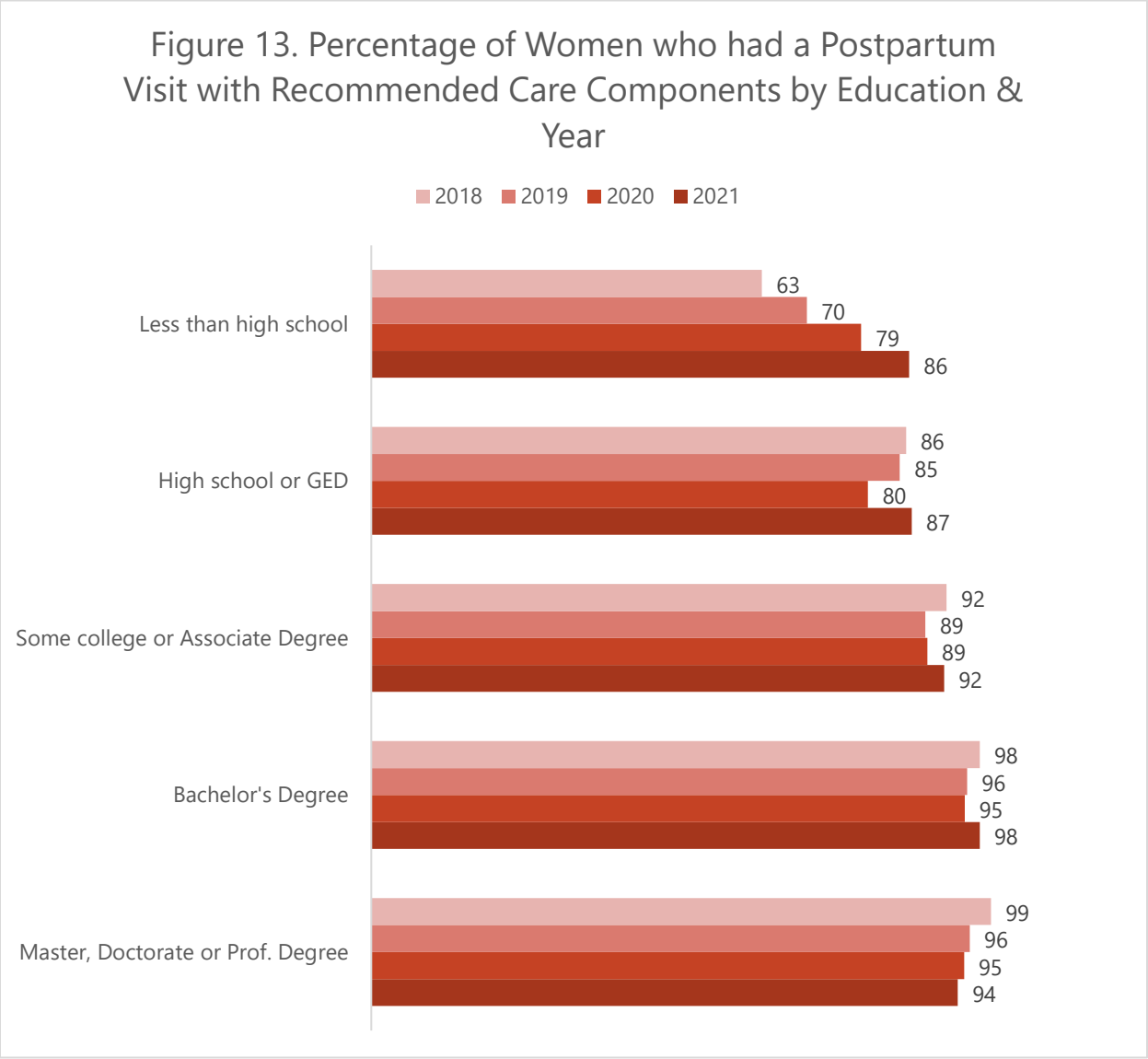
*Due to low counts or large standard error (SE), some data may be unreliable.
Data sources and the years of data presented can be found in the resource document found at the end of the profiles.

Approximately 93 percent of North Dakota mothers reported having a postpartum checkup within 12 weeks after giving birth, which is similar to regional and national averages of 92 percent and 91 percent, respectively. However, postpartum visit attendance varied substantially by race and ethnicity. While 97 percent of White mothers reported a postpartum visit, only 65 percent of American Indian mothers reported a postpartum visit. Fewer American Indian or Alaska Native mothers reported postpartum visit attendance over the years, declining from 70 percent in 2018 to 65 percent in 2022 (Appendix D).

The prevalence of a postpartum checkup in North Dakota was consistent with the regional average and slightly higher than the national average. While 93 percent of North Dakota mothers reported attending a postpartum checkup within 12 weeks after giving birth, only 86 percent reported that a health care provider talked to them about birth control and mental health, the same as regionally (86 percent) and slightly higher than nationally (81 percent). However, the prevalence of postpartum contraception use was lower in North Dakota (72 percent) than both regionally (82 percent) and nationally (76 percent). Postpartum checkup attendance and use of contraceptives was positively correlated to higher levels of educational attainment (Figure 13) and age (Appendix D). Eighty-four percent of North Dakota women received postpartum mental health screening and 21 percent were prescribed medication for depression or anxiety.

The prevalence of preventive dental visits during pregnancy in North Dakota (67 percent) was slightly less than regionally (70 percent) and slightly higher than nationally (62 percent) The prevalence of preventative dental visits was strongly correlated with educational attainment, income, and marital status. Only 43 percent of mothers with a high school diploma or GED had their teeth cleaned during pregnancy compared to 85 percent of women with a professional degree. Similarly, only 22 percent of mothers with a household income less than $28,000 had their teeth cleaned compared to 85 percent of mothers with a household income over $85,000. Married women were more likely to have their teeth cleaned during pregnancy than unmarried women (78 percent and 39 percent, respectively).

Most North Dakota mothers did not report housing instability or discrimination, however, four percent of North Dakota mothers reported being evicted or forced to move in the year prior to a recent live birth; two percent were homeless, slept outside, in a car or shelter; and one percent reported not having a regular place to sleep. Seven percent of North Dakota mothers reported being discriminated against based on their race, ethnicity, or skin color.



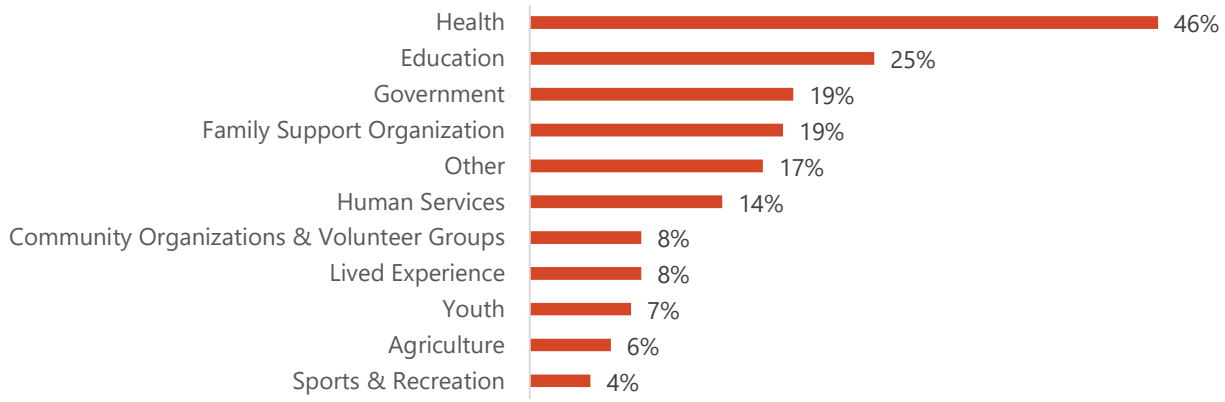
Stakeholder Survey

The 2025 North Dakota Title V MCH Survey to Stakeholders was sent to 198 stakeholders in January 2025. The purpose of the survey was to get stakeholder input and assistance in determining the MCH priority needs for the next five years, for North Dakota's Title V Maternal and Child Health Services Block Grant. In addition to soliciting input on priority measures within each of the MCH population domains, the survey was designed to solicit more input to identify unmet needs and other unique issues that may not be addressed by the defined performance measures within each MCH domain. The following sections highlight key findings from the stakeholder survey. Detailed findings from the stakeholder survey can be found in Appendix C.

Respondent Characteristics

Respondents represented a cross section of employment sectors across the state with most respondents from the health services sector (46 percent) or education sector (25 percent, Figure 14); half worked in the public sector and 37 percent in non-profit organizations (Appendix C). Most respondents described their role in their organization as public health care providers (41 percent) and another 13 percent were private health care providers. Respondents worked and provided services across all MCH population domains reaching residents across all of North Dakota (Figure 2).

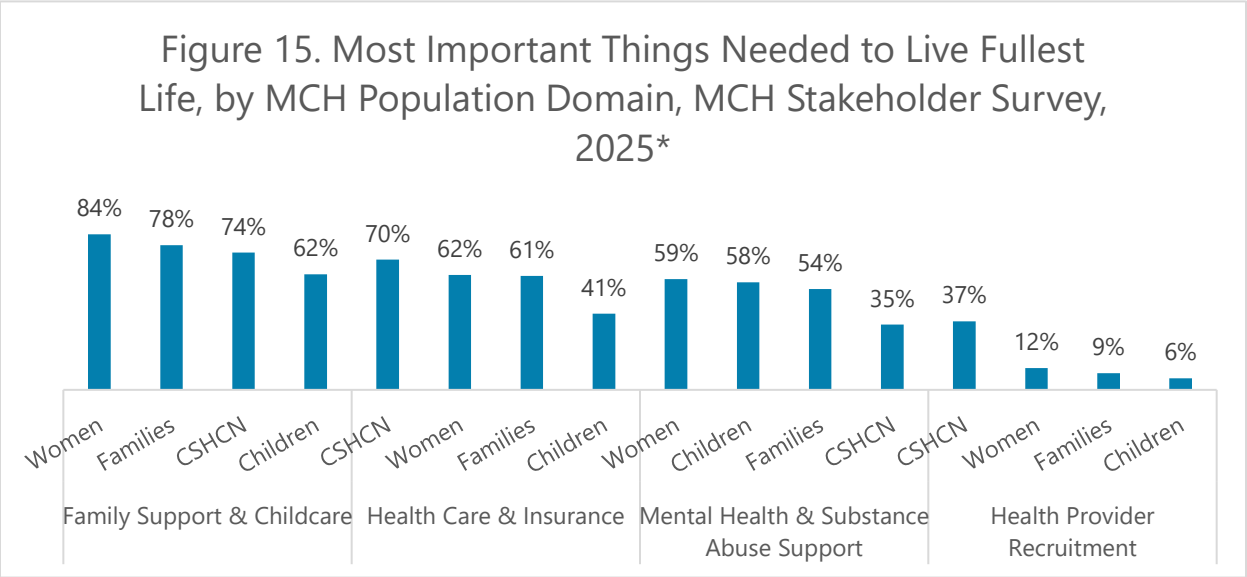
Figure 14. Stakeholder Work by Category, MCH Stakeholder Survey, 2025 (N=134)



Most Important Things Needed to Live Fullest Lives

Stakeholders were asked to rank the top three things people need to live their fullest lives among various groups that align closely with MCH domain populations: women and mothers, children, children with special health care needs, and families. Stakeholders were asked to rank the top three things needed from a list of broad-based public health considerations (Figure 15). Across each of the domain categories, stakeholders consistently identified the same needs. Of the factors listed, 'family support and child care' was ranked as the most important thing needed across all domains; 62 to 84 percent of respondents ranked 'family support and child care' as one of the top three needs. The only identified need that was slightly different based on the population domain was a need identified for children with special health care needs (CSHCN). Respondents identified 'health care provider recruitment' as one of the top three

needs for CSHCN. With the exception of CSHCN, it is striking how respondents identified the same top three needs regardless of population domain category.



*N varies by population. Women (N=170), Children (N=161), CSHCN (N=160), Families (N=157)

Respondents were also asked to list any additional important things that women and mothers, children, children with special health care needs, and families need to live their fullest lives in North Dakota in the form of an open-ended question. Eight themes emerged from this open-ended question. Paid family leave and workforce support (employer-provided child care, workforce development and job opportunities) was the most frequent response. See Appendix C for detailed responses to open-ended survey questions.

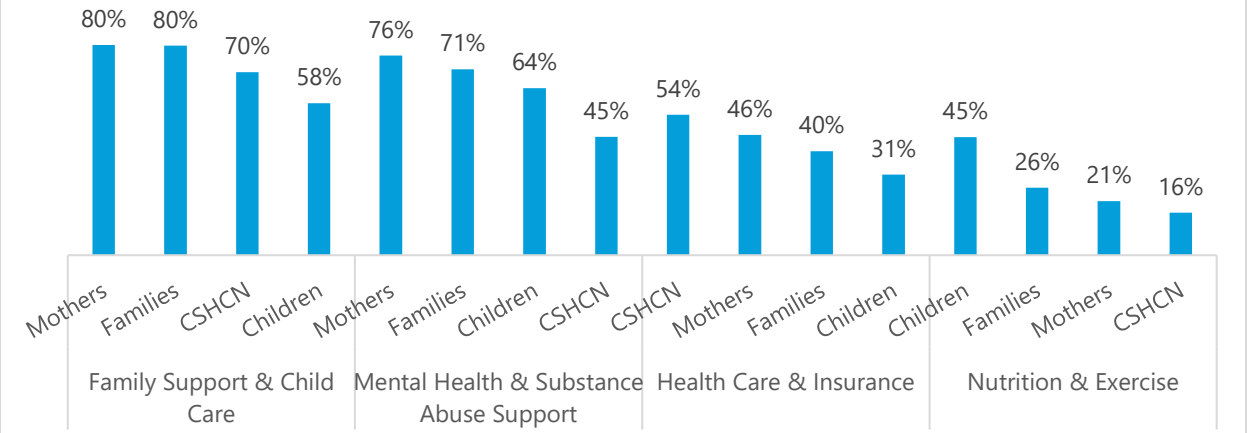
1. Paid Family Leave and Workforce Support
2. Access to Health Care
3. Ease of Obtaining and Using Services
4. Education and Child Development
5. Basic and Comprehensive Needs
6. Mental Health and Community Support
7. Systemic and Policy-Related Issues
8. Information and Resource Accessibility

Top Three Biggest Unmet Needs

Stakeholders were asked to identify the top three unmet needs among various groups that align closely with the MCH population domains: women and mothers, families, children, and CSHCN. The unmet needs identified by stakeholders again was consistent across domain categories (Figure 16). Family support and child care, mental health and substance abuse support, and health care and insurance were identified as unmet needs across all population groups and were

ranked as one of the top three needs in all domain categories except children. Respondents most frequently cited mental health and substance abuse support as the top unmet need for children. Family support and child care was ranked highest across the remaining three domains with 70 to 80 percent of respondents that ranked family support and child care as the number one unmet need. Stakeholders also identified nutrition and exercise among the top three unmet needs for the child population domain.

Figure 16. Top Unmet Needs, by MCH Population Domain, MCH Stakeholder Survey, 2025*



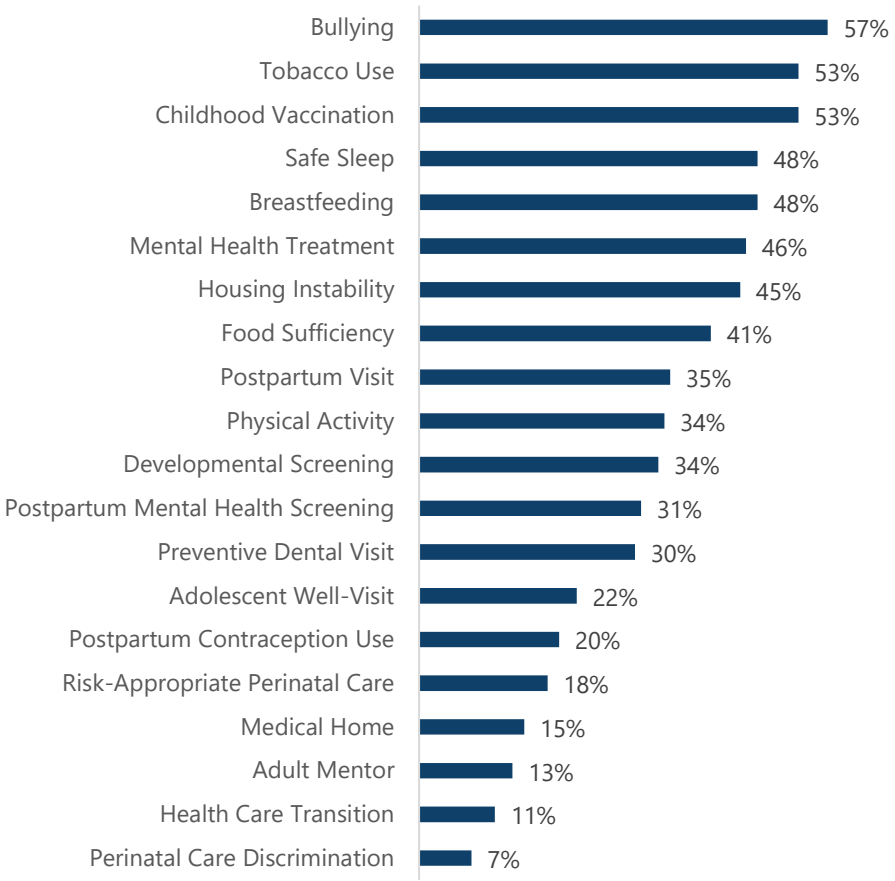
*N varies by population. Women (N=146), Children (N=140), CSHCN (N=142), Families (N=144)

Survey respondents were also asked to list any other important measures and unmet needs of North Dakota's maternal and child health population through an open-ended question. Stakeholders most frequently identified access to health and wellness resources, especially in rural communities, as an important need across populations. Several key themes emerged from the responses. See Appendix C for all stakeholder responses.

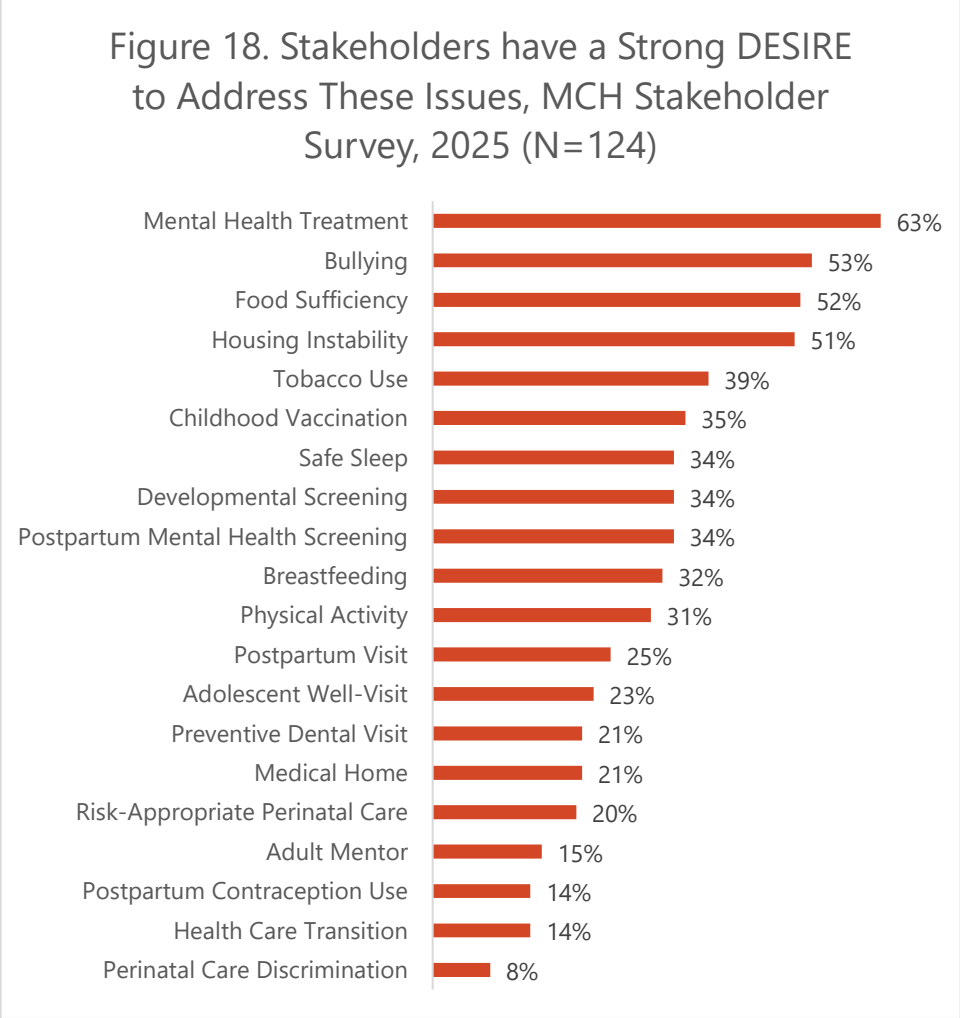
1. Access to Health and Wellness Resources
2. Community and Social Support
3. Education and Awareness
4. Systemic and Policy-Related Challenges
5. Health and Well-Being

For each of the performance measures within each MCH domain, stakeholders were asked to gauge their awareness of, the desire to address, and progress made associated with each of the national performance measures. Stakeholders had the most awareness of needs related to bullying (57 percent), tobacco use among adolescents (53 percent), childhood vaccinations (53 percent), safe sleep practices (48 percent), and breastfeeding (48 percent) (Figure 17). Stakeholders indicated the least amount of awareness of the need to address issues related to adult mentors (13 percent), health care transition (11 percent), and perinatal care discrimination (7 percent).

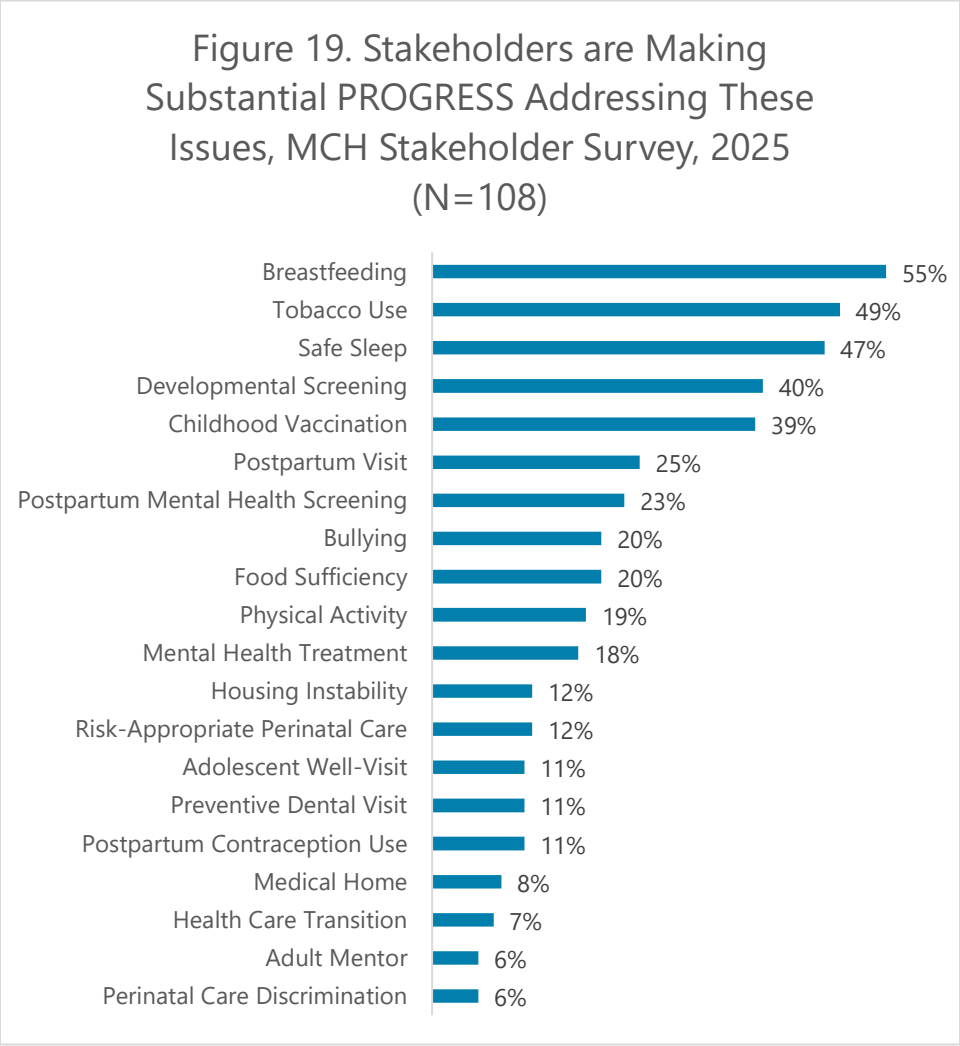
Figure 17. Stakeholders are AWARE of the Need to Address These Issues, MCH Stakeholder Survey, 2025 (N=122)



Stakeholders most frequently indicated the desire to address mental health treatment among adolescents (63 percent), bullying (53 percent), food sufficiency (52 percent), and housing instability (51 percent) (Figure 18). North Dakota stakeholders indicated the least desire to address issues related to postpartum contraception use (14 percent), health care transition (14 percent), and perinatal care discrimination (8 percent).



Stakeholders indicated that substantial progress has been made addressing breastfeeding (55 percent), tobacco use among adolescents (49 percent), safe sleep practices (47 percent), developmental screening (40 percent), and childhood vaccinations (39 percent) (Figure 19). Stakeholders in North Dakota indicated the least amount of progress has been made addressing issues related to health care transition (7 percent), adult mentors (6 percent), and perinatal care discrimination (6 percent).



Stakeholders tended to rank performance measures consistently across their awareness of the issue, desire to address issues, and progress being made towards measures. For example, tobacco use, childhood vaccination, and safe sleep practices were all ranked high for each awareness, desire, and progress. Perinatal care discrimination, health care transition, and adult mentor were all ranked low in terms of stakeholders' awareness, desire, and progress being made towards addressing issues. Some measures had more variability. Bullying is seen as an important and well-recognized issue among stakeholders, with both awareness and desire to address it ranking relatively high. However, the low percentage (20 percent) reporting progress

may suggest a gap between concern and effective action or visible results. Breastfeeding shows a somewhat opposite trend, although fewer stakeholders see it as a pressing issue (moderate awareness and relatively low desire to address it), it is perceived as an area where strong progress is being made.

Identified Priority Measures

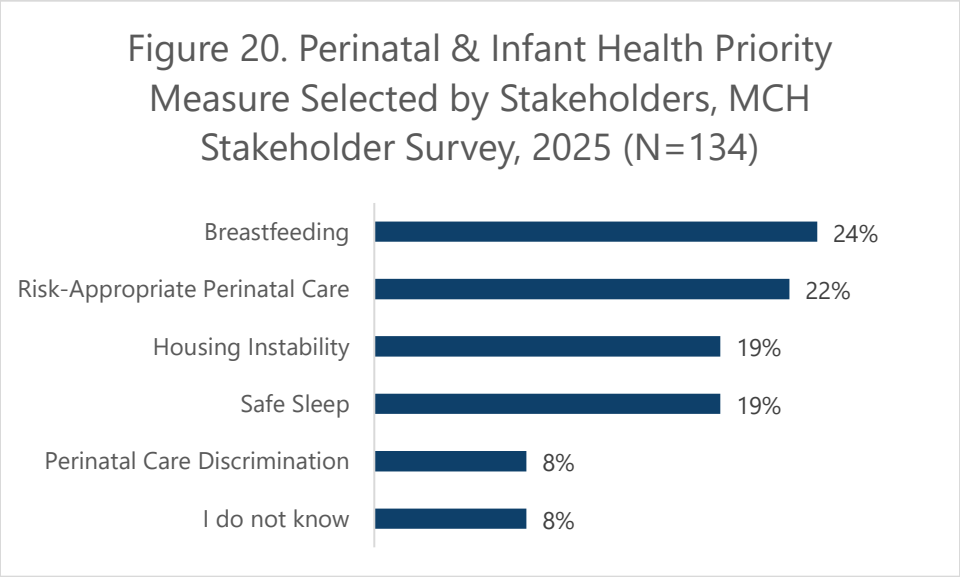
The following were identified as North Dakota's priority measures for each of the MCH population domains. National performance measures for priority needs are detailed in Figure 25.

Perinatal and Infant Health

During the previous reporting period, the primary priority identified within the perinatal and infant health domain focused on increasing the percentage of infants who were breastfed – particularly those exclusively breastfed through six months. While breastfeeding remains an important indicator of infant well-being, a comprehensive reassessment was undertaken that took into account stakeholder survey analysis, population well-being profiles, performance measure analysis, and organizational capacity. Based on this multi-faceted review, HHS leadership selected safe sleep as the new domain priority measure for the 2025-2030 cycle.

Although 24 percent of stakeholders cited breastfeeding as the top priority for perinatal and infant health (Figure 20), other critical needs emerged at comparable rates: risk-appropriate perinatal care, safe sleep, and housing instability each received about 20 percent of responses. Importantly, while breastfeeding indicators remain below regional and national averages – with 26 percent of North Dakota children exclusively breastfed compared to 31 percent regionally and 29 percent nationally – safe sleep reflects an area where variations are more tightly linked to preventable mortality, particularly among sensitive populations.

Safe sleep performance metrics show that North Dakota is making progress in certain areas (e.g., slightly higher percentages of infants placed on their backs and sleeping alone) but continues to underperform in others. For example, fewer mothers reported that their infant sleeps in the same room – one of the most effective risk-reduction strategies – compared to both regional and national benchmarks. Choosing safe sleep as the domain priority reflects an urgent and actionable opportunity to address one of the state's most preventable contributors to infant death.

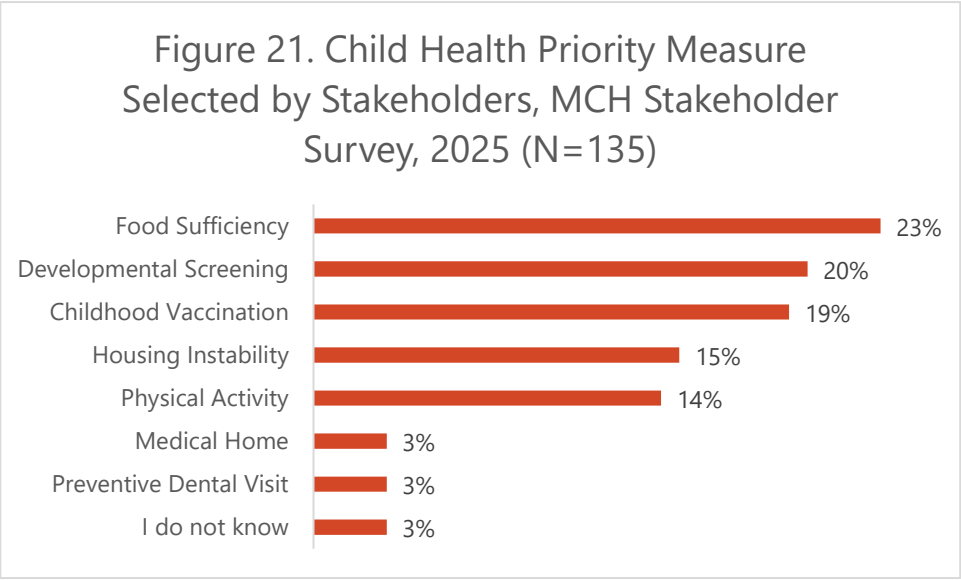


Children's Health

During the previous reporting period, the primary priority identified within the child health domain focused on increasing the percentage of children who were physically active in North Dakota. While physical activity remains an important indicator of child well-being, a comprehensive reassessment was undertaken that took into account stakeholder survey analysis, population well-being profiles, performance measure analysis, and organizational capacity. Based on this multi-faceted review, HHS leadership selected food sufficiency and medical home care coordination as North Dakota's new child health priority measures for the 2025-2030 cycle.

Survey respondents most frequently identified food sufficiency as the top priority within the child health domain (Figure 21). Twenty-three percent of respondents indicated food security should be the top priority within the child health domain. While the percentage of North Dakota households with children 11 and younger that were food sufficient was the same as nationally (69 percent), food sufficiency in North Dakota (69 percent) was less than the regional average (72 percent).

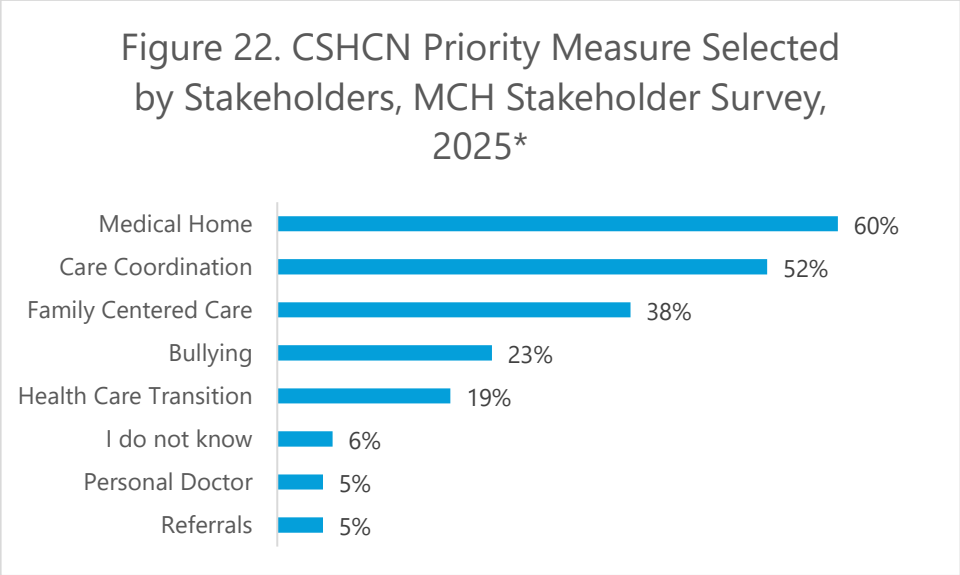
While only 3 percent of survey respondents indicated medical home should be the top priority within the child health domain, care coordination, a component of medical home was selected as a priority measure for North Dakota children to ensure all children are receiving necessary care for optimal health and well-being. Medical home is a mandatory priority measure and the care coordination subcomponent aligns with current work initiatives within North Dakota's child health domain. Three-quarters (75 percent) of North Dakota children are reported by a parent to have received all needed help with care coordination, which is higher than the regional and national average of 67 percent.



Children with Special Health Care Needs Health

During the previous reporting period, the primary priority identified within the CSHCN domain focused on adolescents with and without special health care needs who have received the services necessary to make the transition to adult health care. While health care transition remains an important indicator of well-being among children with special health care needs, a comprehensive reassessment was undertaken that took into account stakeholder survey analysis, population well-being profiles, performance measure analysis, and organizational capacity. Based on this multi-faceted review, HHS leadership selected medical home overall as the new domain priority measure for the 2025-2030 cycle.

A majority of stakeholders indicated medical home should be the next priority measure for CSHCN (Figure 22). Sixty percent of stakeholders indicated medical home should be a priority for children with special health needs. Of stakeholders who selected medical home as the priority measure, respondents most frequently indicated care coordination and family-centered care as the focus within the medical home components. Fifty-two percent of respondents selected care coordination and 38 percent indicated family-centered care. North Dakota compares favorably with regional and national averages for the percentage of children with special health needs that received needed help with care coordination. Sixty-three percent of children with special health needs in North Dakota received needed help with care coordination compared to 54 percent regionally and 53 percent nationally.

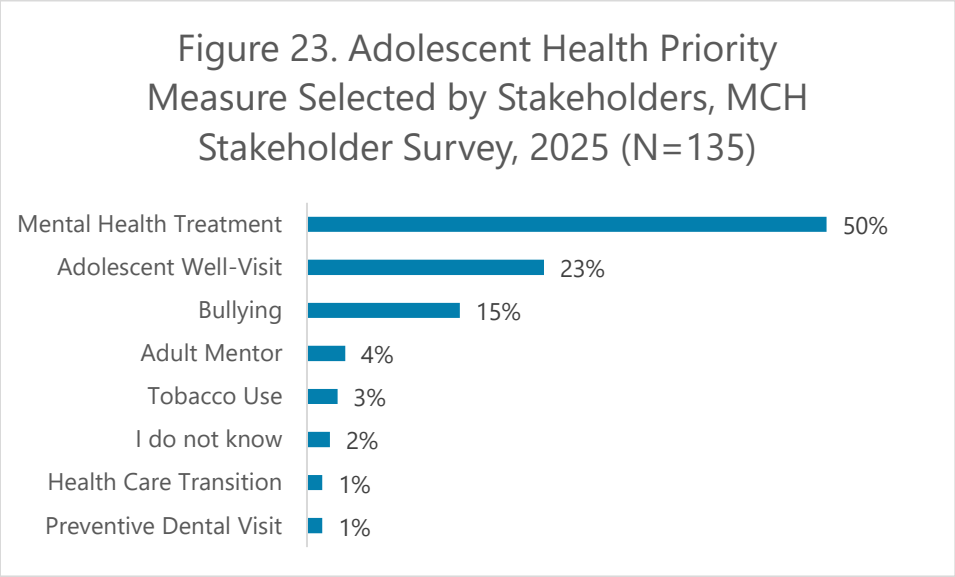


*N varies by response: Medical Home, Bullying, Health Care Transition, & I do not know (N=135); Care Coordination, Family Centered Care, Personal Doctor, & Referrals (N=82).

Adolescent Health

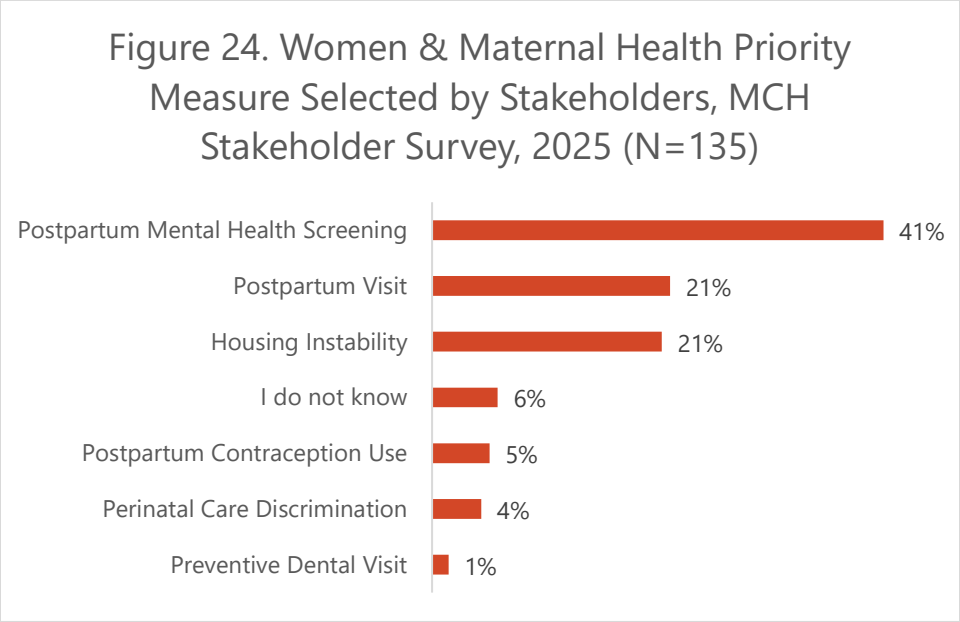
During the previous reporting period, the primary priority identified within the adolescent domain focused on increasing the percentage of adolescents who had a preventive medical visit. While preventive medical visit remains an important indicator of adolescent well-being, a comprehensive reassessment was undertaken that took into account stakeholder survey analysis, population well-being profiles, performance measure analysis, and organization capacity. Based on this multi-faceted review, HHS leadership selected mental health treatment as the new domain priority measure for the 2025-2030 cycle.

While North Dakota compares favorably for the percentage of adolescents that received needed mental health treatment, 50 percent of survey respondents indicated mental health treatment should be the top priority for adolescent health (Figure 23). Ninety percent of ND adolescents received needed treatment or counseling compared to 80 percent regionally and 83 percent nationally. Adolescent well-visits and bullying were the next most frequently cited issues, with 23 and 15 percent of respondents, respectively. The prevalence of adolescent well-visits in North Dakota (68 percent) is slightly less than regionally (71 percent) and nationally (70 percent). The prevalence of adolescents that bully others (17 percent) is slightly less than the regional average (19 percent) but higher than the national average (12 percent). Similarly, the percentage of adolescents that experienced bullying in North Dakota (40 percent) was slightly lower than regionally (44 percent) but higher than nationally (33 percent).



Women and Maternal Health

During the previous reporting period, the primary priority identified within the women and maternal health domain focused on increasing the percentage of women who had an annual preventive visit. While preventive health care visits remain an important indicator of well-being among women and mothers, a comprehensive reassessment was undertaken that took into account stakeholder survey analysis, population well-being profiles, performance measure analysis, and organizational capacity. Based on this multi-faceted review, HHS leadership selected postpartum visit as the new domain priority measure for the 2025-2030 cycle.



The majority of survey respondents indicated postpartum mental health screening should be the priority within in the women and mothers' population domain (Figure 24). Forty-one percent of respondents indicated postpartum mental health screening should be the top priority, while 21 percent selected postpartum visit and 21 percent indicated housing instability should be the top priority. In North Dakota, 84 percent of women received postpartum depression or anxiety screenings, of which 21 percent were prescribed medication for depression or anxiety. The percentage of North Dakota mothers that had a postpartum checkup is similar to regional and national averages. Ninety-three percent of North Dakota mothers had a postpartum checkup compared to 92 percent regionally and 91 percent nationally.

Conclusions

The North Dakota Department of Health and Human Services (HHS) and the North Dakota State University (NDSU) Center for Social Research (CSR) conducted a statewide Needs Assessment of Maternal and Child Health populations across North Dakota (ND) to better understand potential needs and challenges associated with the health and well-being of women and children. The Needs Assessment was used to guide and inform decisions for program planning and development by describing both the strengths and needs of North Dakota MCH populations, prioritizing North Dakota programs and resources, and assessing the resources and assets of North Dakota communities. The final selection of North Dakota's nine priority needs was guided by quantitative and qualitative analysis of the stakeholder survey, national performance measures, and well-being profiles for each MCH Title V population domain. MCH programmatic leaders also considered staff capacity, feasibility, and other potential resource opportunities or constraints in identifying North Dakota's 2025-2030 priority measures (Figure 25). These nine identified priority measures will guide the ND HHS efforts to promote the health and well-being of all mothers and children in North Dakota.

Figure 25. North Dakota 2025–2030 MCH Priorities (10/1/2025 – 9/30/2030)

Performance Measure (NPM OR SPM)	State Priority	MCH Population Domain
NPM: Postpartum Visit A and B A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components	Identify, reduce, or eliminate barriers preventing women from receiving recommended postpartum care components, including but not limited to mental health screening, breastfeeding support, care coordination, etc.	Women
NPM: Safe Sleep A, B, C, and D A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult	Support services, programs, and activities that encourage safe sleep.	Perinatal/Infant
NPM: Food Sufficiency Percent of children, ages 0 through 11, whose households were food sufficient in the past year	Improve accessibility to healthy food options through community resources (schools, food banks, health units, etc.).	Child
NPM: Medical Home – Care Coordination Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination	Improve care coordination to link the MCH population to essential services and resources.	Child
NPM: Mental Health Treatment Percent of adolescents, ages 12 through 17, who receive needed mental health treatment and counseling	Identify, reduce, or eliminate barriers preventing adolescents from receiving mental health treatment and counseling.	Adolescent

NPM: Medical Home – Overall Increase the number of children with special health care needs with a medical home providing comprehensive care	Improve the system of care for children with special health care needs.	Children with Special Health Care Needs (CSHCN)
SPM: Vision Zero State initiative to eliminate fatalities and serious injuries caused by motor vehicle crashes	Reduce serious motor vehicle injuries and fatalities to North Dakotans younger than 21 years of age.	Cross-Cutting
SPM: Implement North Dakota State Mandates Implement ND state mandates for the Maternal Child Health (MCH) population	To implement all North Dakota state mandates delegated to the ND HHS Title V/Maternal and Child Health Programs.	Cross-Cutting
SPM: Improve Access to Health-Related Services Improve access to health-related services to improve health and well-being.	Increase awareness and the utilization of statewide services or resources	Cross-Cutting

Resources

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Appendix A: Study Methods, Well-Being Profiles, & Resource Glossary

North Dakota MCH Title V Well-Being Profiles: Methodology

North Dakota's Title V Maternal and Child Health (MCH) Services Block Grant plan aims to address health service needs and promote the health and well-being of mothers and children, including children with special health care needs (CSHCN) and their families. To support that effort, five Well-Being Profiles were created to present a snapshot of current conditions and put North Dakota in context by comparing to both regional and national conditions. Each profile corresponds to one of the five MCH defined population domains: perinatal and infants, children, children with special health care needs, adolescents, and women and mothers. A total of 20 national performance measures (NPMs) are defined by the MCH Title V Block Grant to gauge trends and outcomes associated with MCH priority areas within each population domain. Performance measures are specific to each population domain with six to nine measures aligning with each of the domains. NPMs are health indicators which are proven to be the most reliable measures to track conditions and measure progress associated with health outcomes such as quality of life, preventable morbidity, and mortality. A resource glossary defining each of these NPMs can be found in the following pages.

Data were compiled from numerous sources and were vetted and approved by the Maternal and Child Health Bureau (MCHB) to define North Dakota's status in relation to each performance measure. Data from North Dakota Pregnancy Risk Assessment Monitoring System (ND PRAMS), was able to provide context for multiple performance measures across nearly every population domain. PRAMS is a population-based surveillance system designed to identify groups of women and infants at high risk for health problems, to monitor changes in health status, and to measure progress towards goals in improving the health of mothers and infants. These data are essential and the best available to describe health and well-being in our state, as it is primary data collected directly from North Dakota mothers. The PRAMS Automated Research File (ARF) was used to collect the same data points for Health Resources and Services Administration (HRSA) Region 8 and nationally to enable comparisons and provide further context of North Dakota's health status in the Midwest and across the United States. HRSA regional offices work to increase the reach, impact, and awareness of local health care services. Region 8 encompasses North Dakota, Colorado, Montana, South Dakota, Utah, and Wyoming. Other data sources used were the Youth Risk Behavior Surveillance System (YRBSS), Federally Available Data (FAD), and the National Survey of Children's Health (NSCH). A full description of each of the data sources can be found in the resource tables. While each data set provides meaningful and insightful data, data are representative of various time periods and time periods are not consistent across all performance measures and demographics. Performance measure analyses are presented from 2021 through 2024. While some data sources provide single year estimates (i.e., 2022, 2023), other sources provide combined two-year estimates (i.e., 2021-2022, 2022-2023). The specific year(s) corresponding to each performance measure are also detailed in the resource pages.

For each MCH population domain profile, the applicable NPMs were summarized in a one-page infographic. Performance measure analysis was conducted for all 20 defined MCH measures. North Dakota estimates were calculated for each measure by various demographics where data were available. Marital status or family structure, educational attainment, age, race and ethnicity, household income, poverty level, and type of health care insurance measures were used for demographic analyses. Key indicators for each performance measure applicable to each population domain were highlighted in population infographics. Metrics are presented for North Dakota and compared to Region 8 and national averages where data were available. Summary data profiles are also color-coded. Measures presented in white or blue indicate a performance measure where North Dakota is performing better than the national average. A data point highlighted in black or grey indicates a performance measure in which North Dakota is performing worse than the United States average. Data that may be unreliable due to low counts or large standard error (SE) are highlighted with an asterisk (*). The Title V MCH Block Grant identifies six to nine performance measures for each population domain, with some measures duplicated in multiple population profiles (for example, bullying is an indicator for both the adolescents and CSHCN domains). A resource document defining the performance measures, the years of data presented, and their data sources can be found following the profiles.

North Dakota

MCH TITLE V WELL-BEING PROFILE

PERINATAL AND INFANTS

Risk-Appropriate Perinatal Care

82% of ND's very low birth weight infants were born in a hospital with a Level III+ NICU

18% of ND infants born weighing less than 1500 grams were transferred to a NICU after birth*

Region 8 N/A | United States N/A

Initiation of Breastfeeding

89% of ND infants were breastfed before hospital discharge

By Race or Ethnicity:
- American Indian: 69%
- White: 90%
- Hispanic: 92%

By Education:
- Less than High School: 74%
- Some College: 91%
- Bachelor's Degree: 94%

Region 8 93% | United States 88%

Perinatal Care Discrimination

1% of ND mothers experienced racial or ethnic discrimination while getting health care

7% of ND women report ever being discriminated against due to race, ethnicity, or skin color

Region 8 N/A | United States N/A

Exclusively Breastfed

26% of ND children (age 6 months to 2 years) were exclusively fed breastmilk for 6 months

By Poverty Level:
- 0 to 199%: 22%*
- 200 to 299%: 27%*
- 300 to 399%: 24%*
- 400% or more: 30%*

Region 8 31% | United States 29%

Housing Instability

15% of ND children's (ages 0 to 11) parents reported being behind on a housing payment, or that the child had lived in three or more places in the past year, or had ever been homeless

Region 8 13% | United States 16%

Placed to Sleep on Their Back

89% of ND women placed their infant to sleep only on their backs in the past two weeks

By Education:
- High School: 80%
- Some College: 86%
- College Degree: 98%

Region 8 88% | United States 83%

Slept Alone

61% of ND infants slept alone in their own crib or bed in the past two weeks

By Family Structure:
- Married: 65%
- Unmarried: 52%

Region 8 58% | United States 59%

Slept Without Soft Objects

57% of ND infants slept without blankets, soft toys, pillows or crib bumper pads in the past two weeks

By Maternal Age:
- 20 to 29 years: 65%
- 30 to 39 years: 59%
- 40+ years: 96%

By Race:
- American Indian: 42%
- Black: 49%
- White: 61%

Region 8 55% | United States 60%

Room Sharing

72% of ND women reported their infant's bed was in the same room where they slept in the past two weeks

By Education
- Less than High School: 83%
- Some College: 70%
- Professional Degree: 68%

By Race or Ethnicity:
- Hispanic: 65%
- White: 68%
- American Indian: 97%

Region 8 80% | United States 82%

*Due to low counts or large standard error (SE), some data may be unreliable.

Data sources and the years of data presented can be found in the resource document found at the end of the profiles.

North Dakota

MCH TITLE V WELL-BEING PROFILE

CHILDREN

Preventive Dental Visit (ages 1 to 17)

80%

of ND children had a dental check up

By Poverty Level:
- 0 to 199%: 71%
- 200 to 299%: 77%
- 400%+ : 86%

By Age:
- 1 to 5 years: 58%
- 6 to 11 years: 90%
- 12 to 17 years: 87%

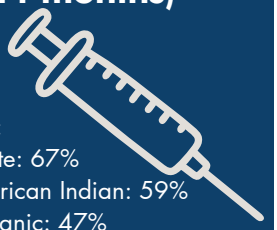
By Insurance Type:
- Public 68%
- Private 84%
- Uninsured 56%*

Region 8 85% | United States 80%

Childhood Vaccinations (7-series by age 24 months)

66%

of ND children completed the full vaccine series



By Race:
- White: 67%
- American Indian: 59%
- Hispanic: 47%

Region 8 N/A | United States 69%

Physical Activity

By Biological Sex:
- Male: 37%
- Female: 27%

By Insurance Type:
- Public: 27%*
- Private: 32%

31%

of ND children (ages 6 to 11) were active 60+ minutes per day

Region 8 26% | United States 26%

Housing Instability

15%

of ND children (ages 0 to 11) live with parents who reported being behind on a housing payment, that the child had lived in three or more places in the past year, or had ever been homeless

By Poverty Level:
- 0 to 199%: 29%
- 300-399%: 17%

By Age:
- 0 to 5 years: 11%
- 6 to 11 years: 19%

By Family Structure:
- Married: 11%
- Unmarried: 24%*
- Single: 28%*

By Insurance Type:
- Public: 22%*
- Private: 11%
- Uninsured: 40%*

Region 8 13% | United States 16%

Developmental Screening

45%

of ND toddlers (ages 9 to 35 months) received a standardized screening

By Education:
- Some College: 34%*
- College Degree+: 53%*

By Poverty Level:
- 0 to 199%: 37%*
- 300 to 399%: 58%*

Region 8 44% | United States 36%

Food Sufficiency

By Insurance Type:
- Private: 76%
- Uninsured: 49%*

By Poverty Level:
- 0 to 199%: 46%
- 400%+ : 90%

By Family Structure:
- Married: 74%
- Unmarried: 60%*
- Single: 48%*

69%

of ND children lived in food secure households

Region 8 72% | United States 69%

*Due to low counts or large standard error (SE), some data may be unreliable.

Data sources and the years of data presented can be found in the resource document found at the end of the profiles.

North Dakota

MCH TITLE V WELL-BEING PROFILE

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Medical Home: Overall

50% of ND children with special health care needs (ages 0 to 17) meet the criteria for having a medical home

By Age:
- 0 to 5 years: 52%*
- 6 to 11 years: 46%*
- 12 to 17 years: 52%*

Region 8 44% | United States 40%

Personal Doctor

77% of ND CSHCN have a personal doctor or nurse

By Family Structure:
- Married: 82%
- Single: 70%*

Region 8 81% | United States 78%

Usual Source of Sick Care

89% of CSHCN in ND have a place they usually go for advice about their health

By Family Structure:
- Married: 94%
- Single: 74%*

Region 8 88% | United States 82%

Bullying

33% of ND CSHCN have bullied others in the past year*

By Education Level:
- Some College: 29%*
- College Degree: 34%*

Region 8 26% | United States 19%

63% of ND CSHCN were bullied in the past year*

By Education Level:
- Some College: 66%*
- College Degree: 65%*

Region 8 63% | United States 51%

Care Coordination

63% of ND CSHCN have received all needed help with care coordination

Region 8 54% | United States 53%

Transition (ages 12 to 17)

32% of ND adolescents with special health care needs received services to prepare for the transition to adult health care

Region 8 27% | United States 22%

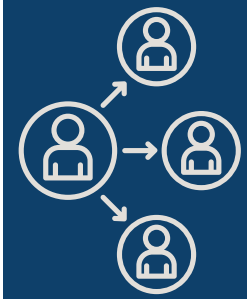
Family Centered Care

91% of ND CSHCN's providers spent time, listened carefully, showed sensitivity, provided information and helped their family be a part of their care

By Age:
- 0 to 5 years: 87%
- 6 to 11 years: 88%
- 12 to 17 years: 96%

Region 8 85% | United States 82%

Referrals



74% of CSHCN in ND have no problem getting needed referrals

By Poverty Level:
- 0 to 199%: 69%*
- 200 to 299%: 87%*
- 400%+: 72%*

Region 8 70% | United States 70%

*Due to low counts or large standard error (SE), some data may be unreliable.

Data sources and the years of data presented can be found in the resource document found at the end of the profiles.

North Dakota

MCH TITLE V WELL-BEING PROFILE

ADOLESCENTS

Preventive Dental Visit (ages 12 to 17)

87% of ND adolescents, ages 12 through 17, had a dental check up

Region 8 N/A | United States N/A

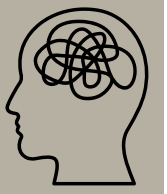
Mental Health Treatment (ages 12 to 17)

11% of ND adolescents needed treatment but did not receive it

Region 8 21% | United States 18%

90% of ND adolescents received needed treatment or counseling

Region 8 80% | United States 83%



Adolescent Well-Visit (ages 12 to 17)

68% of ND adolescents had a preventive medical visit in the past year

By Insurance Type:

- Public: 65%*
- Private: 71%
- Uninsured: 44%*

Region 8 71% | United States 70%

Bullying

17% of ND adolescents (ages 12 to 17) bully others

By Family Structure:

- Married: 15%
- Single: 23%*

Region 8 19% | United States 12%

40% of ND adolescents (ages 12 to 17) are bullied

By Family Structure:

- Married: 40%
- Single: 33%*

Region 8 44% | United States 33%

Tobacco Use (Grades 9 to 12)

20% of ND High schoolers reported use of tobacco products in the past 30 days

By Grade:

- 9th Grade: 12%
- 10th Grade: 18%
- 11th Grade: 27%
- 12th Grade: 24%

Region 8 N/A | United States 18%

Adult Mentor

94% of ND adolescents (ages 12 to 17) have an adult they can rely on for advice or guidance

By Family Structure:

- Married: 96%
- Single: 88%*

Region 8 94% | United States 87%

Medical Home

55% of ND children (ages 0 to 17) meet the criteria for having a medical home

By Family Structure:

- Married: 57%
- Single: 54%

By Poverty Level:

- 0 to 199%: 45%
- 400%+: 60%

Region 8 52% | United States 45%

Transition (ages 12 to 17)

25% of ND adolescents received services to prepare for the transition to adult health care

By Insurance Type:

- Public: 16%*
- Private: 27%

Region 8 21% | United States 18%

*Due to low counts or large standard error (SE), some data may be unreliable.

Data sources and the years of data presented can be found in the resource document found at the end of the profiles.

North Dakota

MCH TITLE V WELL-BEING PROFILE

WOMEN & MOTHERS

Postpartum Checkup

93% of ND mothers attended a postpartum checkup after giving birth

By Race & Ethnicity:
- White 97%
- Hispanic 96%*
- American Indian 65%

Region 8 92% | United States 91%

Housing Instability

4% of ND women reported being evicted or forced to move in the year prior to a recent live birth

2% were homeless or slept outside, in a car, or shelter

1% reported having no regular place to sleep

Region 8 N/A | United States N/A

Perinatal Care Discrimination

1% of ND mothers experienced racial or ethnic discrimination while getting healthcare

7% of ND women report ever being discriminated against due to race, ethnicity, or skin color

Region 8 N/A | United States N/A

Postpartum Checkup with Recommended Care Components

86% of ND mothers had a healthcare provider talk to them about birth control methods and mental health at their postpartum visit

By Race:
- American Indian: 91%
- White: 87%
- Black: 79%

Region 8 86% | United States 81%

Postpartum Contraceptive Use

72% of ND women report using contraception methods after a recent live birth

By Education:
- Less than High School: 49%
- Some College: 69%
- Professional Degree: 84%

By Income:
- $48,000 or less: 65%
- $85,001 or more: 76%

Region 8 82% | United States 76%

Preventive Dental Visit

67% of ND mothers had their teeth cleaned during pregnancy

By Income:
- $28,000 or less: 22%
- $28,000 to $48,000: 48%
- $85,001 or more: 85%

By Marital Status:
- Married: 78%
- Unmarried: 39%

By Education:
- Less than High School: 20%*
- Some College: 68%
- Professional Degree: 85%

Region 8 70% | United States 62%

Postpartum Mental Health Screening

84% of ND women received postpartum depression or anxiety screening

21% of postpartum mothers were prescribed medication for depression or anxiety

Region 8 N/A | United States N/A

*Due to low counts or large standard error (SE), some data may be unreliable.

Data sources and the years of data presented can be found in the resource document found at the end of the profiles.

North Dakota MCH Title V Well-Being Profiles: Resources

Perinatal and Infants

Performance Measure	Goal & Significance	Data Year & Sources
Breastfeeding A. Percent of infants who ever breastfed	To increase the percent of infants who are breastfed. The American Academy of Pediatrics (AAP) recommends all infants (including premature and sick newborns) exclusively breastfeed for about 6 months, followed by continued breastfeeding as complementary foods are introduced for 2 years or longer. However, significant differences in breastfeeding initiation and duration persist by socioeconomic status and race/ethnicity.	2021 National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) PRAMS ARF
Breastfeeding B. Percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months	To increase the percent of infants who are breastfed exclusively for 6 months. The American Academy of Pediatrics (AAP) recommends all infants (including premature and sick newborns) exclusively breastfeed for about 6 months, followed by continued breastfeeding as complementary foods are introduced for 2 years or longer. However, significant differences in breastfeeding initiation and duration persist by socioeconomic status and race/ethnicity.	2022-2023 National Survey of Children's Health (NSCH)
Housing Instability – Children Percent of children, ages 0 through 11, who experienced housing instability in the past year	To reduce the percent of children experiencing housing instability. Safe and secure housing is a fundamental factor that influences health. Housing instability can consist of a variety of challenges, such as difficulty making housing payments, overcrowding, moving frequently, eviction, and homelessness. Housing instability, particularly in early childhood, is linked to poor health and development. The highest risk period for sheltered homelessness is the first year of life and families with children comprise a third of all sheltered homeless people.	2022-2023 National Survey of Children's Health (NSCH)

Perinatal Care Discrimination Percent of women with a recent live birth who experienced racial/ethnic discrimination while getting health care during pregnancy, delivery, or at postpartum care	To reduce the percent of women who experience racial/ethnic discrimination while getting health care during pregnancy, delivery, or postpartum. Significant differences exist in maternal health outcomes for some racial and ethnic minority populations in the United States. These health differences have persisted over time and are attributable to a combination of factors, including patient, community, health care provider, and systems factors. Racial or ethnic discrimination are key drivers of adverse mental and physical health outcomes.	2023 North Dakota PRAMS
Risk-Appropriate Perinatal Care Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	To ensure that higher risk mothers and newborns deliver at appropriate level hospitals. Very low birth weight infants (<1,500 grams or 3.25 pounds) are the most fragile newborns with a risk of death 100 times higher than that of normal birth weight infants (≥2,500 grams or 5.5 pounds). VLBW infants are significantly more likely to survive and thrive when born in a facility with a level-III Neonatal Intensive Care Unit (NICU), a subspecialty facility equipped to handle high-risk neonates.	2022 North Dakota PRAMS
Safe Sleep A. Percent of infants placed to sleep on their backs	To increase the percent of infants placed to sleep on their backs. Sudden Unexpected Infant Deaths (SUID) account for the largest share of infant deaths after the first month of life. Due to heightened risk of SUIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position.	2022 Maternal and Child Health Bureau. Federally Available Data (FAD)
Safe Sleep B. Percent of infants placed to sleep on a separate approved sleep surface	To increase the percent of infants placed to sleep in a safe sleep environment. To further reduce SUID, the AAP has several other recommendations for a safe sleep environment that incorporate using a firm non-inclined sleep surface (e.g., crib or bassinet).	2021 National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) PRAMS ARF

Safe Sleep C. Percent of infants placed to sleep without soft objects or loose bedding	To increase the percent of infants placed to sleep in a safe sleep environment. To further reduce SUID, the AAP recommends avoiding soft bedding and overheating to facilitate a safe sleep environment.	2022 Maternal and Child Health Bureau. Federally Available Data (FAD) – state and national totals & race 2021 National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) PRAMS ARF - age
Safe Sleep D. Percent of infants room-sharing with an adult	To increase the percent of infants placed to sleep in a safe sleep environment. To further reduce SUID, the AAP recommends room-sharing without bed-sharing to facilitate a safe sleep environment.	2021 National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) PRAMS ARF

North Dakota MCH Title V Well-Being Profiles: Resources

Children

Performance Measure	Goal & Significance	Data Year & Sources
Childhood Vaccination Percent of children who have completed the combined 7-vaccine series (4:3:1:3*3:1:4) by age 24 months	To increase the percent of children and adolescents who have completed recommended vaccines. Childhood vaccination is considered among the most cost-effective preventive services available, as it averts a potential lifetime lost to death and disability. Currently, there are 15 different vaccines recommended by the Centers for Disease Control and Prevention from birth through 18, many of which require multiple doses for effectiveness as well as boosters to sustain immunity. The combined 7-vaccine series (4:3:1:3*:3:1:4) contains ≥4 doses of diphtheria and tetanus toxoids and acellular pertussis vaccine; ≥3 doses of poliovirus vaccine; ≥1 dose of measles-containing vaccine; ≥3 or ≥4 doses (depending upon product type) of *Haemophilus influenzae* type b conjugate vaccine; ≥3 doses of hepatitis B vaccine; ≥1 dose of varicella vaccine; and ≥4 doses of pneumococcal conjugate vaccine.	2024 North Dakota Immunization Information System (NDIIS)
Developmental Screening Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	To increase the percent of children who receive a developmental screening. Early identification of developmental delays and disabilities is critical to provide referrals to services that can promote health and educational success. It is an integral function of the primary care medical home. The American Academy of Pediatrics (AAP) recommends developmental screening at the 9, 18, and 24 or 30 month visit. Developmental screening is part of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP. Systems-level quality improvement efforts that build on the medical home are needed to improve rates of developmental screening and surveillance.	2022-2023 National Survey of Children's Health (NSCH)

Food Sufficiency Percent of children, ages 0 through 11, whose households were food sufficient in the past year	To increase the percent of children whose households are always able to afford to eat good nutritious food. Large differences exist by race/ethnicity, disability status, urbanicity, and family structure. Food insecurity among children is associated with poor health status, mental health problems, behavioral and socio-emotional problems, poor educational performance, and academic outcomes.	2022-2023 National Survey of Children's Health (NSCH)
Housing Instability – Children Percent of children, ages 0 through 11, who experienced housing instability in the past year	To reduce the percent of children experiencing housing instability. Difficulty making housing payments, overcrowding, moving frequently, eviction, and homelessness are examples of housing instability Safe and secure housing is a fundamental factor that influences health. Housing instability, particularly in early childhood, is linked to poor health and development. The highest risk period for sheltered homelessness is the first year of life and families with children comprise a third of all sheltered homeless people.	2022-2023 National Survey of Children's Health (NSCH)
Preventive Dental Visit – Children Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	To increase the percentage of pregnant women and children who receive preventive dental visits. Oral health is a vital component of overall health and oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. To prevent tooth decay and oral infection, the American Academy of Pediatric Dentistry (AAPD) recommends preventive dental care for all children after the eruption of the first tooth or by 12 months of age, usually at intervals of every 6 months. Oral Evaluation Dental Services is part of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.	2022-2023 National Survey of Children's Health (NSCH)

Physical Activity Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	To increase the percent of children who are physically active. Physical activity in children improves bone health, weight status, cardiorespiratory and cardiometabolic health, and brain health, including improved cognition and reduced depressive symptoms. Physical activity reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.	2022-2023 National Survey of Children's Health (NSCH) – state and national totals & insurance 2021-2022 Maternal and Child Health Bureau. Federally Available Data (FAD) – biological sex

North Dakota MCH Title V Well-Being Profiles: Resources

Children with Special Health Care Needs

Performance Measure	Goal & Significance	Data Year & Sources
Bullying Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others	To reduce the percent of adolescents with and without special health care needs who are bullied or who bully others. Bullying, particularly among school-age children, is a major public health problem that is associated with a number of behavioral, emotional, and physical adjustment problems. Bullying – Unwanted, aggressive behavior among school aged children that involves a real or perceived power imbalance.	2022-2023 National Survey of Children's Health (NSCH)
Health Care Transition Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transitions to adult health care	To increase the percent of adolescents with and without special health care needs who have received services to prepare for the transitions to adult health care. The transition of youth to adulthood, including the movement from a child to an adult model of health care, has become a priority issue nationwide. Health Care Transition – The process of moving from a child to an adult model of health care. The goal of health care transition (HCT) is to optimize health and assist youth in reaching their full potential, which requires an active process over time that addresses many aspects of a youth's life, including medical, psychosocial, educational, and vocational needs.	2022-2023 National Survey of Children's Health (NSCH)
Medical Home Percent of children with and without special health care needs, ages 0 through 17, who meet the criteria for having a medical home (personal doctor or nurse, usual source for care, family-centered care, referrals if needed, and care coordination if needed)	To increase the percent of children with and without special health care needs who have a medical home. The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.	2022-2023 National Survey of Children's Health (NSCH)

Medical Home – Care Coordination Percent of children with and without special health care needs, ages 0 through 17, who received all needed help with care coordination	To increase the percent of children with and without special health care needs who have a medical home. The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.	2022-2023 National Survey of Children's Health (NSCH)
Medical Home – Family Centered Care Percent of children with and without special health care needs, ages 0 through 17, who's doctor or other health care provider always/usually 1) spent enough time with the child, 2) listened carefully to the child, 3) showed sensitivity to family values, 4) provided the specific information needed concerning the child, and 5) helped the family feel like a partner in the child's care	To increase the percent of children with and without special health care needs who have a medical home. The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.	2022-2023 National Survey of Children's Health (NSCH)
Medical Home – Personal Doctor Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse	To increase the percent of children with and without special health care needs who have a medical home. The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.	2022-2023 National Survey of Children's Health (NSCH)

Medical Home – Referrals Percent of children with and without special health care needs, ages 0 through 17, who have no problem getting needed referrals	To increase the percent of children with and without special health care needs who have a medical home. The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.	2022-2023 National Survey of Children's Health (NSCH)
Medical Home – Usual Source of Sick Care Percent of children with and without special health care needs, ages 0 through 17, who have a place they usually go when the child is sick or needs advice about their health (excluding the hospital emergency room)	To increase the percent of children with and without special health care needs who have a medical home. The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.	2022-2023 National Survey of Children's Health (NSCH)

North Dakota MCH Title V Well-Being Profiles: Resources

Adolescents

Performance Measure	Goal & Significance	Data Year & Sources
Adult Mentor Percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance.	To increase the percent of adolescents with an adult mentor. Having a connection to a caring adult is one of several positive youth experiences and is a protective factor that has been associated with several measures of child well-being, including markers of flourishing, physical activity, participation in activities, talking with parents as well as decreased likelihood of bullying and depression. Furthermore, a growing evidence base demonstrates the effectiveness of programs to foster youth-adult partnerships in wide variety of settings (ex. after school programming).	2022-2023 National Survey of Children's Health (NSCH)
Adolescent Well-Visit Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year	To increase the percent of adolescents who have a preventive medical visit. Adolescence is a period of major physical, psychological, and social development. An annual preventive well visit may help adolescents adopt or maintain healthy habits and behaviors, avoid health—damaging behaviors, manage chronic conditions, and prevent disease. The visit should cover a comprehensive set of preventive services, such as a physical examination, immunizations, and discussion of health-related behaviors including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety.	2020-2021 National Survey of Children's Health (NSCH)
Bullying Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others	To reduce the percent of adolescents with and without special health care needs who are bullied or who bully others. Bullying, particularly among school-age children, is a major public health problem that is associated with a number of behavioral, emotional, and physical adjustment problems. Bullying – Unwanted, aggressive behavior among school aged children that involves a real or perceived power imbalance.	2022-2023 National Survey of Children's Health (NSCH)

Health Care Transition Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transitions to adult health care	To increase the percent of adolescents with and without special health care needs who have received services to prepare for the transitions to adult health care. The transition of youth to adulthood, including the movement from a child to an adult model of health care, has become a priority issue nationwide. Health Care Transition – The process of moving from a child to an adult model of health care. The goal of health care transition (HCT) is to optimize health and assist youth in reaching their full potential, which requires an active process over time that addresses many aspects of a youth's life, including medical, psychosocial, educational, and vocational needs.	2022-2023 National Survey of Children's Health (NSCH)
Medical Home Percent of children with and without special health care needs, ages 0 through 17, who: -have a medical home -have a personal doctor or nurse -have a usual source of sick care -have family centered care -receive needed referrals -receive needed care coordination	To increase the percent of children with and without special health care needs who have a medical home. The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.	2022-2023 National Survey of Children's Health (NSCH)
Mental Health Treatment Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling	To increase the percent of adolescents who receive needed mental health treatment or counseling. Mental disorders among children are described as serious changes in the way children typically learn, behave or handle their emotions, which cause distress and problems getting through the day. The prevalence of mental/behavioral health conditions has been increasing among children and has been found to vary by geographic and sociodemographic factors. However, a significant portion of children diagnosed with a mental health condition do not receive treatment.	2022-2023 National Survey of Children's Health (NSCH)

Preventive Dental Visit – Children Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	To increase the percentage of pregnant women and children who receive preventive dental visits. Oral health is a vital component of overall health and oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. To prevent tooth decay and oral infection, the American Academy of Pediatric Dentistry (AAPD) recommends preventive dental care for all children after the eruption of the first tooth or by 12 months of age, usually at intervals of every 6 months. Oral Evaluation Dental Services is part of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.	2022-2023 National Survey of Children's Health (NSCH)
Tobacco Use Percent of adolescents, grades 9 through 12, who currently use tobacco products	To reduce the percent of adolescents who currently use tobacco products. Tobacco product use in any form is unsafe, and tobacco product use is typically established during adolescence. Tobacco product use in youths is associated with depression, anxiety, and stress. In the United States in 2022, 16.5% of high school students reported using any tobacco product and 14.1% reported using e-cigarettes. North Dakota high school students reported slightly higher tobacco use in 2023, with 19.6% of students reporting any tobacco use and 18.2% using e-cigarettes.	2023 Youth Risk Behavior Surveillance System (YRBSS)

North Dakota MCH Title V Well-Being Profiles: Resources

Women and Mothers

Performance Measure	Goal & Significance	Data Year & Sources
Housing Instability – Pregnancy Percent of women with a recent live birth who experienced housing instability in the 12 months before a recent live birth	To reduce the percent of pregnant women experiencing housing instability. Difficulty making housing payments, overcrowding, moving frequently, eviction, and homelessness are all examples of housing instability. Safe and secure housing is a fundamental factor that influences health. In pregnancy, housing instability is associated with inadequate prenatal care and adverse birth outcomes, including low birthweight and preterm birth. Housing instability is linked to poor health and development. The highest risk period for sheltered homelessness is the first year of life and families with children comprise a third of all sheltered homeless people.	2023 North Dakota PRAMS
Perinatal Care Discrimination Percent of women with a recent live birth who experienced racial/ethnic discrimination while getting health care during pregnancy, delivery, or at postpartum care	To reduce the percent of women who experience racial/ethnic discrimination while getting health care during pregnancy, delivery, or postpartum. Significant differences exist in maternal health outcomes for some racial and ethnic minority populations in the United States. These health differences have persisted over time and are attributable to a combination of factors, including patient, community, health care provider, and systems factors. Racial or ethnic discrimination are key drivers of adverse mental and physical health outcomes.	2023 North Dakota PRAMS
Postpartum Contraceptive Use Percent of women who are using a mostly or moderately effective contraceptive following a recent live birth	To increase the percent of women who are using postpartum contraception. Contraception is recognized as an effective strategy for reducing unintended pregnancies and achieving healthy birth spacing thereby improving maternal and child health outcomes.	2021 National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) PRAMS ARF

Postpartum Mental Health Screening Percent of women screened for depression or anxiety following a recent live birth	To increase the percent of women who receive postpartum depression or anxiety screening. Mental health conditions are common complications during the postpartum period with approximately 1 in 8 women experiencing depressive symptoms following a live birth. Mental health conditions are associated with several adverse health behaviors and outcomes, including poorer maternal and infant bonding, decreased breastfeeding initiation, and delayed infant development. They are also the leading underlying causes of pregnancy-related deaths. Screening for mental health conditions can identify those at risk for depression and increase the provision of treatment or referrals with the potential to reduce other adverse health consequences.	2023 North Dakota PRAMS
Postpartum Visit A. Percent of women who attended a postpartum checkup within 12 weeks after giving birth	To increase the percent of women who have a postpartum visit within 12 weeks after giving birth. The postpartum period is an important time for maternal health and well-being. Data from Maternal Mortality Review Committees in 36 states suggest that more than half of pregnancy related deaths occur from 7 to 365 days postpartum.	2022 Maternal and Child Health Bureau. Federally Available Data (FAD)
Postpartum Visit B. Percent of women who attended a postpartum checkup and received recommended care components	To increase the percent of women who have a postpartum visit within 12 weeks after giving birth and received recommended care components. A comprehensive postpartum visit is an opportunity to improve maternal health by providing recommended clinical services, including screening, counseling, and management of health issues. Anticipatory guidance and screening for mental health conditions and contraceptive counseling are key components of postpartum care that are recommended by national quality standards and professional organizations.	2022 Maternal and Child Health Bureau. Federally Available Data (FAD)

Preventive Dental Visit – Pregnancy Percent of women who had a preventive dental visit during pregnancy	To increase the percentage of pregnant women and children who receive preventive dental visits. Oral health is a vital component of overall health and oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper.	2021 National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) PRAMS ARF

Appendix B: News Release

NEWS RELEASE | **FOR IMMEDIATE RELEASE** | March 14, 2025

New five-year priorities for maternal child block grant available for public comment

BISMARCK, N.D. – Federal Title V Block Grant funds support preventive and primary care health services for women and children. The Title V Block Grant is a federal-state partnership to address priority needs identified through a comprehensive needs assessment. North Dakota Health and Human Services (HHS) has recently completed its five-year needs assessment to identify new or emerging priorities for the maternal and child health population. New activities for the priorities will begin on October 1, 2025, and run until Sept. 30, 2030. HHS is inviting public comment on the priorities now through March 31, 2025.

North Dakota's priorities address the state's plan to provide services to various population domains. The following goals based on national performance measures were identified:

- Identify, reduce, or eliminate barriers preventing women from receiving recommended postpartum care components, including but not limited to mental health screening, breastfeeding support, care coordination, etc.
- Utilize statewide resources to educate about/implement safe sleep best practices
- Expand partnerships with existing community resources (schools, food banks, health units, etc.) to improve accessibility to healthy food options
- Improve care coordination to link the pediatric population to essential services and resources
- Identify, reduce, or eliminate barriers preventing adolescents from receiving mental health treatment and counseling
- Improve the system of care for children with special health care needs

In addition to the federal performance goals, the Title V staff also monitors North Dakota's progress on three crosscutting state priority measures and a variety of health indicators.

Goals for these state priorities:

- Reduce motor vehicle incidents (crashes, injuries, fatalities) among the pediatric/adolescent/young adult populations
- Increase awareness and the utilization of statewide services or resources, and
- Implement all North Dakota state mandates delegated to the HHS Title V/Maternal and Child Health Programs.

Public Comment

To view the draft priorities, visit: https://www.hhs.nd.gov/nd-mch-priorities. Copies will also be provided upon request.

Individuals can provide public comment by March 31, 2025, by email to krhruby@nd.gov, by phone to (701) 328-4854, 711 (TTY) or by mail to North Dakota Health and Human Services - Public Health Division, Attn: Kimberly Hruby, 600 E. Boulevard Ave., Dept. 325, Bismarck, N.D., 58505-0250.

Appendix C: Stakeholder Survey Analysis

2025 ND Title V MCH Survey to Stakeholders Analysis

Sent to 198 stakeholders with a request to forward on to other colleagues

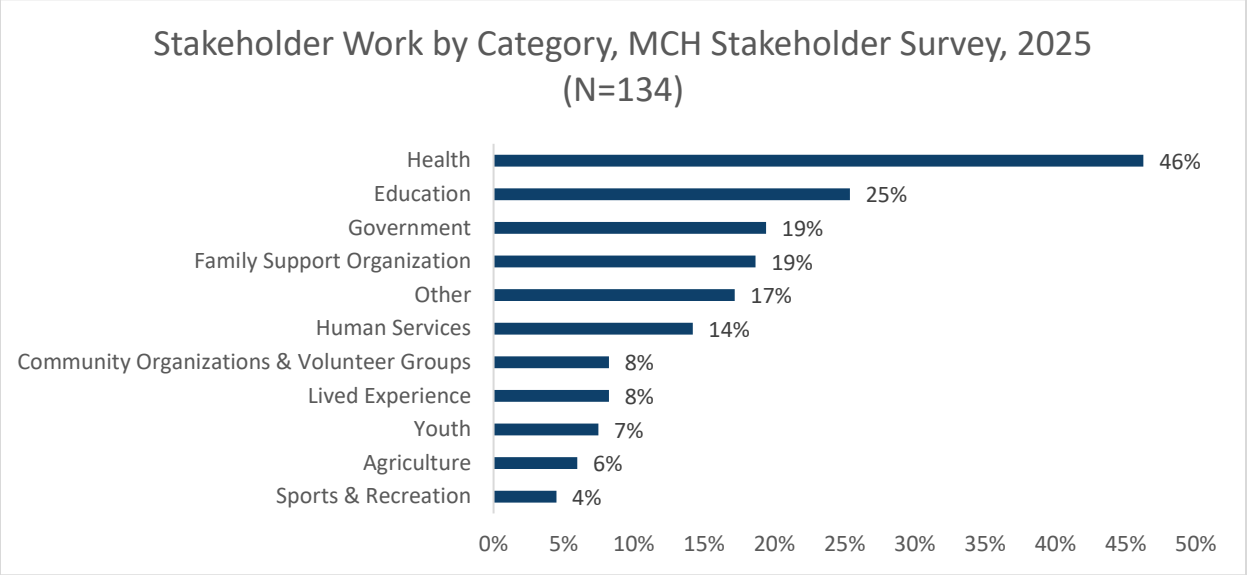
- 13 bounced back undeliverable and received a handful of out of office responses

196 total responses

- 134 completed 100% of the survey
- 62 partially completed surveys

All open-ended responses are verbatim. The views and opinions expressed in these responses are solely those of the respondent and do not necessarily reflect the official views or opinions of the Center for Social Research or ND Department of Health and Human Services.

Which of the following *best* describes *your* work with North Dakota's maternal and child health populations? *Please check all that apply.*

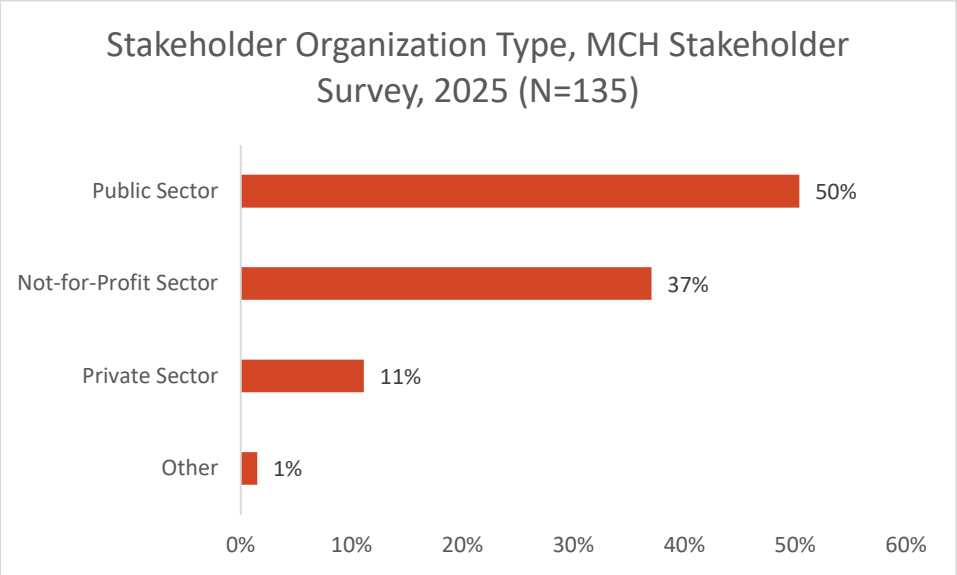


Collapsed low count categories into 'Other': Other (17 percent), Religion (3 percent), Media (3 percent), Law Enforcement & Corrections (3 percent), Service/Fraternal organizations (1 percent), Environment (1 percent), Business (1 percent), and Arts & Culture (1 percent)

Which of the following best describes your work with North Dakota's maternal and child health populations? Please select all that apply. - OTHER (Please specify):

- Safe Kids - Childhood Injury Prevention
- Home visiting/child development screening
- Fire & EMS
- Daycare
- Childcare
- Child care provider

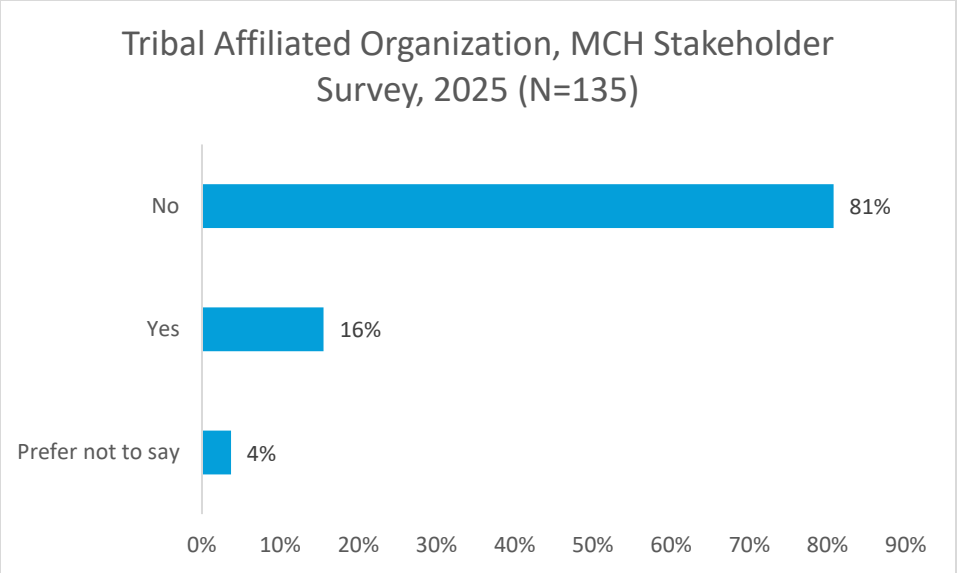
Which of the following categories *best* describes your organization? Please select ONE.



Which of the following categories best describes your organization? Please select ONE. - Other (Please specify):

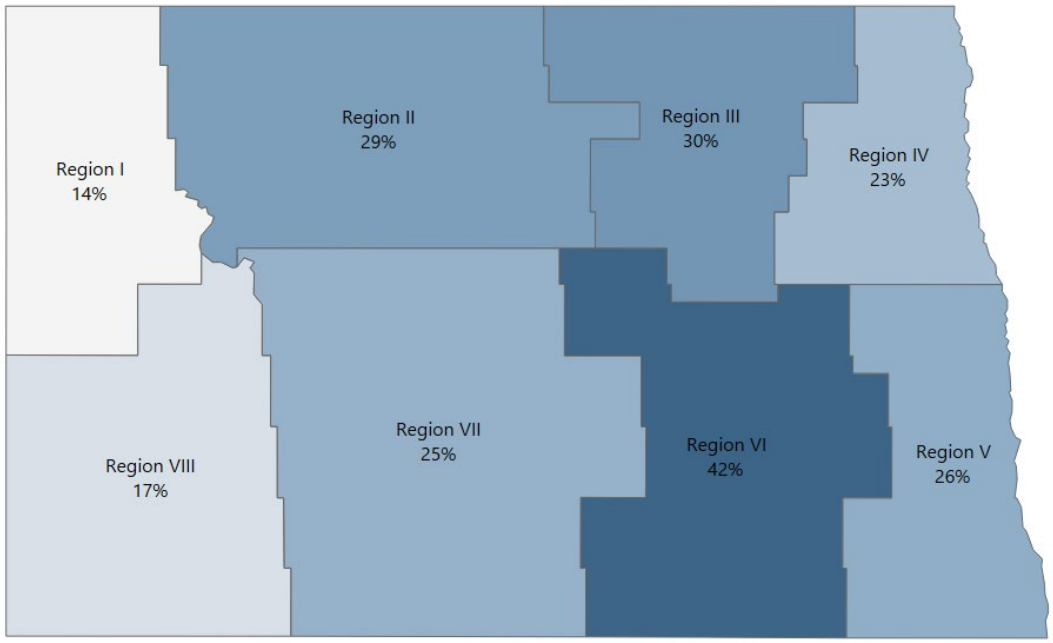
- Emergency and Urgent Care
- Public Health

Do you or your organization have a tribal affiliation?



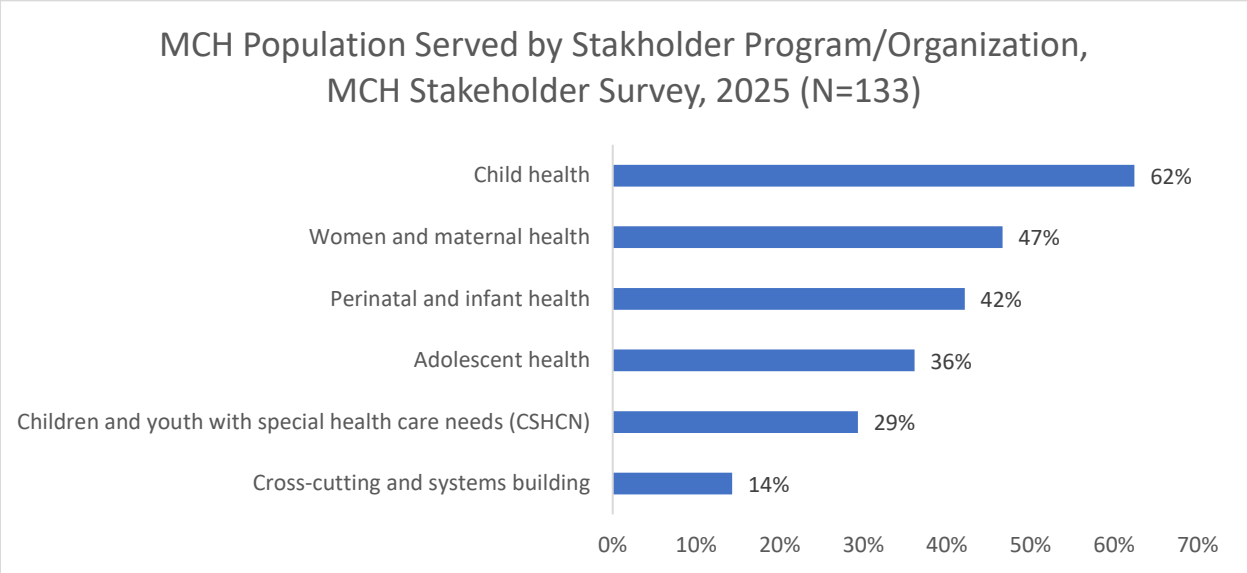
Please indicate the North Dakota counties you serve. *Select all that apply.*

Survey Respondents Area of Service, by North Dakota State Planning Region, MCH Stakeholder Survey, 2025 (N=132)

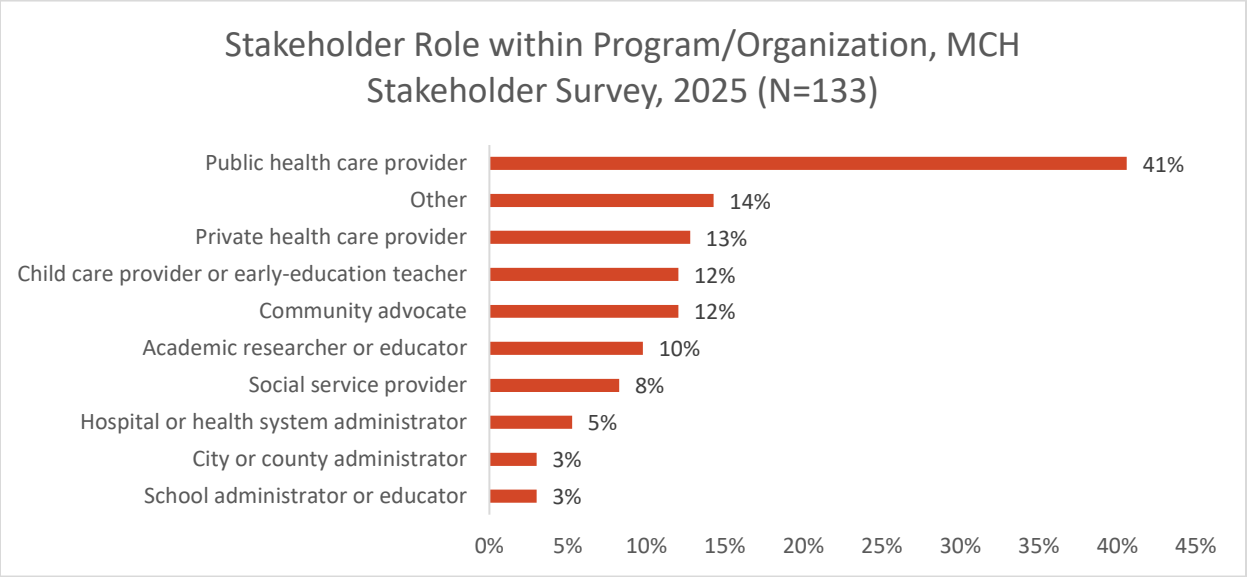


*27 percent of stakeholders reported their work served all of North Dakota.

North Dakota's MCH Block Grant Program is responsible for promoting the health of all mothers and children, including children with special health care needs and their families. The MCH Block Grant identifies six population groups. Please indicate which of the following best describes the MCH population your program/organization serves? *Please select all that apply.*



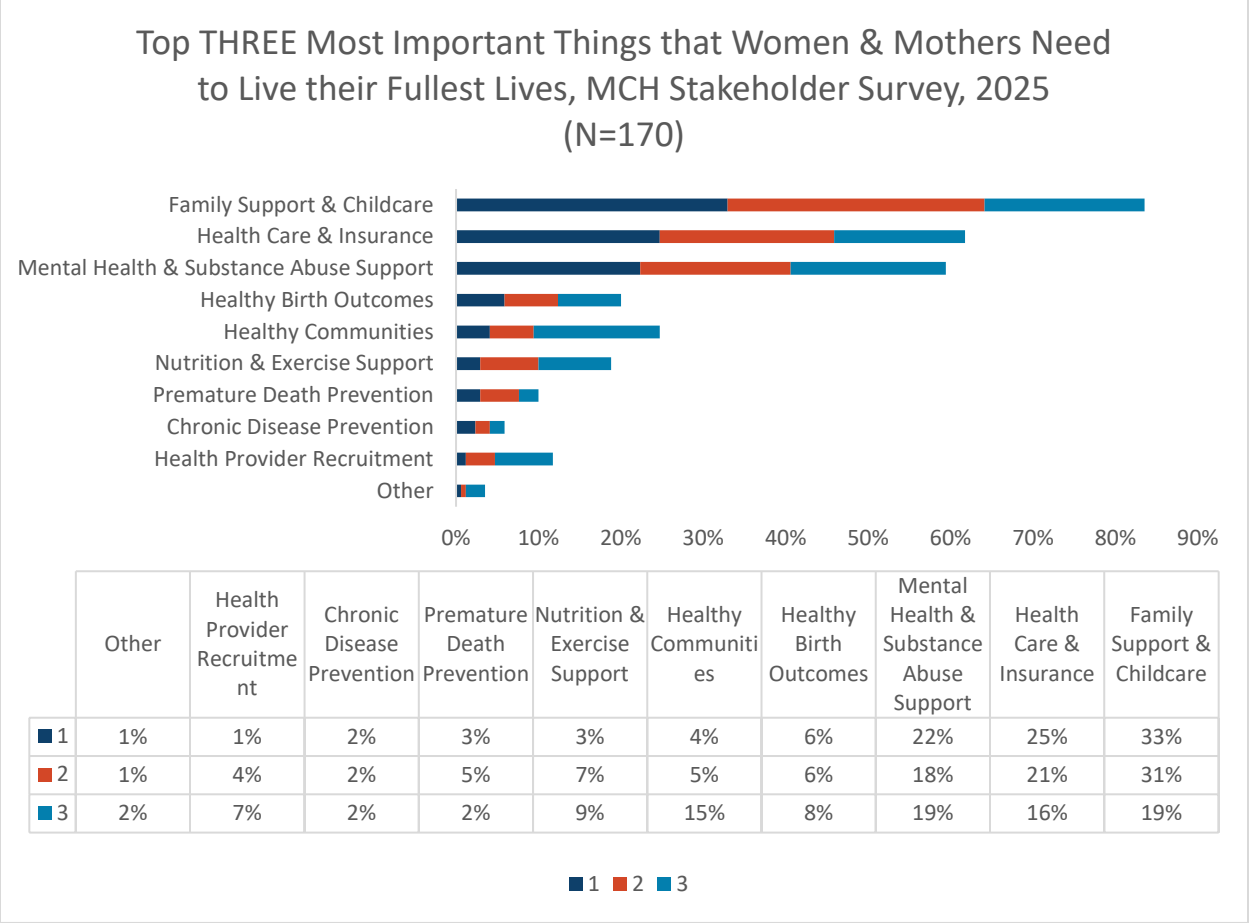
What is your role within your organization? *Please select all that apply.*



What is your role within your organization? *Please select all that apply* - Other (Please specify):

- Administration
- Chief of Police
- Director of daycare
- extension
- Extension Agent
- Extension educator
- Family Support Specialist - home visiting
- Fire Department Administrator
- Founder and head
- Home visitor/family support specialist
- law enforcement
- Law Enforcement
- Pregnancy care center
- Program coordinator/home visitor
- Program Director
- Program Manager
- Public Educator
- School Superintendent
- urgent and emergent care

In North Dakota, what are the top THREE most important things that women and mothers (all adult women, mothers, and identifying pregnant women through 60 days postpartum) need to live their fullest lives? Select your top three categories from the list below. Indicate your response by typing the number 1, 2, or 3 into the box, with 1 being your most important category.



	Other	Health Provider Recruitment	Chronic Disease Prevention	Premature Death Prevention	Nutrition & Exercise Support	Healthy Communities	Healthy Birth Outcomes	Mental Health & Substance Abuse Support	Health Care & Insurance	Family Support & Childcare
1	1%	1%	2%	3%	3%	4%	6%	22%	25%	33%
2	1%	4%	2%	5%	7%	5%	6%	18%	21%	31%
3	2%	7%	2%	2%	9%	15%	8%	19%	16%	19%

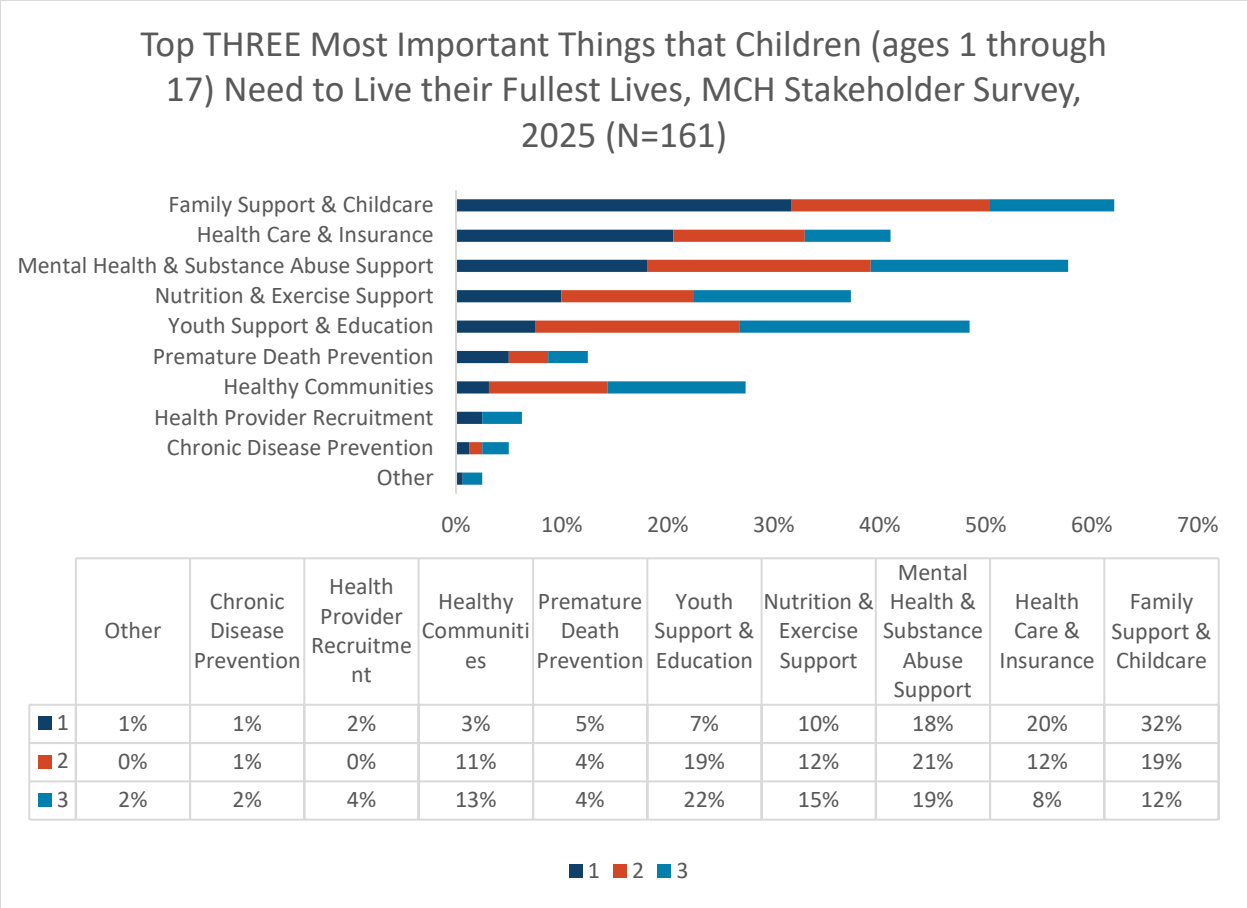
Family support and childcare was identified as the most important and also received the highest 2nd and 3rd priority picks. Health care and insurance was identified as the second most important with mental health and substance abuse support being the 3rd highest priority for women and mothers in North Dakota.

OTHER - Please specify:

- Breastfeeding education both providers and families
- laws or policies that provide educational or work accommodations for new Mothers until the child can attend daycare. Some ND universities are not "new mom friendly" causing women who are pursuing education to drop out prematurely.
- money & housing
- Support throughout like navigators to assist them in connecting with need services and resources. Pregnancy resource centers provide these services.

- This would be chronic disease but making sure oral health is covered for prevention and care
- WIC, Anne Carlsen, Medicaid and other free resources and screenings that families can utilize to help be proactive in their childs care as well as help meet financial and nutrient needs.

In North Dakota, what are the most important things that children (ages 1 through 17) need to live their fullest lives? Select your top three categories from the list below. Indicate your response by typing the number 1, 2, or 3 into the box, with 1 being your most important category.



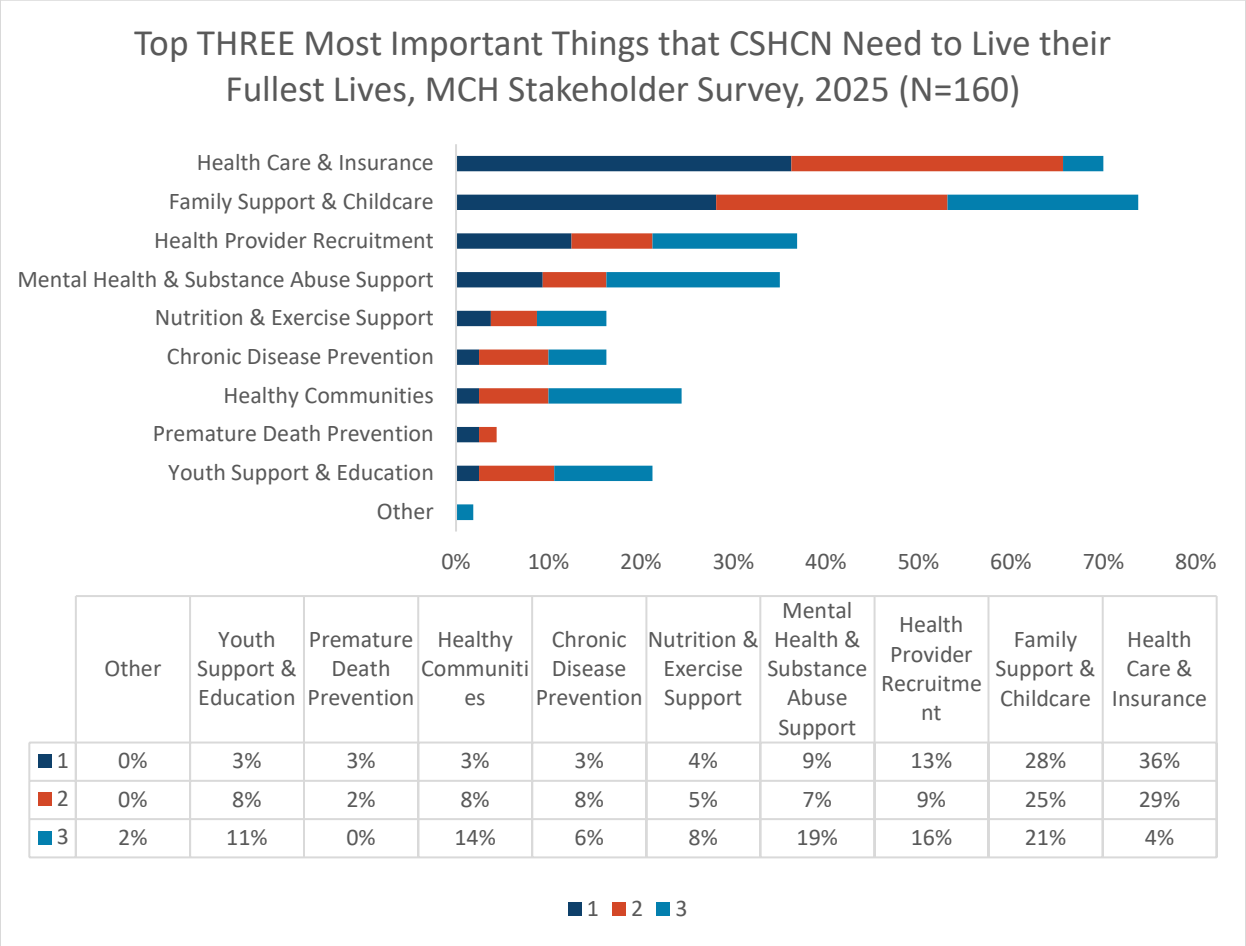
	Other	Chronic Disease Prevention	Health Provider Recruitment	Healthy Communities	Premature Death Prevention	Youth Support & Education	Nutrition & Exercise Support	Mental Health & Substance Abuse Support	Health Care & Insurance	Family Support & Childcare
1	1%	1%	2%	3%	5%	7%	10%	18%	20%	32%
2	0%	1%	0%	11%	4%	19%	12%	21%	12%	19%
3	2%	2%	4%	13%	4%	22%	15%	19%	8%	12%

For children (ages 1 through 17) family support and childcare was also identified as the most important followed by mental health and substance abuse support and the 3rd most important being youth support and education. Other highly ranked priorities were health care and insurance as well as nutrition and exercise support.

OTHER - Please specify:

- Food, mental health/substance abuse, housing/place for the homeless children/adolescence
- oral health prevention and care which could be under chronic disease but you don't have this mentioned any place as oral health impact overall health
- Parents at home
- School Health

In North Dakota, what are the most important things that children with special health care needs (ages 0 through 21) need to live their fullest lives? Select your top three categories from the list below. Indicate your response by typing the number 1, 2, or 3 into the box, with 1 being your most important category.



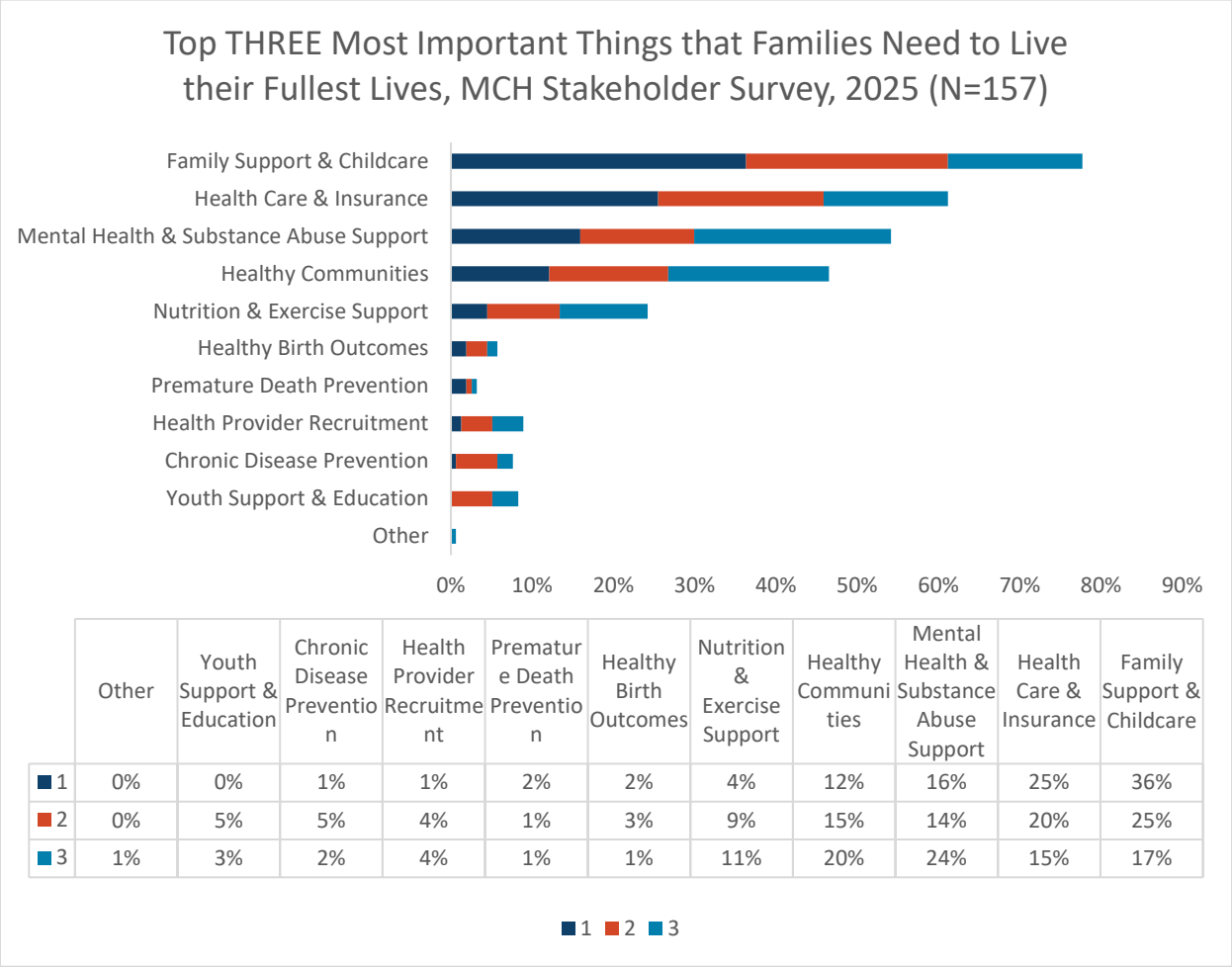
	Other	Youth Support & Education	Premature Death Prevention	Healthy Communities	Chronic Disease Prevention	Nutrition & Exercise Support	Mental Health & Substance Abuse Support	Health Provider Recruitment	Family Support & Childcare	Health Care & Insurance
1	0%	3%	3%	3%	3%	4%	9%	13%	28%	36%
2	0%	8%	2%	8%	8%	5%	7%	9%	25%	29%
3	2%	11%	0%	14%	6%	8%	19%	16%	21%	4%

Among children with special health care needs (CSHCN), stakeholders identified health care and insurance and family support and childcare as the most important priorities in the state. Health provider recruitment and mental health and substance abuse support were identified as close 3rd and 4th priorities for the CSHCN population.

OTHER - Please specify:

- Access to providers especially within the ASD community
- oral health screening and prevention which would be under chronic disease as stated before
- Support for condition

In North Dakota, what are the most important things that families need to live their fullest lives? Select your top three categories from the list below. Indicate your response by typing the number 1, 2, or 3 into the box, with 1 being your most important category.



	Other	Youth Support & Education	Chronic Disease Prevention	Health Provider Recruitment	Premature Death Prevention	Healthy Birth Outcomes	Nutrition & Exercise Support	Healthy Communities	Mental Health & Substance Abuse Support	Health Care & Insurance	Family Support & Childcare
1	0%	0%	1%	1%	2%	2%	4%	12%	16%	25%	36%
2	0%	5%	5%	4%	1%	3%	9%	15%	14%	20%	25%
3	1%	3%	2%	4%	1%	1%	11%	20%	24%	15%	17%

Stakeholders identified family support and childcare as the most important for families. Other important things for families that were identified were health care and insurance, mental health and substance abuse, followed by healthy communities.

OTHER - Please specify:

- housing, transportation, healthy food, mental health/substance abuse, activities that can be done in tribal areas, cultural activities on/off reservation

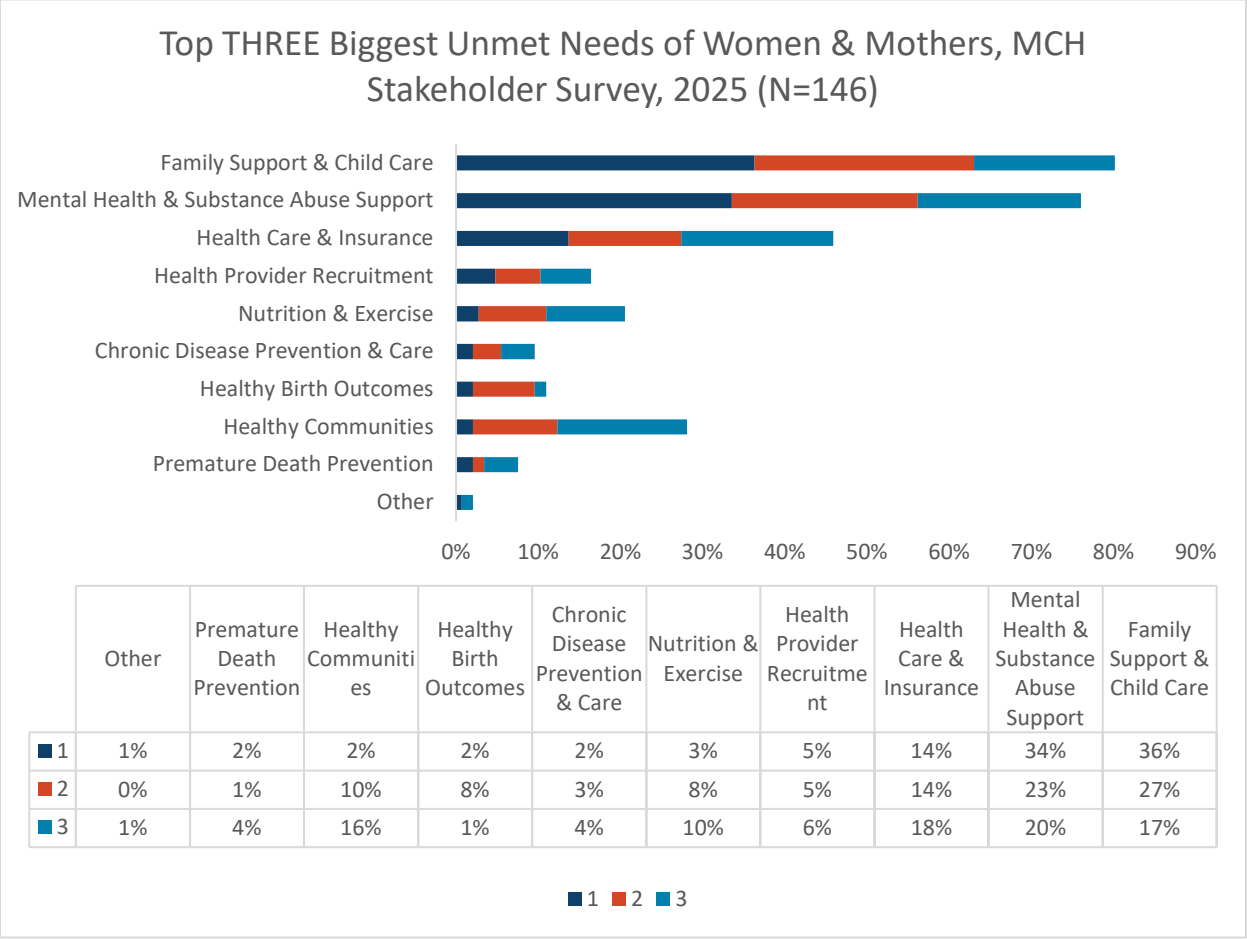
Please use this space to tell us of any other important things that women and mothers, children, children with special health care needs, and families need to live their fullest lives in North Dakota. Verbatim responses can be found at the end of this Appendix. Themes identified from the open-ended prompt:

1. Paid Family Leave and Workforce Support
    - Paid maternity and paternity leave
    - Paid dependent care leave for aging family members
    - Childcare offered by employers
    - Affordable, quality childcare and after-school programs
    - Workforce development and job opportunities, including for those without formal education
2. Access to Health Care
    - Affordable health care and better insurance options
    - Access to mental health services, including in schools and rural areas
    - More mental health providers and reduced wait times for services
    - Specialty care access without the need for long-distance travel
    - Culturally competent prenatal and postpartum care
    - Access to reproductive health education and full-spectrum care
    - Support for neurodivergent youth and children with special health care needs
3. Ease of Obtaining and Using Services
    - Wheelchair-accessible childcare and specialized care for children with special needs
    - Translation services for non-English speakers
    - Culturally appropriate health and healing services, particularly for tribal nations
    - Community health ambassadors for navigating health systems
    - Accessible health care in rural and underserved areas
4. Education and Child Development
    - High-quality early childhood education and childcare centers
    - Support for public K-12 education, including special education (speech/PT/OT)
    - Parental education and involvement, including lactation and prenatal support
    - Sexual and pregnancy health education for teens and young adults
5. Basic and Comprehensive Needs
    - Affordable housing, including for single parents
    - Access to nutritious, culturally appropriate food
    - Transportation access, particularly for rural and low-income families
    - Financial education and management support
    - Safety and stability in communities (housing, reduced substance use, safe homes)
6. Mental Health and Community Support
    - Trauma-informed care and support for families with high needs
    - Peer support groups and community programs to reduce social isolation
    - Mental health support for educators and community workers
    - Community spaces for education, advocacy, and social connection

(Continued…) Please use this space to tell us of any other important things that women and mothers, children, children with special health care needs, and families need to live their fullest lives in North Dakota. Verbatim responses can be found at the end of this Appendix. Themes identified from the open-ended prompt:

7. Systemic and Policy-Related Issues
    - Addressing community factors that influence health outcomes
    - Assurance that MCH populations achieve their full health potential
    - Past trauma and history, fair access, and systemic disadvantages
    - Investment in vulnerable populations and preventive health services
    - Policy support for public health, housing, and childcare systems
8. Information and Resource Accessibility
    - Awareness and navigation of existing resources and community programs
    - Clear communication about available services and eligibility
    - Community spaces for information dissemination and support

In your community, what are the top THREE biggest unmet needs of women and mothers (all adult women, mothers, and identifying pregnant women through 60 days postpartum)? Select your top three categories from the list below. Hover over each category for more detail. Indicate your response by typing the number 1, 2 or 3 into the box, with 1 being your most important category.



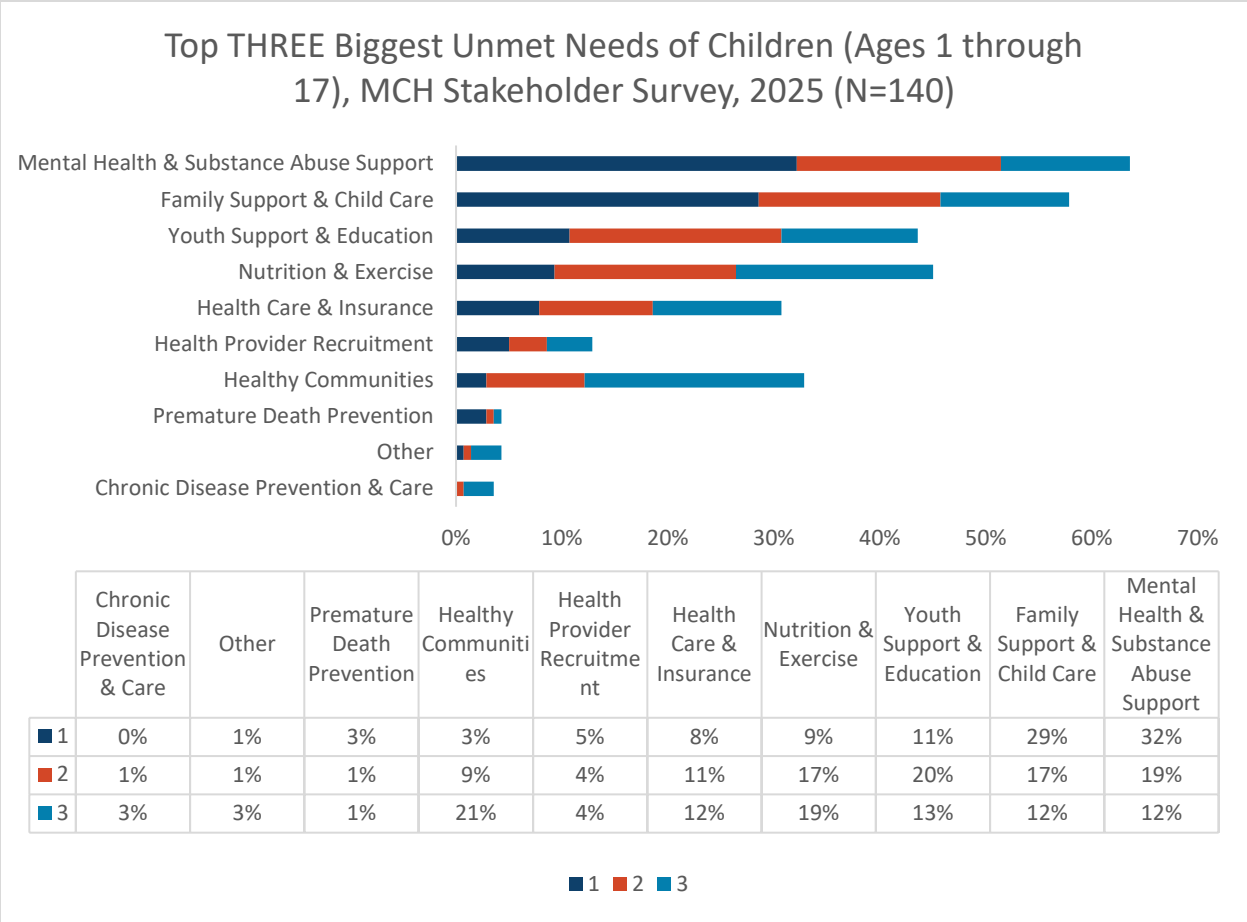
	Other	Premature Death Prevention	Healthy Communities	Healthy Birth Outcomes	Chronic Disease Prevention & Care	Nutrition & Exercise	Health Provider Recruitment	Health Care & Insurance	Mental Health & Substance Abuse Support	Family Support & Child Care
1	1%	2%	2%	2%	2%	3%	5%	14%	34%	36%
2	0%	1%	10%	8%	3%	8%	5%	14%	23%	27%
3	1%	4%	16%	1%	4%	10%	6%	18%	20%	17%

Stakeholders identified the same priorities for women and mothers' unmet needs as they identified for importance statewide: family support and child care, mental health and substance abuse support (3rd most important but 2nd highest unmet need) and health care and insurance (2nd most important and 3rd most important need).

Other - Please specify:

- Cost of living
- oral health which is under chronic disease

In your community, what are the top THREE biggest unmet needs of children (ages 1 through 17)? Select your top three categories from the list below. Hover over each category for more detail. Indicate your response by typing the number 1, 2, or 3 into the box, with 1 being your most important category.



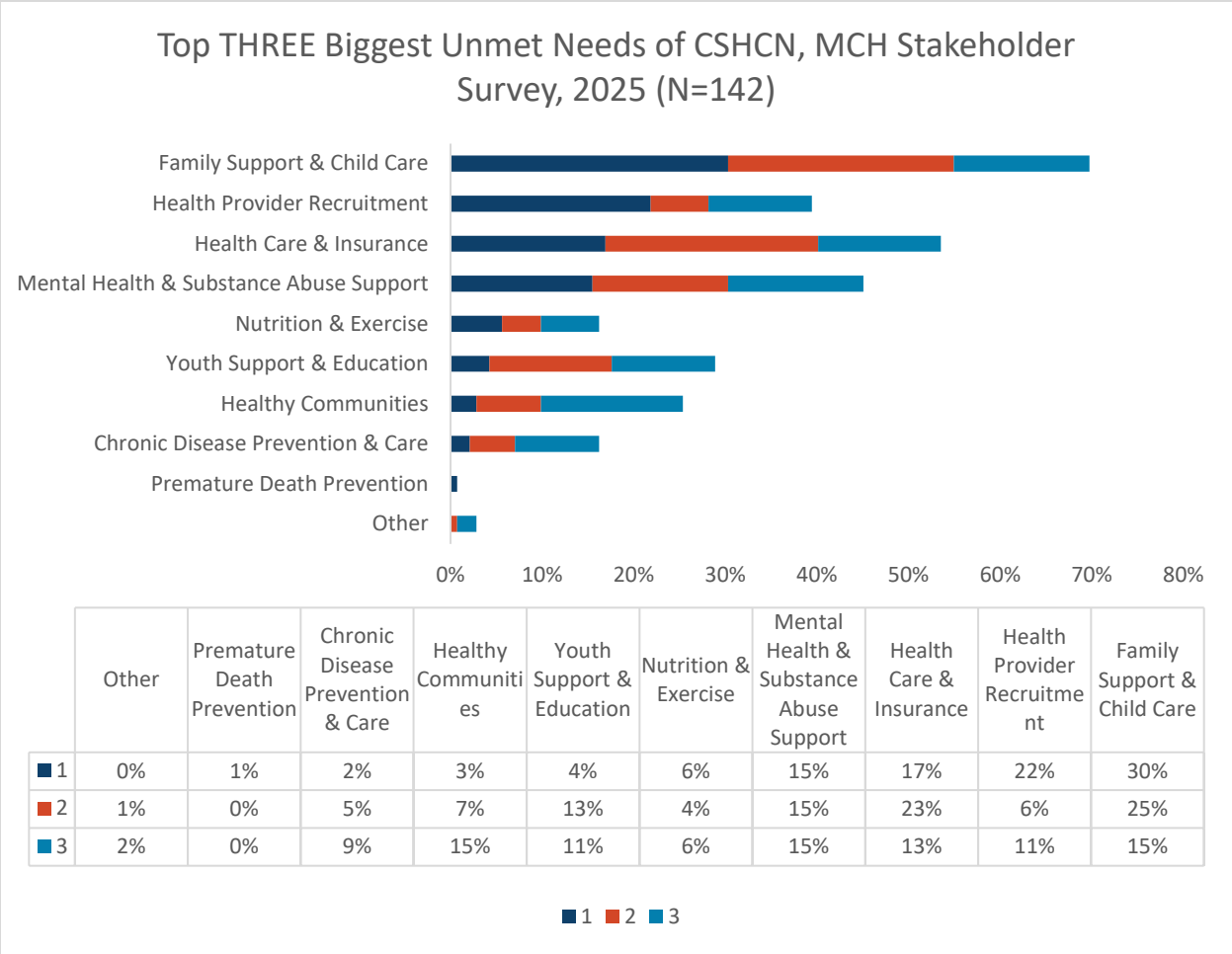
	Chronic Disease Prevention & Care	Other	Premature Death Prevention	Healthy Communities	Health Provider Recruitment	Health Care & Insurance	Nutrition & Exercise	Youth Support & Education	Family Support & Child Care	Mental Health & Substance Abuse Support
1	0%	1%	3%	3%	5%	8%	9%	11%	29%	32%
2	1%	1%	1%	9%	4%	11%	17%	20%	17%	19%
3	3%	3%	1%	21%	4%	12%	19%	13%	12%	12%

Stakeholders identified similar priorities for children in North Dakota as they did for unmet needs in their communities. Mental health and substance abuse support was the largest unmet need and 2nd most important in ND. Family support and childcare was identified as the number 1 most important statewide and the 2nd largest unmet need among children. Youth support and education as well as nutrition and exercise were identified as the 3rd priorities.

Other - Please specify:

- Cost of living
- dental care
- Dental Care
- housing
- oral health/chronic disease
- Pediatric care

In your community, what are the top THREE biggest unmet needs of children with special health care needs (ages 0 through 21)? Select your top three categories from the list below. Hover over each category for more detail. Indicate your response by typing the number 1, 2, or 3 into the box, with 1 being your most important category.

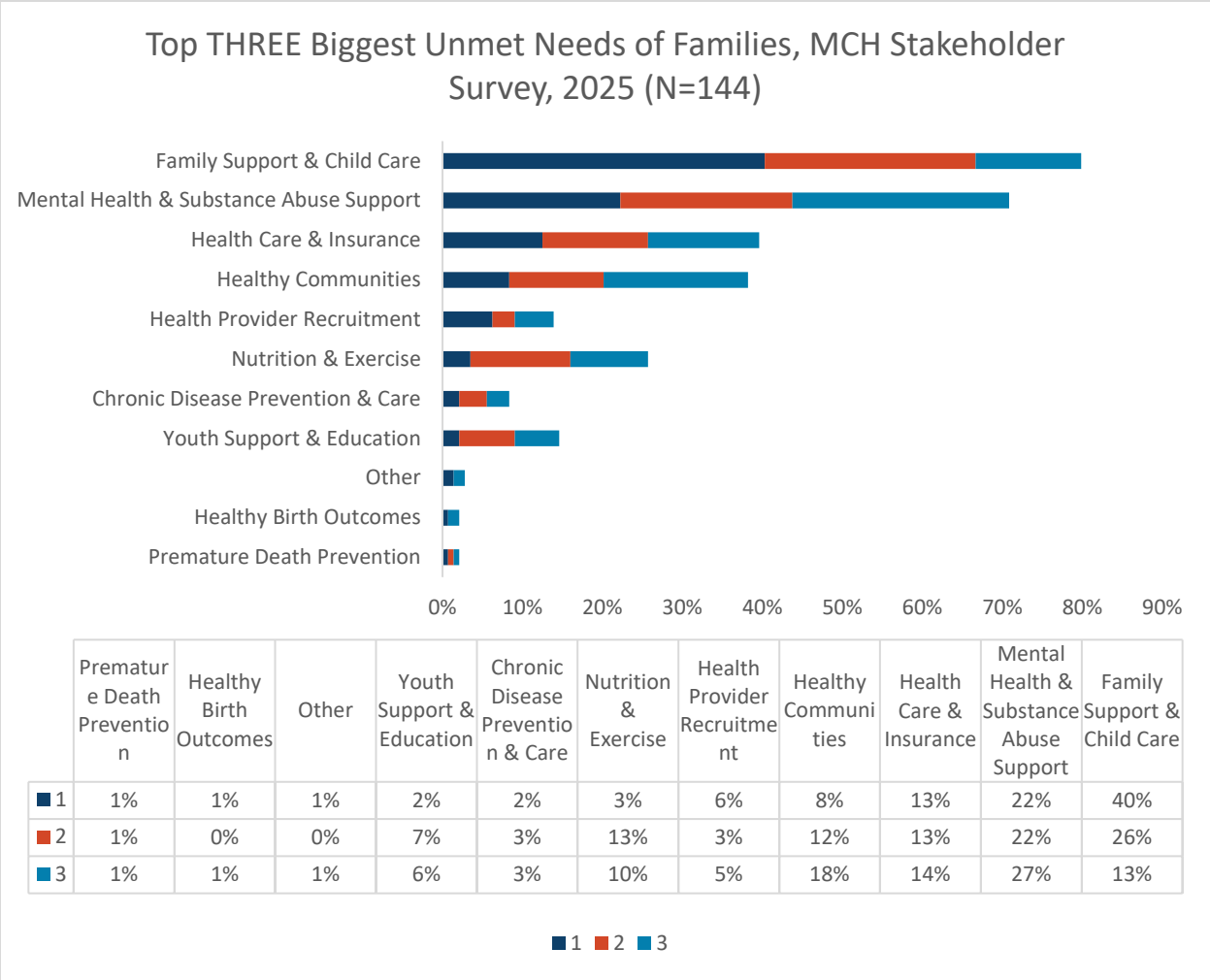


	Other	Premature Death Prevention	Chronic Disease Prevention & Care	Healthy Communities	Youth Support & Education	Nutrition & Exercise	Mental Health & Substance Abuse Support	Health Care & Insurance	Health Provider Recruitment	Family Support & Child Care
1	0%	1%	2%	3%	4%	6%	15%	17%	22%	30%
2	1%	0%	5%	7%	13%	4%	15%	23%	6%	25%
3	2%	0%	9%	15%	11%	6%	15%	13%	11%	15%

In your community, what are the top THREE biggest unmet needs of children with special health care needs? Select your top three categories from the list below. Hover over each category for more detail. Indicate your response by typing the number 1, 2, or 3 into the box, with 1 being your most important category. - Other - Please specify:

- Pediatric OT, PT, speech
- oral health
- awareness of programs available
- Access to Special needs providers

In your community, what are the top THREE biggest unmet needs of families? Select your top three categories from the list below. Hover over each category for more detail. Indicate your response by typing the number 1, 2, or 3 into the box, with 1 being your most important category.



	Premature Death Prevention	Healthy Birth Outcomes	Other	Youth Support & Education	Chronic Disease Prevention & Care	Nutrition & Exercise	Health Provider Recruitment	Healthy Communities	Health Care & Insurance	Mental Health & Substance Abuse Support	Family Support & Child Care
1	1%	1%	1%	2%	2%	3%	6%	8%	13%	22%	40%
2	1%	0%	0%	7%	3%	13%	3%	12%	13%	22%	26%
3	1%	1%	1%	6%	3%	10%	5%	18%	14%	27%	13%

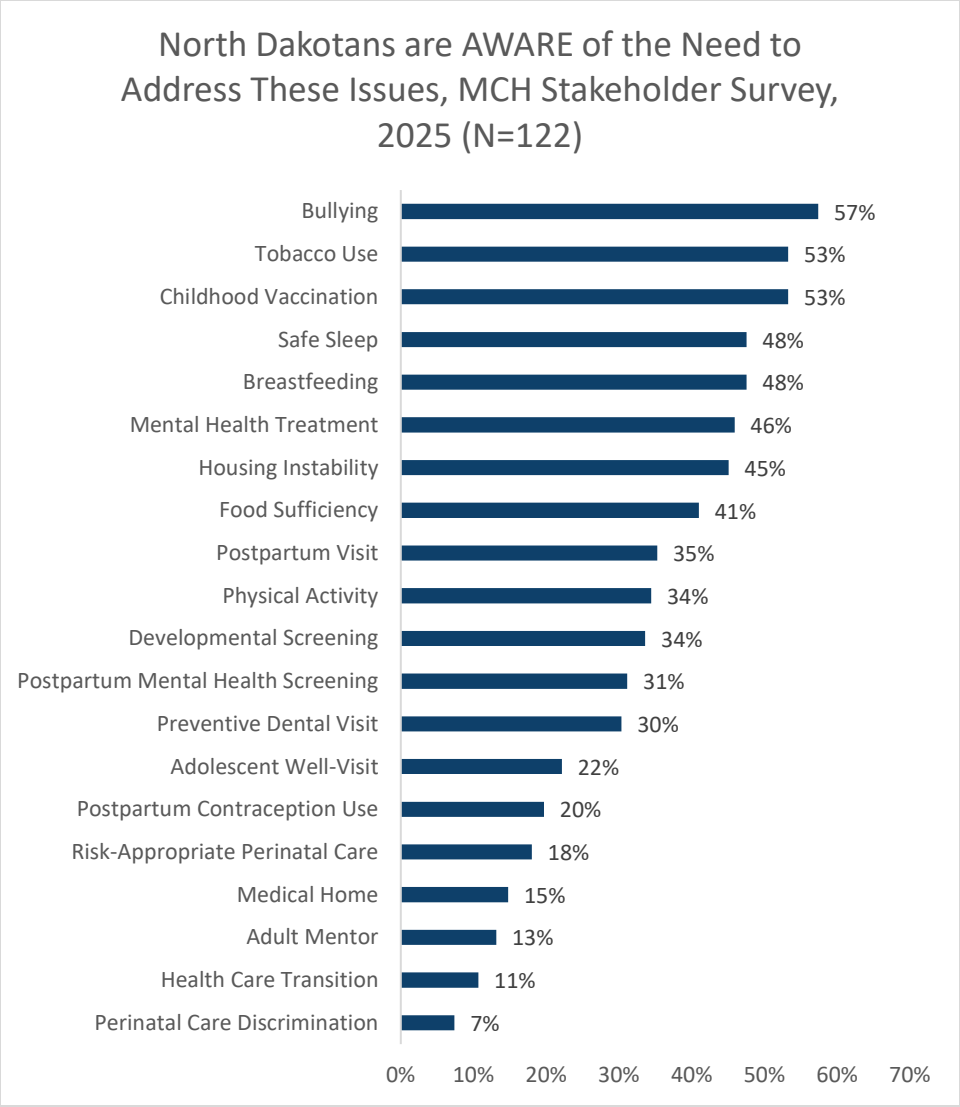
In your community, what are the top THREE biggest unmet needs of families? Select your top three categories from the list below. Hover over each category for more detail. Indicate your response by typing the number 1, 2, or 3 into the box, with 1 being your most important category. - Other - Please specify:

- housing, transportation, food
- oral health

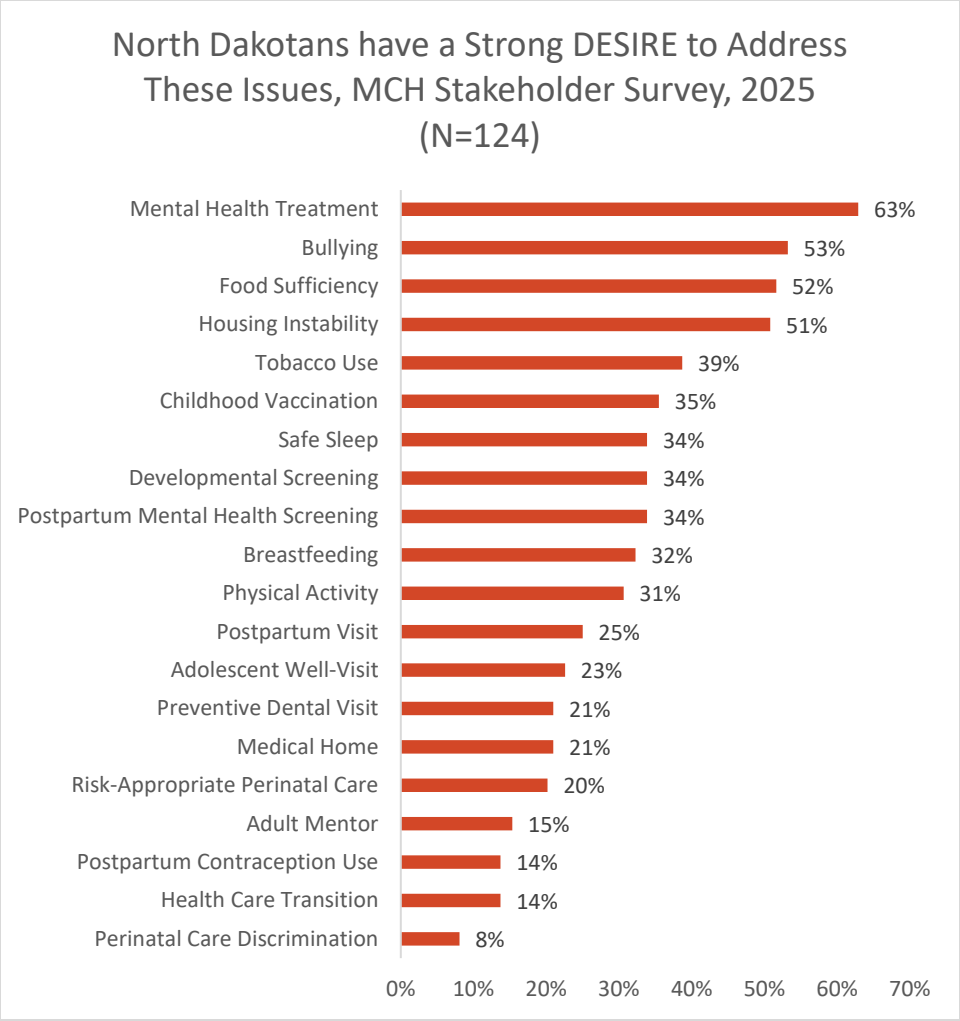
Please use this space to tell us of any other unmet needs of women and mothers, children, children with special health care needs, and families in your community. Verbatim responses can be found at the end of this Appendix. Themes identified from the open-ended prompt:

1. Access to Health and Wellness Resources:
    - Childcare: Scarcity, high cost, and lack of specialized care for children with special needs.
    - Housing: Lack of affordable housing, homelessness, and housing instability.
    - Health care: Limited access to health care providers, mental health services, and specialty care, especially in rural areas.
    - Food Security: Issues with food accessibility and insecurity.
    - Transportation: Limited transportation options impacting access to services.
2. Community and Social Support:
    - Community Building and Social Connections: Need for community support, healthy relationships, and opportunities for social interaction.
    - Respite Care and Support for Caregivers: Especially for parents and families of children with special needs.
    - General Support Systems: Importance of human interactive support and community involvement.
3. Education and Awareness:
    - Public Health Education: Awareness about preventive health, substance abuse risks, and other public health concerns.
    - Educational Resources: Need for educational materials in multiple languages and public knowledge of available programs.
    - Financial Education and Workforce Development: Education to enhance financial stability and employment opportunities.
4. Systemic and Policy-Related Challenges:
    - Service Accessibility and Navigation: Complexity of service eligibility and overwhelming paperwork, suggesting a need for better service navigation systems.
    - Rural Community Challenges: Limited local infrastructure, including lack of grocery stores, clinics, and other essential services.
    - Policy Gaps and Advocacy Needs: Need for systemic changes in housing policies, health care coverage, and childcare support.
5. Health and Well-being:
    - Mental Health: Scarcity of mental health providers and support systems.
    - Preventive Health and Chronic Disease Care: Lack of preventive health focus and insufficient health care resources.
    - Physical Activity and Recreation: Limited access to physical activities and safe recreational spaces.

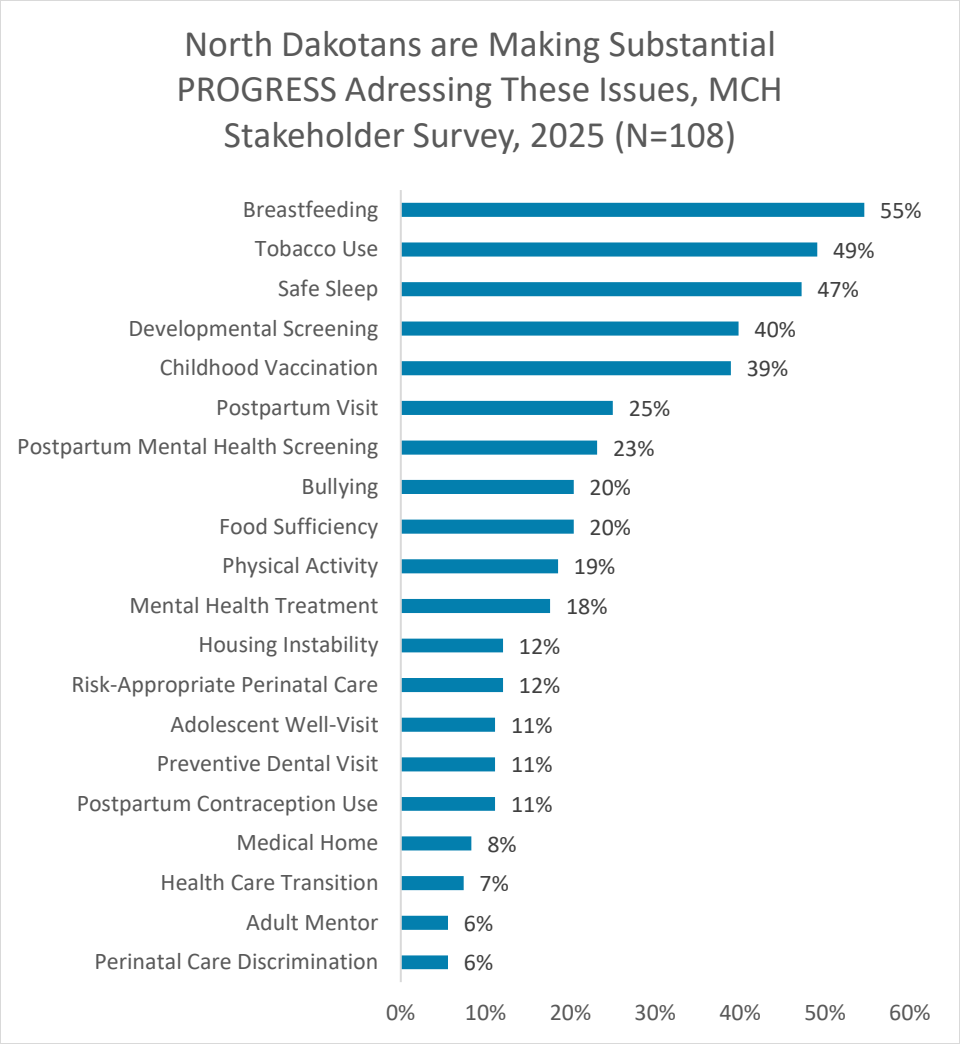
Below is a list of national MCH Block Grant performance measures that have been established across the population areas (women and mothers, infants, adolescents, and children, including children with special health care needs). Please hover over each one for important details or refer to the Performance Measure Glossary in your survey invitation. Please select the measures you believe support this statement:



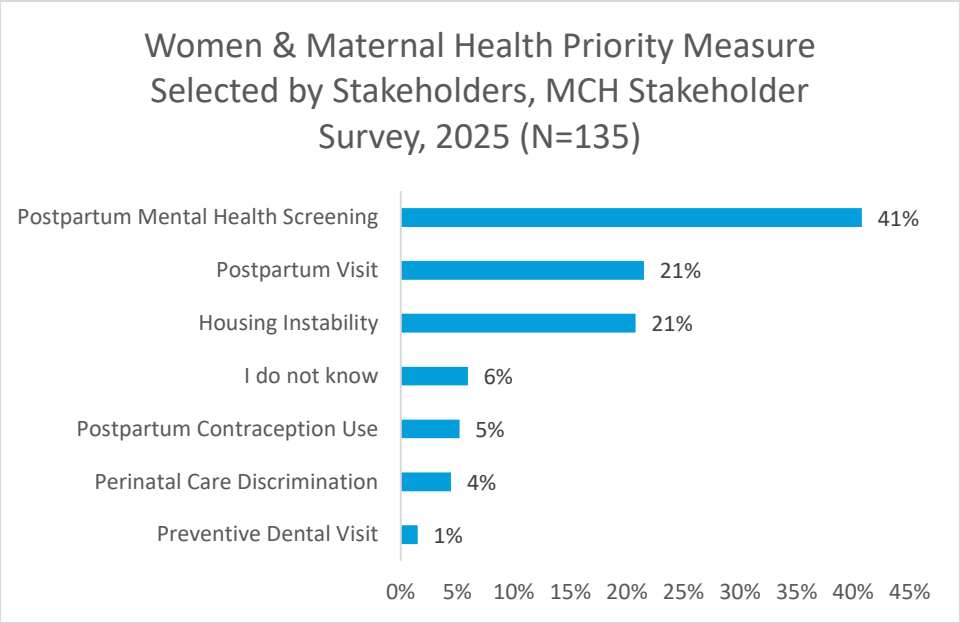
Below is a list of national MCH Block Grant performance measures that have been established across the population areas (women and mothers, infants, adolescents, and children, including children with special health care needs). Please hover over each one for important details or refer to the Performance Measure Glossary in your survey invitation. Please select the measures you believe support this statement:



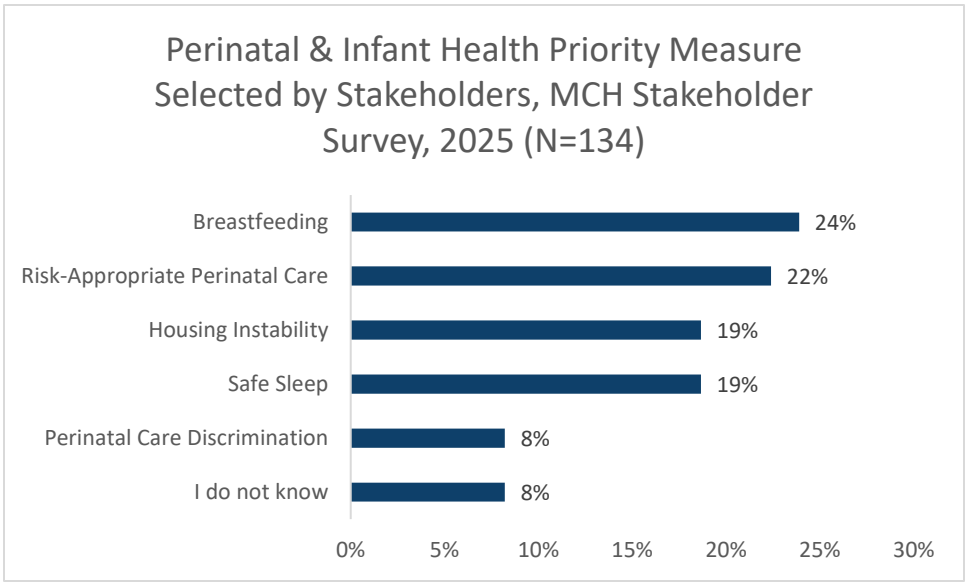
Below is a list of national MCH Block Grant performance measures that have been established across the population areas (women and mothers, infants, adolescents, and children, including children with special health care needs). Please hover over each one for important details or refer to the Performance Measure Glossary in your survey invitation. Please select the measures you believe support this statement:



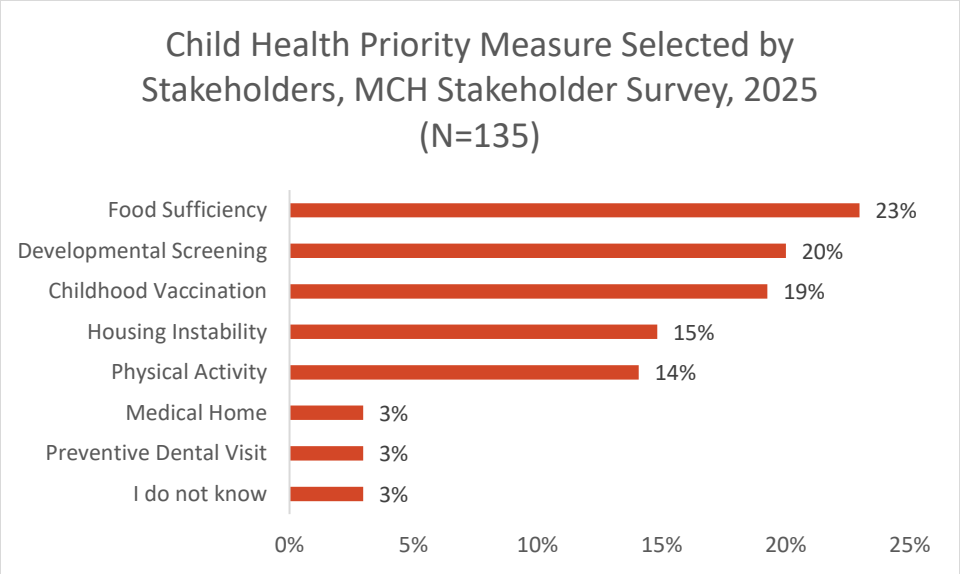
Please select the ONE performance measure you think should be the priority for the <u>women and maternal health</u> population group (all adult women, mothers, and identifying pregnant women through 60 days postpartum).



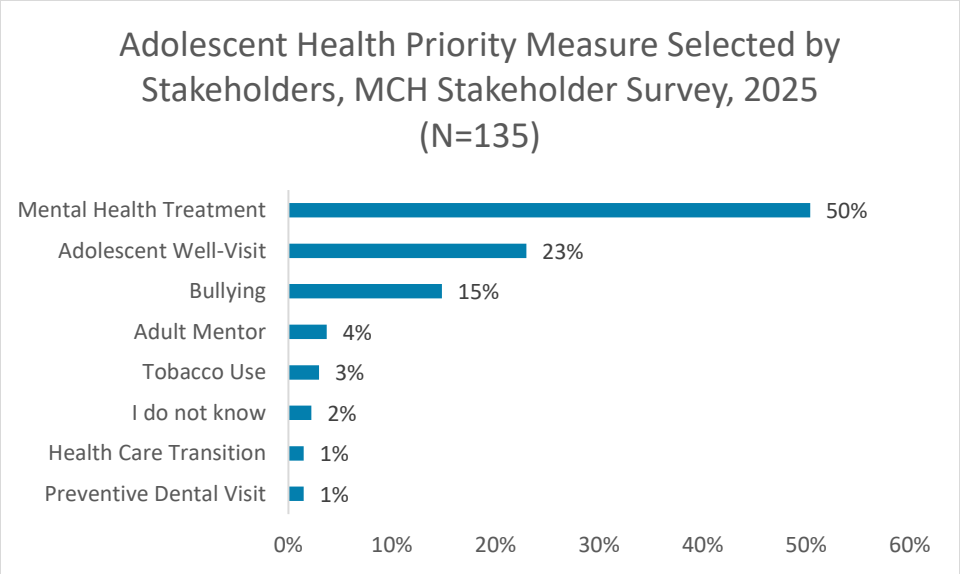
Please select the ONE performance measure you think should be the priority for the <u>perinatal and infant health</u> population group (including the perinatal period immediately before and after birth and including infants less than one year old).



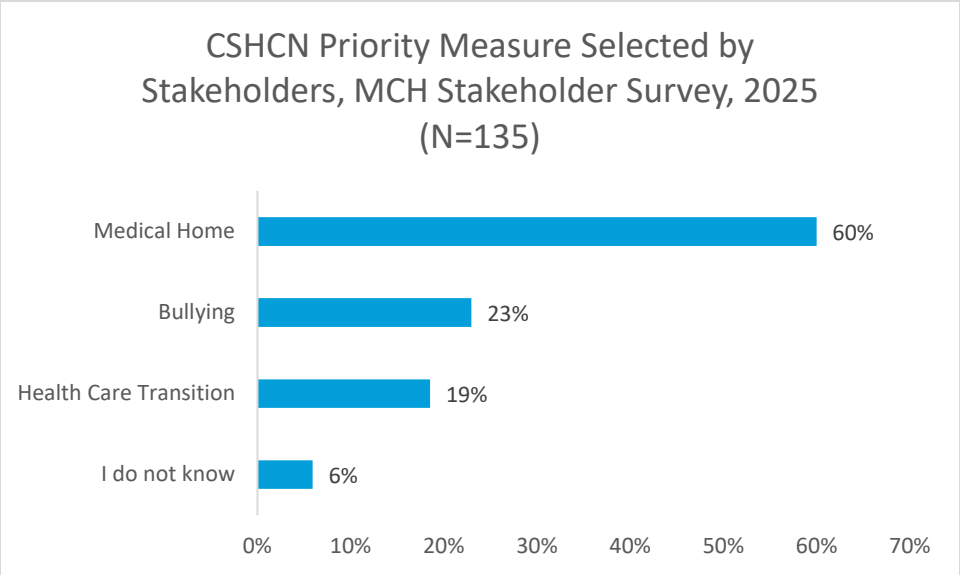
Please select the ONE performance measure you think should be the priority for the <u>child health</u> population group (ages 1 through 17).



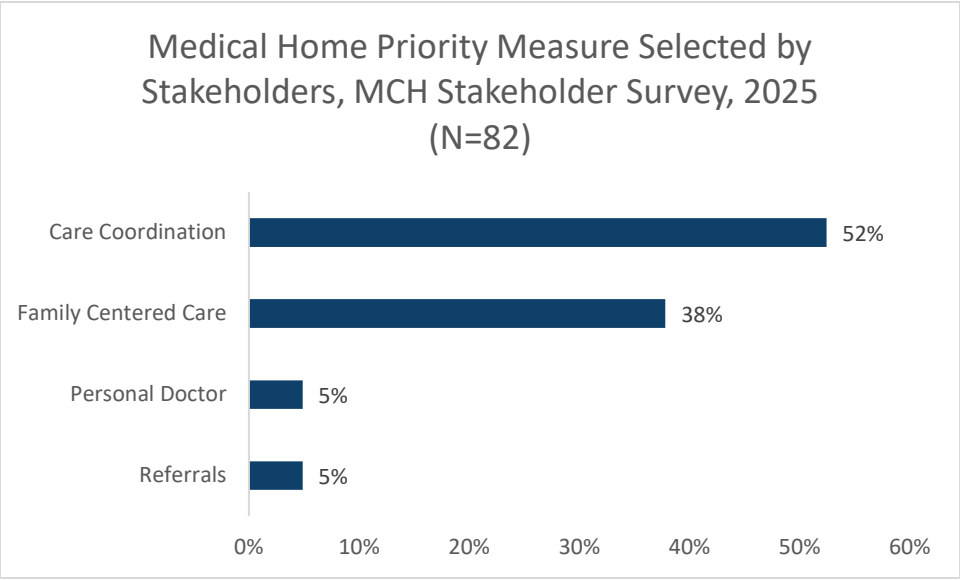
Please select the ONE performance measure you think should be the priority for the <u>adolescent health</u> population group (ages 12 through 17).



Please select the ONE performance measure you think should be the priority for the children with special health care needs population group (ages 0 through 21).



You selected medical home as the priority measure for at least one population group (adolescents and/or CSHCN). A medical home is a patient-centered model of care that provides comprehensive primary care and coordinates care across the health care system. There are multiple components of a medical home. Can you please specify the ONE medical home component that you think should be the priority within medical home? Hover over each medical home component below for more detail.



Please use this space to tell us of any other important measures and unmet needs we may have missed or any other comments and feedback you would like us to consider for North Dakota's Title V Maternal and Child Health Services Block Grant. Verbatim responses can be found at the end of this Appendix. Themes identified from the open-ended prompt:

1. Access to Health and Wellness Resources
    - Safe and healthy physical activity, including swimming.
    - Lack of physical activity opportunities due to weather or geographic constraints.
    - Need for IBCLC (lactation support) in rural communities.
2. Mental Health and Social-Media
    - Mental health concerns related to social media usage and medical misinformation.
    - Inpatient mental health treatment for children.
    - Perinatal mental health screening and awareness.
    - Screening for depression, anxiety, and other mental health issues in the perinatal and postpartum periods.
3. Child and Family Services
    - Quality childcare/preschool access.
    - Parent education.
    - School health services and injury prevention.
    - Support for schools, especially for special needs children.
4. Access to Health Ccare
    - Specialty care shortages (e.g., dentists, optometrists, orthodontists, mental health professionals) in rural areas.
    - Medicaid Waiver Program challenges impacting access to medical care.
    - Unmet needs of minority groups and New American populations.
5. Factors Influencing Health Outcomes
    - Food insecurity among youth.
    - Transportation challenges and expenses in rural areas.
    - Cost of living impacting program sustainability and affordability for families.
6. Financial Support and Sustainability
    - Reliance on donor funding for nonprofit operations.
    - Need for financial assistance for providers to manage rising costs.
    - Grants and resources to maintain programs and reduce costs for parents.
7. Community and Stakeholder Involvement
    - Opportunities for programs to align with community needs.
    - Desire for further discussion with stakeholders for program alignment

What is the name of your organization or program? - Please specify: Verbatim Responses:
▪ DHHS
▪ Advocates Leading their Lives
▪ Altru Health System
▪ ambulance service
▪ Aquafun
▪ BBPH
▪ Central Valley Health District
▪ Central Valley Health District
▪ CHI St Alexius Health Williston
▪ Child care
▪ childcare
▪ DHHS
▪ Dunn County Sheriff
▪ Early Explorers Head Start
▪ Early Explorers Head Start & Early Head Start
▪ Extension
▪ Extension
▪ Families Flourish North Dakota
▪ Family Voices
▪ Fargo Cass Public Health
▪ Fargo Fire Department
▪ Grand Forks Public Health
▪ Health & Human Services
▪ Health Tracks
▪ Healthy Families
▪ Healthy Families UspireND
▪ HHS
▪ HHS
▪ HHS, HSC
▪ Indigenous Association, NDSCS
▪ Jamestown Regional Medical Center
▪ Killdeer Area Ambulance
▪ LaMoure County Public Health Department
▪ Learn & Play House
▪ Lil Hawks and Lil Sparks Daycare
▪ Little Hero's Daycare
▪ Little Scholars Learning Centers
▪ Mandaree EMS/ White Shield EMS
▪ Minot Infant Development Program
▪ MyAlly Health
▪ ND DHHS
▪ ND EMSC
▪ NDDHHS
▪ NDDoHYAB
▪ NDSU Extension

What is the name of your organization or program? - Please specify: Verbatim Responses:
▪ NDSU Extension
▪ NDSU Extension
▪ NDSU Extension
▪ NDSU Extension
▪ NDSU Extension
▪ NDSU Extension - Stutsman County
▪ NDSU Extension Mercer County
▪ NDSU Extension- Parent Educator
▪ NDSU Extension-Family Nutrition Program Agent
▪ Nelson-Griggs District Health Unit
▪ North Dakota Health & Human Services
▪ North Dakota Perinatal Quality Collaborative
▪ North Dakota State University Extension
▪ Red River Children's Advocacy Center
▪ Rolette County Public Health
▪ Rolette County Public Health District
▪ Safe Kids Bismarck-Mandan
▪ Safe Kids Fargo-Moorhead
▪ Safe KIds Grand Forks
▪ Safe Kids Grand Forks
▪ Sanford health
▪ Sanford Health
▪ Special Health Services
▪ Trinity Health
▪ UND Center for Family Medicine/NDDHHS
▪ UPPER MISSOURI DISTRICT HEALTH UNIT
▪ USpireND
▪ USpireND - Healthy Families
▪ USpireND Healthy Families
▪ Uspirend healthy families nd
▪ Valley-Edinburg School District
▪ WCDHU
▪ Wells County District Health
▪ Wells County District Health Unit
▪ West River Head Start
▪ Western Plains PH
▪ Western Plains Public Health
▪ WIC
▪ Women Empowering Women
▪ Women's Care Center

Please use this space to tell us of any other important things that women and mothers, children, children with special health care needs, and families need to live their fullest lives in North Dakota. Verbatim responses to the open-ended prompt:

- 3 months paid maternity leave for woman and men, help caring for family members who are aging- emphasis on paid dependent leave, childcare offered by employers,
- A focus on decreasing social media and finding healthy replacements for time spent on line.
- Access to affordable after school programs and school transportation. Access to affordable outpatient services for those without insurance.
- Access to affordable and high quality child care to rejoin the workforce
- Access to better insurance to cover medical costs. Child care centers that have the training and building to have wheelchair accessible and staff with knowledge of care for any children with special needs.
- Access to culturally competent prenatal and post partum care.
- Access to dental care - have to travel 2-3 hours for simple exam/cleaning and wait months for work.
- Access to affordable healthy foods - cost of fresh fruits and vegetables is outrageous.
- More mental health providers.
- More better/services in the school - speech/PT/OT
- Support for educators - more kids have special needs
- Access to healthcare resources and an understanding of how to access. I like the idea of community health ambassadors who can work with individuals one on one to help them navigate the system and find the resources they need.
- Access to mental health services in their community and in their school.
- Access to OB, etc. within their community. More visuals/videos explaining things rather than just at doctors office-people tend to forget what was told to them.
- Access to services is a challenge. Services is are available, but how to acquire them or afford them is a challenge. Long wait times for mental health services is a significant barrier.
- Access to specialty care that is affordable to everyone.
- access to specialty services to meet specific needs, without having to travel across the state for care.
- Access to translation services for those not speaking English. Access to affordable housing and childcare. Mental health support.
- Adequate health insurance and supports
- Affordable Healthcare. Support from family, Healthcare professionals and work/school
- Affordable, quality childcare is in high demand and short supply. We need to increase numbers of available mental health care providers.
- All of the categories listed in the survey are important for North Dakotan's to live their healthiest lives. Each area may be different. Rural areas have different struggles than urban areas. In our rural community's access to healthy foods, healthcare services, childcare and options for physical activity are all struggles.
- Anything that promotes sanity in being asked to have and raise children, work full time +, and support the community
- Better access to healthcare, more insurance options (affordable) for the self-employed workers, farmers, ranchers, etc. In addition, more access to education in our rural, remote areas.
- Better Doctors, especially in speciality areas.
- Better education and resources in rural areas for childcare and special education

Please use this space to tell us of any other important things that women and mothers, children, children with special health care needs, and families need to live their fullest lives in North Dakota. Verbatim responses to the open-ended prompt:

- Childcare is a huge issue across our region that prevents families from being able to work which then provides financial strains as well. Mental health resources also lack in our community and substance abuse is becoming more and more of a problem.
- Education and Workforce Development, Housing Stability, Transportation Access
- Education on what spending time with the family means." Spending time with the family" verses "Quality time with the Family".
- Families need access to social connections or access to a social network of positive individuals, starting prenatally. They need access to affordable and safe housing. Pregnant women need more access to perinatal mental health supports.
- Families need community support with friends, faith-based relationships or other relationships that support them.
- Families need to be able to afford the basic necessities. Health insurance should be unaffordable for ANYONE in this god-forsaken country.
- financial education and management support
- General overall support. There are so many facets a healthy, fully thriving life, and what support is most needed is going to vary vastly from one family to another. Having resources *available* is only half the need. The also need to be accessible, and sometimes that takes an extra hand to help navigate through. Community, human interactive support, is what women and mothers, children, children with special health care needs, and families need the most to live their lives to the fullest.
- Have more options for transporatation.
- Affordable daycare
- Having community programs that offer peer interaction and promote healthy behaviors can be so helpful.
- Healthcare, jobs, childcare, Higher education can present opportunities for people live their fullest life in ND
- Help for rape and abuse victims. Supporting working families with childcare, more time off for mothers who wish to stay home with their newborn until 3 or more months.
- High quality childcare and early education.
- Safe affordable housing.
- Jobs with pay parity at a livable wage
- Access to healthy communities including food sources, clean air, safe physical opportunities.
- Mental and behavioral health tools.
- Home visitation support
- I feel that we need better transportation needs for families that do not have the transportation to and from appointments specifically the ones that need to be seen out of town or state.
- I recently learned about Anne Carlsen. I was blown away that even though we do not financially qualify for services, we qualify due to our child's medical needs. Because we qualify, we now have free weekly therapy, free insurance, medical bill assistance, access to WIC, and so much more. It is a free consult that ANYONE can have to see if their child 0-3 qualifies. It is such a great resource that I wish more knew about. It would help so many families. Families need help learning about free resources.. Families do not know what they do not know. When you are in the thick of everything, you do what is familiar for there is not time to try something that will not work. Families want to be healthy and thrive, they just need help finding clear paths that

Please use this space to tell us of any other important things that women and mothers, children, children with special health care needs, and families need to live their fullest lives in North Dakota. Verbatim responses to the open-ended prompt:

will not waist their time. (If there was a way to help bring families together for group play, I think that would be very beneficial. Learning about mental health and eating well while children play. Allowing the whole family to be involved while connecting with others in the community.)

- I think one of the biggest things is barriers in transportation with the bussing system being very difficult to understand and utilize.
- In my opinion the most important thing that ND needs access to is quality affordable childcare, giving over half of my monthly income to childcare is unfortunate, and because my husband and I have good paying jobs we qualify for no help with any assistance
- In rural communities mental health training for teachers and parents to recognize when children need help. Also more mental health resources for children.
- Information and support on how to obtain "important things" as anticipated or needed.
- Insurance is the biggest challenge for mothers and children in the NFI community
- It is difficult to articulate the stresses families are facing from mental health concerns to financial worries (cost of child care, high costs of living, etc.). One thing builds on the other and often makes it hard to know where to start first when providing support to a family. In addition there are concerns with things like screen time (for all members of the family), substance use challenges, etc. These are very broad topics but impacting so many families.
- Living in a town with a critical access hospital it is hard to care for the community when we dont have specialty care or hard to keep providers at all.
- Lower housing and grocery prices Middle-income families are struggling but do not qualify for any assistance. programs.
- Many ND Families struggle with childcare access while working multiple jobs to support single families. Parents often have limited time and resources to raise their family while earning enough to keep rooves over their heads and food on tables while children suffer from not having more interpersonal time with their parents.
- Most importantly for children with special health care needs, most behavioral health centers do not provide medication management services; a missing piece is the care continuum for this population.
- Mothers and children need lactation support as it is the first food. Women often do not have access to specialized lactation support from an IBCLC. Increasing access to specialized lactation support will increase out breastfeeding rates and duration. Breastfeeding helps keep out communities healthy and is also good for our economy.
- No suggestions
- normalize neurodivergency in youth. create trainings for athletic coaches, teachers, aides, EVERYBODY needs to understand this more in order to remain patient when guiding youth.
- North Dakota needs a plan to support the creation and operation of more high quality childcare centers in our communities. They also need to get serious about supporting public K-12 education in the state. Consequences of not supporting childcare and education in the state may not be clear today, but we will undoubtedly see the affects of this lack of investment in the future.
- Opportunities for sexual health and pregnancy education for teens and young adults. It takes supported parents to have these educational conversations with their children, otherwise they learn it from peers or online.
- Pregnancy and women's health education is also important. These experiences in life often happen after high school where, if you don't have the correct support and guidance, it can be

Please use this space to tell us of any other important things that women and mothers, children, children with special health care needs, and families need to live their fullest lives in North Dakota. Verbatim responses to the open-ended prompt:
hard to find trustworthy sources of information to learn more about our bodies processes (ex. hormones, healthy eating, healthy cycles and pregnancies). Visiting your doctor is a great resource, but if cost is a barrier it would be hard to schedule and appointment to ask all the questions.
▪ Oral health prevention and screening impacts overall health.
▪ Parent involvement.
▪ Parent who live on the edge (e.g. history of substance abuse disorder, CPS involvement, incarceration, etc.) do not have enough support to stay successful. They get dropped by the child welfare system too quickly and are too often on their own to figure out transportation for their children with special healthcare needs to get specialist care across the state or in Minnesota. They don't get enough in-home support and mentoring and are essentially set up to fail. If the transition to child-parent reunification, or following a CPS complaint that required some action, was followed by a higher level of support, including mental health/substance abuse support, parents would have a better chance at being successful. They need accountability from a system of care that will support the child with special needs (I work in early intervention), provide crisis care and transportation to appointments, and provide in home support care to teach life skills and parenting skills. We have all these mental health/behavioral health programs approved by the Dept. of HHS but not enough providers.
▪ Peer groups/support groups
▪ Please don't think because the state provides a service that it is available to EVERYONE in ND. Some of the programs listed in the previous questions are attainable in the big cities but not in rural ND. I think a better way to ask is: What do women in metropolitan ND need? What do youth in rural ND need? etc.
▪ primary prevention.
▪ quality childcare, becoming independent of benefits in steps vs. 'all or nothing", quality education no matter what school district you are in, mental health and addiction services, affordable/safe housing.
▪ Resources-resources are not always talked about or known. It's important that women, children, and families are aware of the resources in the community and the ease to build a support system.
▪ Respite care
▪ Safe and reliable daycare, safe and affordable housing, safe and supportive communities
▪ Safe homes
▪ Less drug/alcohol use
▪ Education
▪ Health care providers that have time to address needs
▪ School health services for rural schools, as many do not have school nurses; In years past MCH funding was utilized to provide school health. Also so important are preventable disease topics such as CPR/First Aid/Safe Sitter/Child passenger safety, in addition to prenatal and breastfeeding support.
▪ Services as close to the home, using champions to deliver service is best. Paid family caregiver and peer support, such as Experienced Parent Program or FVND consultants, or Federation of Families provides a critical lens and support for families.

Please use this space to tell us of any other important things that women and mothers, children, children with special health care needs, and families need to live their fullest lives in North Dakota. Verbatim responses to the open-ended prompt:

- There are so many important things that women, children, and families need to live their fullest lives and to reduce risks such as family violence, neglect, and abuse that it can be challenging to know where to start. However, research has shown that starting with basic needs such as housing, access to transportation, food, and paid family leave, can reduce the risk of those things incredibly. So, while mental health and substance abuse support is fantastic and much needed, it is overall unhelpful when families are unsure where their next meal is coming from or if they are worried about where they are going to sleep tonight.
- They need to have access to resources that will help them make healthy living decisions. Healthcare is always the number one concern for families since costs can be astronomical. An ounce of prevention would help many families live healthier and happier lives.
- To have better mental health. Not to have it to be so hard long to get served
- Trauma is a huge issue for our families with high needs, we need to figure out how to support both the parents and the children especially the youngest children in obtaining services as well as learning to be successful as a family unit once needs can be met.
- We are finding it more and more difficult to connect with clients that need our services due to language barriers. We are seeing many more languages spoken in our communities and we seem to be lacking in communication resources to assist them successfully.
- We need a community space that can be used for holding classes, informative sessions, resource area, and advocate for parents. children and families. Many people do not know where to look for resources or feel comfortable. We need a community building with no charge to host to the public to hold community events!
- Thank you!
- We need adequate childcare with well-compensated and trained childcare providers. We need classrooms where teachers can teach and children can learn. Most of all, we need parents who can parent!
- When a client (Parent or Child) has a screening and needs a referral the community needs to have the appropriate supports/professionals to meet the needs. Example: Depression and Anxiety Screening - client will benefit from Mental Health Services yet waiting list for services. Also the need for clients to be screened and is that being done?

Please use this space to tell us of any other unmet needs of women and mothers, children, children with special health care needs, and families in your community. Verbatim responses to the open-ended prompt:

- Access to affordable childcare!
- Access to housing, child care and mental health is a struggle for all families, especially low income families or families with children with special needs.
- Access to providers. Access to healthy food.
- Access to respite care. Access to services that are within 20 miles of home
- Affordable Housing that gives the homeless an opportunity to get out of the situation. Unmet, needs in the area of homelessness applies across the life trajectory which means all ages can be affected.
- Being in a very small, rural community, there are not a lot of opportunities for families in general, so to have any options would be helpful. We do not have a grocery store, clinic, or gym to name options to keep families healthy. People have to travel great distances and for those families in need that is a huge barrier.
- Childcare and pediatric care in my community is scarce/unavailable.
- Childcare is incredibly expensive. Families are doing what they can to make ends meet. Many moms have to work nights or not at all so that they can bring their child to appointments and care for them. Small community daycare centers can not care for children with special health needs.
- Chronic disease prevention and care.
- Community Building
- Creating a uniform intake that identifies what services a family would be eligible for would be huge. The amount of paperwork it takes to see if you are eligible and to receive services is overwhelming. Having state navigators instead of overworked case managers that do not have the time would be beneficial. We need access to services.
- Education and public knowledge of programs. Families need to learn how to be a productive family.
- Education and Workforce Development, Housing Stability, Transportation Access
- financial education and support
- focus on preventive measures, not just acute reactions - seems we have lost our understanding of the value and importance of preventive health personal responsibility
- Food insecurity
- General overall support. There are so many facets a healthy, fully thriving life, and what support is most needed is going to vary vastly from one family to another. Having resources *available* is only half the need. The also need to be accessible, and sometimes that takes an extra hand to help navigate through. Community, human interactive support, is what women and mothers, children, children with special health care needs, and families need the most to live their lives to the fullest.
- Health care coverage and child care
- Lack of affordable housing, child care, and jobs that pay a living wage.
- Lack of importance placed on prevention with lack of providers in area. We don't have enough resources (dentist, optometrist, PCP, OB-GYN) to make preventative services a priority - takes weeks to months to see any provider so people only go in when it's an emergency.
- lack of options for children in relation to maintain healthy options in the community
- lack of specialty services within close proximity

Please use this space to tell us of any other unmet needs of women and mothers, children, children with special health care needs, and families in your community. Verbatim responses to the open-ended prompt:

- Mental health care providers are hard to find and access and have coverage to pay for those services. Transportation is limited for many folks who don't have vehicles. Housing for many as we have a large homeless or housing unstable population. Drug and ETOH use.
- mental health services (counselors), access to physical activities other than sanctioned sports, childcare services are limited, and all facilities have long waiting lists.
- n/a
- n/a
- Na
- NA
- No suggestions
- none
- Oral health screening and prevention which impacts overall health.
- Our community needs education on SUID causes and prevention. Childcare would be helpful for mothers to get breaks from the stresses of child rearing. IE; after school programs, recreation programs to help kids have safe places to play.
- People are disconnected and need support of community members. They need good healthy relationships with opportunities for lasting friendships and people to connect them with resources.
- Safe homes and communities
- Remove easy access to addictive substances
- Help moms feel confident and supported to raise their children
- Same as previous answer
- Some educational materials with vital information for members of my community are not translated into other languages, making it difficult for my community members to understand it's content
- support, walkability for less reliance on vehicles for commuting to all destinations (grocery stores, doctors offices)
- There are little to no providers providing mental health treatments in rural North Dakota.
- there are NOT enough providers in the state and nowhere near enough on tribal lands; health insurance is huge issue; food insecurity and housing are huge for indigenous people, many couch surf and look to drugs and sex trafficking to cope with survival needs
- There is a childcare crisis in our community and a mental health crisis. It's hard to find quality care for your child. If your child needs mental health services, you could be on a waitlist for weeks, months, years before getting in to see someone.
- There is very little access to support for children with Autism in my community, and in the rural areas of North Dakota. In my community, there is very limited access to professionals trained specifically in perinatal mental health. Safe and affordable housing is extremely hard to find for families in my community, and this has been an on-going challenge. Accessing affordable housing if there is a criminal history, even if it's been a couple years, is almost impossible to find in my community.
- Translation services and educational materials. Better processes in place for New American refugees coming to our community in large numbers that seem to not have great plans for support.
- Transportation

Please use this space to tell us of any other unmet needs of women and mothers, children, children with special health care needs, and families in your community. Verbatim responses to the open-ended prompt:

- Transportation to appointments.
- We have a lot of teen and young mothers who struggle to care for their children, especially when the child has special healthcare needs. They may be trying to live on their own, with a questionable partner, or with family that is dysfunctional and not fully supportive due to their own needs. We also need to do some public health education on the risks to babies from pregnant mothers using marijuana. I wish the public health agencies would spend some dollars on this as all I see in the public health arena is smoking cessation. Marijuana can cause respiratory failure in infants at birth, causing HIE and seizures, the need for resuscitation, and extended NICU stays. And yet, we see NOTHING out there. We often see these babies go home with their mothers and no support, other than maybe a Right Track referral. I don't even hear public health messaging against driving under the influence of marijuana--a separate issue. We have a lot of babies being born with multiple substances in their systems and especially for teen and young moms struggling with mental health and addiction issues, I wish there was more information and support in North Dakota.
- We have a lot of things to offer they just are not utilized as much as they could be.
- We lack a hospital, and the local clinic offers little to no services. We need community healthcare. We do not have a county health unit. Our health unit comes from Jamestown once a month. We deserve better from our county commissioners.
- We live in a very rural community where we do not have access to many services, child care, health care, healthy food options are difficult for families.
- We strongly, strongly lack child care options in Wells County. This creates a huge stress on mothers and children. This causes mothers to have to drive 20+ miles one way for child care or keep their children in unsafe, inadequate childcare, or remove their child from childcare and care for them at home while quitting their job causing undue financial and mental health stress. This also causes families to move away or choose not to relocate to our community due to not enough child care.

Please use this space to tell us of any other important measures and unmet needs we may have missed or any other comments and feedback you would like us to consider for North Dakota's Title V Maternal and Child Health Services Block Grant. Verbatim responses to the open-ended prompt:

- Access to safe and healthy physical activity and swimming is our mission.
- As a non-profit organization, we rely on our generous donors to support our every need. If we were to be considered for this grant, we would love to be able to purchase more educational modules for our clients. Thank you!
- Financial assistance through grants and other resources to help the providers rising cost. Often times support is only given to the families but not the providers. This would assist in programs remaining open and to keep parents' costs down.
- Focus on mental health concerns of social media. Medical misinformation on social media.
- I think raising awareness of perinatal mental health screening is vital for the health of pregnant women and their children. A lot of people are more aware of postpartum depression and anxiety because it has been talked about quite a bit in recent years. However, people don't talk about perinatal mental health as much which can be just as crucial to address and provides a great indicator/heads-up that mental health issues may continue or worsen in the postpartum period.
- I was unable to select more than one county in the previous question. It was one or a range but no way to select more than one county not adjacent on the list to another.
- I see so many more opportunities for our program to respond to the needs identified in these areas and would welcome more discussion on how we can further our work to align with your goals!
- Inpatient mental health treatment for children
- Access to IBCLC (lactation support) in rural communities
- Food insecurity to youth
- Lack of transportation or expense of transportation in rural areas. Lack of food resources and cost of food. Lack of child and family access to physical activity, especially in cold or wet weather.
- n/a
- NA
- Need significantly better access to quality childcare/preschool throughout the state
- Parent Education
- School Health services; Injury Prevention; While the current physical activity and breastfeeding are extremely important, we have chronic health, injury prevention and school health are vital services that are not currently funding and we can only support very limited services at the present.
- Screening for issues like depression, anxiety, hypertension, diabetes, and intimate partner violence in both the perinatal period and the postpartum period. These are main drivers of maternal mortality.
- Support for school - children spend nearly half their day at school. Educators need support for growing number of children with special needs.
- Specialty care - dentists, optometrists, orthodontists, mental health professionals, early intervention services; there just aren't enough in rural areas and people don't have the funds or transportation to get to the urban areas

Please use this space to tell us of any other important measures and unmet needs we may have missed or any other comments and feedback you would like us to consider for North Dakota's Title V Maternal and Child Health Services Block Grant. Verbatim responses to the open-ended prompt:

- This may not be fully related but is important. We service families free of charge through the Medicaid Waiver Program. Ever since they did the big system update, we have had challenges to family coverage. Sometimes they don't get their renewal letter and get dropped; sometimes there's an error in one child's coverage (a system issue) and they drop a sibling too; sometimes families are harassed about providing income when that is not required for early intervention; sometimes families are told they have to do some type of cost-share, also not a thing with the Medicaid Waiver Program. Not all of our families are good at self-advocating and so we work with DD program managers to try and resolve it. However, it has impacted some families' ability to receive timely medical care and this is not okay. I don't know why the system seems so prone to issues in the last year or so, but it would be nice if this could be resolved.
- Unmet needs of minority groups should be more specifically addressed.
- We serve people from all over the state.
- With the increase in the New American population across the state, it is pertinent to conduct a targeted needs assessment of this population to understand the landscape of their needs and barriers to health-related social needs.

Appendix D: Performance Measure Analysis

Postpartum Visit A: Percent of women who reported attending a postpartum checkup within 12 weeks after giving birth 2022 (FAD)		
ND 93.2%	Region 8 91.6%	United States 90.8%

North Dakota totals FAD (2022)

Metro 94.6% Non-Metro 91.6%	Married 96.4% Unmarried 86.3%

Postpartum visit attendance by education & year (PRAMS ARF)				
	2018	2019	2020	2021
Less than high school	64.9%	74.4%	82.9%	86.2%
High school or GED	87.1%	84.9%	80.9%	87.2%
Some college or Associate Degree	92.2%	88.8%	89.2%	92%
Bachelor Degree	98.7%	96.1%	95.9%	97.5%
Master, Doctorate or Prof. Degree	99.3%	95.9%	94.9%	94%

Postpartum visit attendance by race/ethnicity & year (PRAMS ARF)					
	2018	2019	2020	2021	2022 (FAD)
Hispanic	78.9%	81.7%	79.5%	87.8%	96.4%*
Am. Indian or Alaska Native	70.3%	67.8%	71.9%	68.2%	64.5%
Asian	87.8%	73%	X	89.8%	89.0%*
Black	96.5%	83.2%	79%	86.2%	84.6%
Nat. Hawaiian or other Pacific Islander	51.6%*	66.7%*	72.8%	X	X
White	94.6%	93.6%	91.8%	96.2%	96.7%
Other or multiple races	76.8%	83.3%	90.5%	84.2%	X

Postpartum visit attendance by age & year (PRAMS ARF)				
	2018	2019	2020	2021
Less than 20 years	87.9%	86.6%	87.8%	81.5%
20 through 29 years	89.0%	86.6%	88.7%	95%
30 through 39 years	93.9%	92.1%	90.2%	90.6%
40 years and older	97.8%	98.5%	80.8%	92.8%

Postpartum visit attendance by income & year (PRAMS ARF)				
	2018	2019	2020	2021
$0 to $28,000	79%	76.6%	79.5%	82.6%
$28,001 to $48,000	93.8%	93.4%	84.7%	97.6%
$48,001 to $85,000	96.4%	94.5%	94.2%	94%
$85,001 or more	97.7%	94.3%	96.1%	95.9%

Postpartum visit attendance by health insurance type & year (PRAMS ARF)					
	2018	2019	2020	2021	2022 (FAD)
Medicaid	80.1%	82.6%	75.8%	89%	84.6%
Private	95.7%	95.2%	95%	95.5%	97.4%
Other Public	92.6%	85.8%	89.7%	89.4%	90.0%
Uninsured	81.4%	62.9%	85.5%	89.4%	X

Due to low counts or large standard error (SE), some data may be unreliable. We bring attention to these data by representing it with an asterisk (*). Data points that have an unweighted denominator less than 30 are not reportable and have been omitted, noted with an X.

Postpartum Visit B: Percent of women who reported attending a postpartum checkup within 12 weeks after giving birth and that a healthcare provider talked to them about birth control methods and what to do if they felt depressed or anxious 2022 (FAD)		
ND 85.7%	Region 8 85.5%	United States 81.4%

North Dakota totals FAD (2022)

Metro 82.1% Non-Metro 89.7%	Married 85.0% Unmarried 87.3%

Postpartum visit with recommended care components by education & year (PRAMS ARF)				
	2018	2019	2020	2021
Less than high school	62.6%	69.8%	78.5%	86.2%
High school or GED	85.7%	84.7%	79.6%	86.6%
Some college or Associate Degree	92.2%	88.8%	89.1%	91.8%
Bachelor Degree	97.5%	95.5%	95.1%	97.5%
Master, Doctorate or Prof. Degree	99.3%	95.9%	95%	94%

Postpartum visit with recommended care components by race/ethnicity & year (PRAMS ARF)					
	2018	2019	2020	2021	2022 (FAD)
Hispanic	76.1%	77.3%	79.5%	87.8%	75.3%*
Am. Indian or Alaska Native	68.8%	67%	70.4%	68.2%	90.6%*
Asian	87.8%	73%	91.9%	89.8%	84.0%*
Black	96.5%	79.9%	76.2%	83.6%	78.9%
Nat. Hawaiian or other Pacific Islander	51.6%*	66.7%*	72.8%	X	X
White	93.6%	93.4%	91.6%	96.2%	86.5%
Other or multiple races	76.8%	78.6%	90.5%	83.6%	X

Postpartum visit with recommended care components by age & year (PRAMS ARF)				
	2018	2019	2020	2021
Less than 20 years	82.8%	86.6%	87.8%	81.5%
20 through 29 years	88.3%	85.8%	87.9%	94.7%
30 through 39 years	93.2%	91.3%	89.3%	90.5%
40 years and older	97.8%	98.5%	80.8%	92.8%

Postpartum visit with recommended care components by income & year (PRAMS ARF)				
	2018	2019	2020	2021
$0 to $28,000	78.4%	76.6%	78.3%	82.1%
$28,001 to $48,000	93.8%	93.4%	84.7%	97.6%
$48,001 to $85,000	96.4%	94.5%	94.2%	94.1%
$85,001 or more	97.7%	94.3%	96.2%	95.9%

Postpartum visit with recommended care components by health insurance type & year (PRAMS ARF)					
	2018	2019	2020	2021	2022 (FAD)
Medicaid	79%	82.4%	75.3%	89%	81.7%
Private	95.2%	94.9%	95%	95.5%	86.6%
Other Public	92%	85.7%	86.6%	89.1%	93.1%*
Uninsured	78%	57.8%	81.2%	83.2%	X

Due to low counts or large standard error (SE), some data may be unreliable. We bring attention to these data by representing it with an asterisk (*). Data points that have an unweighted denominator less than 30 are not reportable and have been omitted, noted with an X.

Postpartum Contraception Use: Percent of women who reported they are using a most effective (long-acting reversible contraceptive such as contraceptive implants and intrauterine devices or systems as well as irreversible surgical contraception) or moderately effective (injectables, oral pills, patches, rings, or diaphragms) method of contraception 2021 (PRAMS ARF)		
ND 71.6%	Region 8 82.1%	United States 75.7%

North Dakota totals 2021 (PRAMS ARF)

Metro 71.2% Non-Metro 72.0%	Married 73.9% Unmarried 66.6%

Women who are using a most or moderately effective contraceptive following a recent live birth by education & year (PRAMS ARF)				
	2018	2019	2020	2021
Less than high school	70.7%	65.2%	67.2%	49.4%
High school or GED	72.8%	68.7%	67.2%	73%
Some college or Associate Degree	76.4%	73.9%	74.9%	69.1%
Bachelor Degree	76.3%	80%	75.7%	75%
Master, Doctorate or Prof. Degree	83.2%	84.9%	80.1%	83.6%

Women who are using a most or moderately effective contraceptive following a recent live birth by race/ethnicity & year (PRAMS ARF)				
	2018	2019	2020	2021
Hispanic	73.1%	41.3%	56.9%	74.3%
Am. Indian or Alaska Native	71.2%	65.2%	67.7%	58.5%
Asian	87.5%	85.8%	79.4%	72.1%
Black	61.1%	64.5%	74.4%	71.6%
Nat. Hawaiian or other Pacific Islander	X	X	X	75%
White	76.6%	79%	72.3%	74.4%
Other or multiple races	71.4%	38.6%	90.7%	56.9%

Women who are using a most or moderately effective contraceptive following a recent live birth by age & year (PRAMS ARF)				
	2018	2019	2020	2021
Less than 20 years	85.2%	65.1%	85.1%	70.2%
20 through 29 years	74.6%	72.8%	71.8%	74.3%
30 through 39 years	75.7%	77.3%	74.9%	69.6%
40 years and older	68.6%	80.7%	71.6%	48.4%

Women who are using a most or moderately effective contraceptive following a recent live birth by income & year (PRAMS ARF)				
	2018	2019	2020	2021
$0 to $28,000	71.8%	66.1%	67.5%	65.1%
$28,001 to $48,000	80.2%	66.4%	72.2%	65.2%
$48,001 to $85,000	78.5%	80.6%	73.3%	73.4%
$85,001 or more	75.7%	83.3%	79.2%	75.8%

Women who are using a most or moderately effective contraceptive following a recent live birth by health insurance type & year (PRAMS ARF)				
	2018	2019	2020	2021
Medicaid	76%	63.2%	64.3%	64.4%
Private	75.5%	78.1%	79.2%	74.7%
Other Public	75.9%	81.8%	67%	67.7%
Uninsured	66.6%	65.7%	78.2%	79.1%

Due to low counts or large standard error (SE), some data may be unreliable. We bring attention to these data by representing it with an asterisk (*). Data points that have an unweighted denominator less than 30 are not reportable and have been omitted, noted with an X.

Risk-Appropriate Perinatal Care: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) by year (ND PRAMS)						
	2017	2018	2019	2020	2021	2022
Level III+ NICU	95.7%	100.0%	64.7%	58.4%*	100.0%	82.4%
Non-Level III+ NICU Hospital	4.3%*	-	35.3%	41.6%*	-	17.6%*

Infant Transferred: Percent of infants who were transferred after birth by very low birth weight (VLBW) status and year (ND PRAMS)						
Infant's Birth Weight	2017	2018	2019	2020	2021	2022
Less than 1500 grams (VLBW)	4.3%*	-	17.7%*	41.6%*	-	17.6%*
1500 grams and higher	0.9%	0.7%	0.5%	0.7%	1.7%	0.8%

For all available years (2017-2022) there is a weighted total of 493 VLBW infants born in hospital with a Level III+ NICU and 94 VLBW infants born at home or in a hospital without a Level III+ NICU. All available data points are reported but should be interpreted with caution. Those with a weighted total less than 30 are noted with an asterisk (*).

Breastfeeding A: Percent of infants for whom breastfeeding was initiated by hospital discharge 2021 (PRAMS ARF)		
ND 89.2%	Region 8 93.2%	United States 87.7%

North Dakota totals 2021 (PRAMS ARF)

Metro 88.9% Non-Metro 89.5%	Married 90.5% Unmarried 86.2%

Percent of infants who were ever breastfed by maternal education & year (PRAMS ARF)				
	2018	2019	2020	2021
Less than high school	79%	65.2%	79%	73.7%
High school or GED	79.3%	86.6%	85.2%	85.7%
Some college or Associate Degree	90.3%	90.4%	88.5%	90.7%
Bachelor Degree	96%	93%	94.5%	93.5%
Master, Doctorate or Prof. Degree	X	99.8%	92%	92.6%

Percent of infants who were ever breastfed by maternal race/ethnicity & year (PRAMS ARF)				
	2018	2019	2020	2021
Hispanic	99.1%	81.1%	91.5%	91.5%
Am. Indian or Alaska Native	71.3%	65.2%	70.8%	69.4%
Asian	91.4%	73%	93.5%	X
Black	85.2%	87.4%	83%	91.9%
Nat. Hawaiian or other Pacific Islander	X	66.7%*	X	75%
White	91.3%	93.3%	90.5%	89.8%
Other or multiple races	92.3%	77.8%	95.9%	95%

Percent of infants who were ever breastfed by maternal age & year (PRAMS ARF)				
	2018	2019	2020	2021
Less than 20 years	76.9%	71.1%	88.1%	79.2%
20 through 29 years	91.9%	89.8%	90%	90.1%
30 through 39 years	86.9%	89.5%	88.6%	89%
40 years and older	X	97.7%	78.2%	96%

Percent of infants who were ever breastfed by maternal income & year (PRAMS ARF)				
	2018	2019	2020	2021
$0 to $28,000	81.6%	79.3%	83%	87%
$28,001 to $48,000	93.2%	92.2%	88.6%	84.3%
$48,001 to $85,000	90.8%	92.1%	90%	88.9%
$85,001 or more	95.7%	94.7%	92.3%	93.5%

Percent of infants who were ever breastfed by maternal health insurance type & year (PRAMS ARF)				
	2018	2019	2020	2021
Medicaid	81.3%	73.4%	83.8%	85.2%
Private	93.9%	93.8%	91.2%	90%
Other Public	89.5%	90.5%	87.3%	90.1%
Uninsured	83.7%	89.1%	89.2%	95.2%

Due to low counts or large standard error (SE), some data may be unreliable. We bring attention to these data by representing it with an asterisk (*). Data points that have an unweighted denominator less than 30 are not reportable and have been omitted, noted with an X.

Breastfeeding B: Percent of children, ages 6 months through 2 years, who are reported by a parent to have been breastfed or fed breast milk exclusively for 6 months			
	2020 (FAD)	2021-2022 (NSCH)	2022-2023 (NSCH)
ND	28.4%	28.6%	26.2%
Region 8	28.3%	32.7%	31.1%
United States	25.4%	27.6%	28.7%

Percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months by family structure and year (NSCH)		
	2021-2022	2022-2023
Two parents, currently married	32.9%	29.0%
Two parents, not currently married	X	X
Single parent (mother or father)	X	X

Percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months by highest level of education of adult in the household and year (NSCH)		
	2021-2022	2022-2023
Less than high school	X	X
High school or GED	X	X
Some college or Technical School	22.7%*	27.3%*
College degree or higher	36.1%	29.4%

Percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months by child race/ethnicity & year (NSCH)		
	2021-2022	2022-2023
Hispanic	X	X
Black	X	X
White	33.7%	31.8%
Other or multiple races	X	12.4%*

Percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months by percent of poverty level (SCHIP) and year (NSCH)		
	2021-2022	2022-2023
0-199% of poverty level	25.4%*	21.8%*
200-299% of poverty level	23.1%*	26.9%*
300-399% of poverty level	25.5%*	23.9%*
400% or more of poverty level	36.9%*	30.1%*

Percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months by current insurance status & year (NSCH)		
	2021-2022	2022-2023
Public only	X	X
Private only	30.8%	27.6%
Public & private	X	X
Uninsured	X	X

Due to low counts or large standard error (SE), some data may be unreliable. We bring attention to these data by representing it with an asterisk (*). Data points that have an unweighted denominator less than 30 are not reportable and have been omitted, noted with an X.

Safe Sleep A: Percent of women who reported that they placed their infant to sleep only on their backs (not stomach or side) in the past two weeks 2022 (FAD)		
ND 88.8%	Region 8 87.7%	United States 82.8%

North Dakota totals 2022 (FAD)

Metro 89.6% Non-Metro 87.9%	Married 90.2% Unmarried 85.7%

Infants placed to sleep on their backs by maternal education & year					
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)	2022 (FAD)
Less than high school	59.9%	78.1%	80.5%	61.5%	64.2%*
High school or GED	86.3%	84.0%	76.1%	80.0%	80.1%
Some college or Associate Degree	83.0%	83.0%	81.0%	81.9%	85.9%
Bachelor Degree	91.3%	90.6%	87.6%	92.5%	98.1% (College - Grad)
Master, Doctorate or Prof. Degree	91.6%	91.7%	87.5%	98.6%	-

Infants placed to sleep on their backs by maternal race/ethnicity & year					
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)	2022 (FAD)
Hispanic	79.6%	87.6%	74.3%	77.6%	87.3%*
Am. Indian or Alaska Native	82.4%	82.4%	83.2%	89.9%	90.3%
Asian	71.8%	88.5%	67.9%	81.8%	77.3%*
Black	47.4%	60.8%	61.0%	61.6%	66.0%
Nat. Hawaiian or other Pacific Islander	51.6%*	66.7%*	54.5%*	50.0%*	X
White	89.7%	89.6%	86.3%	88.0%	92.8%
Other or multiple races	70.4%	75.0%	77.7%	77.3%	X

Infants placed to sleep on their backs by maternal age & year				
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)
Less than 20 years	61.8%	78.8%	82.7%	74.7%
20 through 29 years	84.4%	85.3%	77.6%	85.6%
30 through 39 years	86.5%	87.9%	87.2%	85.7%
40 years and older	97.8%	85.1%	X	X

Infants placed to sleep on their backs maternal income & year				
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)
$0 to $28,000	76.6%	82.6%	73.5%	82.7%
$28,001 to $48,000	82.5%	78.9%	84.7%	85.3%
$48,001 to $85,000	90.7%	87.3%	83.9%	83.0%
$85,001 or more	90.0%	93.8%	88.9%	93.3%

Infants placed to sleep on their backs by maternal health insurance type & year					
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)	2022 (FAD)
Medicaid	77.7%	79.9%	78.0%	78.7%	83.1%
Private	89.4%	90.0%	86.6%	91.8%	90.9%
Other Public	82.6%	83.4%	79.3%	79.8%	91.2%
Uninsured	73.5%	75.1%	70.7%	40.5%	X

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Safe Sleep B: Percent of women who reported that their infant always slept alone in their own crib or bed while they themselves were sleeping in the past two weeks 2021 (PRAMS ARF)		
ND 60.8%	Region 8 57.6%	United States 59.2%

North Dakota totals 2021 (PRAMS ARF)

Metro 63.4% Non-Metro 57.7%	Married 64.9% Unmarried 51.7%

Infants placed to sleep on a separate approved sleep surface by maternal education & year				
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)
Less than high school	48.9%	55.5%	39.6%	43.7%
High school or GED	57.5%	54.2%	51.8%	55.9%
Some college or Associate Degree	61.5%	59.4%	55.4%	59.3%
Bachelor Degree	60.3%	75.8%	65.0%	65.9%
Master, Doctorate or Prof. Degree	70.5%	79.8%	62.3%	68.8%

Infants placed to sleep on a separate approved sleep surface by maternal race/ethnicity & year					
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)	2022 (FAD)
Hispanic	48.1%	54.1%	36.7%	66.6%	19.2%*
Am. Indian or Alaska Native	49.3%	44.1%	41.4%	47.5%	24.0%
Asian	37.3%	56.4%	25.9%*	47.5%	25.5%*
Black	52.7%	60.2%	59.7%	50.9%	24.8%
Nat. Hawaiian or other Pacific Islander	X	66.7%*	27.2%*	50.0%*	X
White	63.6%	69.8%	60.4%	64.5%	37.4%
Other or multiple races	47.7%	38.3%	45.2%	46.6%	X

Infants placed to sleep on a separate approved sleep surface by maternal age & year				
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)
Less than 20 years	46.9%	33.3%	47.7%	36.3%
20 through 29 years	59.4%	63.4%	53.6%	58.1%
30 through 39 years	62.2%	70.4%	61.0%	66.7%
40 years and older	42.5%*	56.6%	49.7%	44.4%*

Infants placed to sleep on a separate approved sleep surface by income & year				
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)
$0 to $28,000	49.9%	56.8%	41.5%	51.4%
$28,001 to $48,000	60.3%	57.2%	52.6%	53.9%
$48,001 to $85,001	65.4%	67.8%	59.3%	58.6%
$85,001 or more	64.7%	75.9%	63.9%	68.6%

Infants placed to sleep on a separate approved sleep surface by maternal health insurance type & year					
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)	2022 (FAD)
Medicaid	54.3%	50.5%	43.2%	48.5%	28.1%
Private	66.2%	73.4%	60.7%	67.6%	36.4%
Other Public	47.4%	56.8%	59.7%	50.1%	33.2%
Uninsured	47.5%	52.1%	65.7%	76.9%	X

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Safe Sleep C: Percent of women who reported that their infant was not placed to sleep with comforters, quilts, blankets, non-fitted sheets, soft toys, cushions, pillows, or crib bumper pads in the past two weeks 2022 (FAD)		
ND 57.3%	Region 8 55.0%	United States 59.6%

North Dakota totals 2022 (FAD)

Metro 61.4% Non-Metro 52.8%	Married 61.5% Unmarried 48.3%

Infants placed to sleep without soft objects or loose bedding by maternal education & year				
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)
Less than high school	11.1%	18.7%	31.9%	35.3%
High school or GED	26.6%	47.0%	42.5%	52.3%
Some college or Associate Degree	34.7%	44.1%	38.8%	57.9%
Bachelor Degree	51.1%	50.5%	50.7%	69.3%
Master, Doctorate or Prof. Degree	55.1%	73.9%	75.6%	76.4%

Infants placed to sleep without soft objects or loose bedding by maternal race/ethnicity & year					
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)	2022 (FAD)
Hispanic	22.7%	18.6%*	42.7%	48.3%	50.7%*
Am. Indian or Alaska Native	22.9%	29%	30.5%	34.1%	41.8%
Asian	21.0%*	12.8%*	16.3%*	51.1%	51.8%*
Black	23.2%	43.2%	39.3%	48.4%	48.9%
Nat. Hawaiian or other Pacific Islander	X	66.7%	X	50.0%*	X
White	41.9%	53.0%	51.4%	66.4%	61.3%
Other or multiple races	27.3%	23.4%*	45.7%	46.5%	X

Infants placed to sleep without soft objects or loose bedding by maternal age & year				
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)
Less than 20 years	22.4%	25.6%*	28.0%*	24.5%*
20 through 29 years	37.4%	46.1%	45.0%	65.2%
30 through 39 years	38.2%	51.3%	50.2%	58.7%
40 years and older	36.6%*	40.2%	15.0%*	96.0%

Infants placed to sleep without soft objects or loose bedding by income & year				
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)
$0 to $28,000	18.6%	30.6%	22.6%	54.3%
$28,001 to $48,000	36.8%	40.3%	52.5%	42.2%
$48,001 to $85,000	47.4%	52.1%	50.4%	64.1%
$85,001 or more	48.3%	61.5%	60.3%	73.0%

Infants placed to sleep without soft objects or loose bedding by maternal health insurance type & year					
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)	2022 (FAD)
Medicaid	24.1%	28.1%	31.9%	49.0%	46.4%
Private	45.9%	55.1%	54.4%	70.1%	60.8%
Other Public	30.8%	43.5%	42.3%	47.1%	64.4%
Uninsured	20.1%	48.7%	40.4%	36.9%	X

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Safe Sleep D: Percent of women who reported that their infant's crib or bed was in the same room where they or another adult slept in the past two weeks 2021 (PRAMS ARF)		
ND 72.2%	Region 8 80.3%	United States 82.1%

North Dakota totals 2021 (PRAMS ARF)

Metro 70.6% Non-Metro 74.2%	Married 71.4% Unmarried 74.3%

Infants room-sharing with an adult during sleep by maternal education & year				
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)
Less than high school	88.0%	91.7%	93.8%	82.9%
High school or GED	85.5%	84.7%	87.8%	84.1%
Some college or Associate Degree	72.5%	72.9%	76.8%	70.3%
Bachelor Degree	70.8%	67.3%	63.9%	67.0%
Master, Doctorate or Prof. Degree	84.8%	64.4%	80.1%	68.4%

Infants room-sharing with an adult during sleep by maternal race/ethnicity & year				
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)
Hispanic	89.1%	94.5%	84.8%	65.3%
Am. Indian or Alaska Native	96.0%	94.5%	94.5%	96.9%
Asian	86.0%	73.8%	X	88.6%
Black	X	92.8%	91.6%	90.0%
Nat. Hawaiian or other Pacific Islander	X	X	X	75.0%
White	74.1%	69.2%	72.9%	68.2%
Other or multiple races	74.3%	91.3%	79.4%	72.7%

Infants room-sharing with an adult during sleep by maternal age & year				
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)
Less than 20 years	87.6%	97.1%	87.4%	83.5%
20 through 29 years	76.6%	71.7%	75.4%	70.7%
30 through 39 years	78.0%	74.2%	78.2%	73.5%
40 years and older	84.4%	87.6%	85.4%	58.2%

Infants room-sharing with an adult during sleep by income & year				
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)
$0 to $28,000	86.3%	87.4%	91.8%	86.3%
$28,001 to $48,000	73.8%	74.3%	85.0%	76.1%
$48,001 to $85,000	76.1%	71.1%	74.7%	69.6%
$85,001 or more	70.7%	66.9%	66.2%	65.6%

Infants room-sharing with an adult during sleep by maternal health insurance type & year				
	2018 (PRAMS ARF)	2019 (PRAMS ARF)	2020 (PRAMS ARF)	2021 (PRAMS ARF)
Medicaid	87.4%	89.4%	89.9%	84.3%
Private	72.9%	67.9%	71.8%	68.0%
Other Public	77.7%	70.6%	75.6%	70.9%
Uninsured	86.2%	92.2%	93.6%	81.7%

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Housing Instability – Child: Number of children, ages 0 through 11, whose parents reported being behind on a housing payment in the past year, that the child had lived in three or more places in the past year, or that they had ever been homeless 2022-2023 (NSCH)		
ND 15.1%	Region 8 13.4%	United States 16.4%

North Dakota totals

Percent of children, ages 0 through 11, who experienced housing instability in the past year by family structure & year	
	2022-2023 (NSCH)
Two parents, currently married	11.4%
Two parents, not currently married	24.4%*
Single parent (mother or father)	27.9%*

Percent of children, ages 0 through 11, who experienced housing instability in the past year by highest level of education of adult in the household & year	
	2022-2023 (NSCH)
Less than high school	X
High school or GED	30.4%*
Some college or technical school	18.2%
College degree or higher	8.6%

Percent of children, ages 0 through 11, who experienced housing instability in the past year by child race/ethnicity & year	
	2022-2023 (NSCH)
Hispanic	30.1%*
Black	X
White	11.9%
Other or multiple races	17.7%*

Percent of children who experienced housing instability in the past year by age & year	
	2022-2023 (NSCH)
0 through 5 years old	11.3%
6 through 11 years old	18.5%

Percent of children, ages 0 through 11, who experienced housing instability in the past year by percent of poverty level (SCHIP) and year (NSCH)	
	2022-2023 (NSCH)
0-199% of poverty level	28.5%
200-299% of poverty level	12.7%
300-399% of poverty level	17.3%
400% or more of poverty level	3.9%*

Percent of children, ages 0 through 11, who experienced housing instability in the past year by child type of health insurance & year	
	2022-2023 (NSCH)
Public only	21.6%*
Private only	11.1%
Public & Private	23.9%*
Uninsured	39.6%*

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Developmental Screening: Percent of children, ages 9 through 35 months (2 years), whose parents reported completing a standardized developmental screening questionnaire from a health care provider in the past year with age-specific content on language development and social behavior 2022-2023 (NSCH)		
ND 45.0%	Region 8 43.9%	United States 35.6%

North Dakota totals (NSCH)

Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year by highest level of education of adult in the household & year				
	2019-2020 (NSCH)	2020-2021 (NSCH)	2021-2022 (NSCH)	2022-2023 (NSCH)
Less than high school	X	X	X	X
High school or GED	X	X	X	X
Some college or technical school	30.1%*	34.6%*	38.3%*	34.1%*
College degree or higher	34.1%*	45.2%*	53.6%	52.9%*

Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year by child race/ethnicity & year				
	2019-2020 (NSCH)	2020-2021 (NSCH)	2021- 2022 (FAD)	2022-2023 (NSCH)
Hispanic	X	X	X	X
Black	X	X	X	X
White	34.5%	41.6%	49.8%	47.5%
Other or multiple races	X	X	X	35.1%*

Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year by family structure & year				
	2019-2020 (NSCH)	2020-2021 (NSCH)	2021-2022 (NSCH)	2022-2023 (NSCH)
Two parents, currently married	31.3%	43.0%	50.2%	46.9%
Two parents, not currently married	X	X	X	X
Single parent (mother or father)	X	X	X	X

Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year by percent of poverty level (SCHIP) and year (NSCH)				
	2019-2020 (NSCH)	2020-2021 (NSCH)	2021-2022 (NSCH)	2022-2023 (NSCH)
0-199% of poverty level	32.9%*	53.3%*	45.8%*	37.4%*
200-299% of poverty level	32.6%*	30.4%*	35.6%*	30.7%*
300-399% of poverty level	34.5%*	40.5%*	55.6%*	58.2%*
400% or more of poverty level	26.5%*	37.7%*	47.2%*	51.1%*

Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year by type of health insurance & year				
	2019-2020 (NSCH)	2020-2021 (NSCH)	2021-2022 (NSCH)	2022-2023 (NSCH)
Public only	X	X	X	X
Private only	31.3%	40.1%	50.4%	51.0%*
Public & Private	X	X	X	X
Uninsured	X	X	X	X

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Childhood Vaccination: Percent of children who have completed the combined 7-vaccine series of routinely recommended vaccinations (4:3:1:3*:3:1:4 or ≥ 4 doses of diphtheria and tetanus toxoids and acellular pertussis vaccine; ≥ 3 doses of poliovirus vaccine; ≥ 1 dose of measles-containing vaccine; ≥ 3 doses of hepatitis B vaccine; ≥ 1 dose of varicella vaccine; and ≥ 4 doses of pneumococcal conjugate vaccine) by age 24 months in 2021 by race and geography (KFF)				
	White	Black	Hispanic	Other or Multiple Races
United States	73.1%	63.2%	67.9%	70.2%
North Dakota	77.3%	X	84.4%	60.0%

North Dakota totals (NDIIS)

Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months in North Dakota Quarter 3 - 2024	65.6%

Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months by race in 2024	
Hispanic	47.1%
American Indian	59.1%
Asian	61.8%
Black	54.8%
Other	67.5%
White	67.3%
Pacific Islander	52.0%

Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months by gender in 2024	
Male	65.7%
Female	65.4%

Preventive Dental Visit – Pregnancy: Percent of women who reported having their teeth cleaned by a dentist or a dental hygienist during pregnancy 2021 (PRAMS ARF)		
ND 67.4%	Region 8 69.5%	United States 62.2%

North Dakota totals 2021 (PRAMS ARF)

Metro 67.3% Non-Metro 67.6%	Married 77.9% Unmarried 38.5%

Women who had a preventive dental visit during pregnancy by education & year (PRAMS ARF)				
	2018	2019	2020	2021
Less than high school	46.6%	40.7%	36.6%	20.3%*
High school or GED	55.4%	46.4%	50.2%	43.4%
Some college or Associate Degree	65.4%	62.4%	59.5%	67.5%
Bachelor Degree	82.1%	88.1%	68.1%	78.4%
Master, Doctorate or Prof. Degree	84.4%	87.8%	82.3%	85.1%

Women who had a preventive dental visit during pregnancy by race/ethnicity & year (PRAMS ARF)				
	2018	2019	2020	2021
Hispanic	40.4%	56.6%	47.0%	68.8%
Am. Indian or Alaska Native	47.9%	47.4%	40.1%	37.2%
Asian	54.7%	13.4%*	22.3%*	63.0%
Black	44.6%	31.7%*	66.7%	29.5%
Nat. Hawaiian or other Pacific Islander	X	X	X	X
White	73.6%	76.4%	65.1%	72.2%
Other or multiple races	60.4%	68.6%	79.2%	48.0%

Women who had a preventive dental visit during pregnancy by age & year (PRAMS ARF)				
	2018	2019	2020	2021
Less than 20 years	56.8%	41.4%*	80.9%	44.7%
20 through 29 years	65.2%	65.8%	54.5%	62.4%
30 through 39 years	76.8%	80.8%	71.4%	75.0%
40 years and older	61.2%	41.4%	55.5%	54.4%

Women who had a preventive dental visit during pregnancy by income & year (PRAMS ARF)				
	2018	2019	2020	2021
$0 to $28,000	46.6%	53.7%	43.5%	22.0%
$28,001 to $48,000	47.1%	60.8%	54.7%	48.3%
$48,001 to $85,000	73.4%	70.8%	61.4%	71.0%
$85,001 or more	85.3%	87.1%	77.4%	85.1%

Women who had a preventive dental visit during pregnancy by health insurance type & year (PRAMS ARF)				
	2018	2019	2020	2021
Medicaid	50.0%	49.2%	53.6%	31.5%
Private	77.8%	80.1%	69.0%	79.7%
Other Public	67.0%	66.2%	51.1%	63.2%
Uninsured	19.0%*	32.9%*	X	32.9%*

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Preventive Dental Visit – Child: Percent of children, ages 1 through 17, who are reported by a parent to have seen a dentist or other oral health care provider for preventive dental care in the past year 2022-2023 (NSCH)		
ND 79.7%	Region 8 84.5%	United States 79.2%

North Dakota totals FAD (2021-2022)

MSA, Central City 78.1% MSA, Non-Central City 78.9% Non-MSA 76.8%	Female 78.5% Male 76.8% CSHCN 79.1% Non-CSHCN 77.3%

Children, ages 1 through 17, who had a preventive dental visit in the past year by age & year				
	2019-2020 (NSCH)	2020-2021 (NSCH)	2021-2022 (NSCH)	2022-2023 (NSCH)
1 through 5 years	46.3%	49.3%	57.7%	58.0%
6 through 11 years	86.0%	87.0%	88.9%	90.2%
12 through 17 years	85.5%	83.4%	83.6%	87.1%

Children, ages 1 through 17, who had a preventive dental visit in the past year by highest level of education of adult in the household & year				
	2019-2020 (NSCH)	2020-2021 (NSCH)	2021-2022 (NSCH)	2022-2023 (NSCH)
Less than high school	X	X	X	X
High school or GED	60.4%*	68.2%	72.0%	73.3%
Some college or technical school	74.3%	69.3%	71.0%	75.1%
College degree or higher	79.0%	77.9%	82.4%	84.4%

Children, ages 1 through 17, who had a preventive dental visit in the past year by child race/ethnicity & year				
	2019-2020 (NSCH)	2020-2021 (NSCH)	2021-2022 (NSCH)	2022-2023 (NSCH)
Hispanic	78.8%*	62.7%*	62.3%*	77.7%*
Black	X	53.6%*	63.0%*	49.9%*
White	78.2%	77.2%	80.9%	82.3%
Other or multiple races	56.3%*	69.6%*	70.5%*	76.4%

Children, ages 1 through 17, who had a preventive dental visit in the past year by household structure & year				
	2019-2020 (NSCH)	2020-2021 (NSCH)	2021-2022 (NSCH)	2022-2023 (NSCH)
Two parents, currently married	77.2%	77.8%	82.4%	83.3%
Two parents, not currently married	65.2%*	60.7%*	65.4%*	63.9%*
Single parent (mother or father)	63.4%*	70.9%	75.1%	74.7%

Children, ages 1 through 17, who had a preventive dental visit in the past year by household income-poverty ratio & year				
	2019-2020 (NSCH)	2020-2021 (NSCH)	2021-2022 (NSCH)	2022-2023 (NSCH)
0-199% of poverty level	63.9%	61.0%	64.2%	70.6%
200-299% of poverty level	75.3%	77.9%	79.2%	76.6%
300-399% of poverty level	77.2%	74.0%	81.1%	84.4%
400% or more of poverty level	80.4%	84.2%	86.9%	86.4%

Children, ages 1 through 17, who had a preventive dental visit in the past year by health insurance type & year				
	2019-2020 (NSCH)	2020-2021 (NSCH)	2021-2022 (NSCH)	2022-2023 (NSCH)
Public only	52.8%*	53.3%*	61.8%*	67.9%
Private only	80.9%*	80.6%	82.9%	84.2%
Public and Private	64.8%*	73.4%*	78.7%*	80.9%*
Uninsured	42.4%*	45.9%*	53.4%*	55.5%*

Due to low counts or large standard error (SE), some data may be unreliable. We bring attention to these data by representing it with an asterisk (*). Data points that have an unweighted denominator less than 30 are not reportable and have been omitted, noted with an X.

Physical Activity: Percent of children, ages 6 through 11, who are reported by a parent to be physically active at least 60 minutes per day in the past week 2022-2023 (NSCH)		
ND 31.1%	Region 8 25.9%	United States 25.6%

North Dakota totals FAD (2021-2022)

MSA, Central City 28.1% MSA, Non-Central City 28.1% Non-MSA 36.9%	Female 26.5% Male 36.9% CSHCN 29.8%* Non-CSHCN 32.6%

Children, ages 6 through 11, who were physically active at least 60 minutes per day by child race/ethnicity & year		
	2021-2022 (NSCH)	2022-2023 (NSCH)
Hispanic	X	X
Black	X	X
White	32.0%	29.8%
Other or multiple races	38.2%*	36.2%*

Children, ages 6 through 11, who were physically active at least 60 minutes per day by highest level of education of adult in the household & year		
	2021-2022 (NSCH)	2022-2023 (NSCH)
Less than high school	X	X
High school or GED	31.8%*	26.1%*
Some college or technical school	33.4%*	31.1%*
College degree or higher	31.3%	32.1%

Children, ages 6 through 11, who were physically active at least 60 minutes per day by household structure & year		
	2021-2022 (NSCH)	2022-2023 (NSCH)
Two parents, currently married	32.6%	32.1%
Two parents, not currently married	X	X
Single parent (mother or father)	27.3%*	26.7%*

Children, ages 6 through 11, who were physically active at least 60 minutes per day by household income-poverty ratio & year		
	2021-2022 (NSCH)	2022-2023 (NSCH)
0-199% of poverty level	33.8%*	29.7%*
200-299% of poverty level	29.5%*	32.3%*
300-399% of poverty level	36.0%*	31.0%*
400% or more of poverty level	29.6%	31.6%

Children, ages 6 through 11, who were physically active at least 60 minutes per day by health insurance type & year		
	2021-2022 (NSCH)	2022-2023 (NSCH)
Public only	38.4%*	26.8%*
Private only	30.1%	32.0%
Public and Private	X	X
Uninsured	X	X

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Food Sufficiency: Percent of children, ages 0 through 11, whose households are reported by a parent to have always been able to afford to eat good nutritious food in the past year 2022-2023 (NSCH)		
ND 68.7%	Region 8 71.6%	United States 68.6%

North Dakota totals (NSCH)

Percent of children, ages 0 through 11, whose households were food sufficient in the past year by age & year		
	2021-2022 (NSCH)	2022-2023 (NSCH)
0 through 5 years old	73.9%	71.9%
6 through 11 years old	70.4%	65.8%

Percent of children, ages 0 through 11, whose households were food sufficient in the past year by child race/ethnicity & year		
	2021-2022 (NSCH)	2022-2023 (NSCH)
Hispanic	61.4%*	57.0%*
Black	X	X
White	75.1%	73.6%
Other or multiple races	61.4%*	57.5%*

Percent of children, ages 0 through 11, whose households were food sufficient in the past year by highest level of education of adult in the household & year		
	2021-2022 (NSCH)	2022-2023 (NSCH)
Less than high school	X	X
High school or GED	45.2%*	37.8%*
Some college or technical school	61.3%	58.8%
College degree or higher	82.7%	78.8%

Percent of children, ages 0 through 11, whose households were food sufficient in the past year by household structure & year		
	2021-2022 (NSCH)	2022-2023 (NSCH)
Two parents, currently married	77.4%	73.8%
Two parents, not currently married	58.2%*	59.8%*
Single parent (mother or father)	55.7%*	48.2%*

Percent of children, ages 0 through 11, whose households were food sufficient in the past year by percent of poverty level (SCHIP) & year		
	2021-2022 (NSCH)	2022-2023 (NSCH)
0-199% of poverty level	55.0%	45.6%
200-299% of poverty level	66.1%	67.6%
300-399% of poverty level	71.7%	66.5%
400% or more of poverty level	90.3%	89.7%

Percent of children, ages 0 through 11, whose households were food sufficient in the past year by health insurance type & year		
	2021-2022 (NSCH)	2022-2023 (NSCH)
Public only	55.2%*	49.7%*
Private only	77.9%	76.2%
Public and Private	45.7%*	52.9%*
Uninsured	63.1%*	49.4%*

Due to low counts or large standard error (SE), some data may be unreliable. We bring attention to these data by representing it with an asterisk (*). Data points that have an unweighted denominator less than 30 are not reportable and have been omitted, noted with an X.

Adolescent Well-Visit: Percent of adolescents, ages 12 through 17, who are reported by a parent to have had a preventive medical check-up with a health care provider in the past year 2020-2021 (NSCH)		
ND 67.6%	Region 8 70.7%	United States 69.6%

North Dakota totals (NSCH)

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year by child race/ethnicity & year		
	2019-2020 (NSCH)	2020-2021 (NSCH)
Hispanic	X	X
Black	X	X
White	78.2%	71.5%
Other or multiple races	74.7%*	53.6%*

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year by highest level of education of adult in the household & year		
	2019-2020 (NSCH)	2020-2021 (NSCH)
Less than high school	X	X
High school or GED	64.3%*	50.0%*
Some college or technical school	68.3%*	61.8%*
College degree or higher	81.9%	76.5%

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year by household structure & year		
	2019-2020 (NSCH)	2020-2021 (NSCH)
Two parents, currently married	75.7%	71.2%
Two parents, not currently married	X	X
Single parent (mother or father)	70.3%*	61.5%*

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year by percent of poverty level (SCHIP) & year		
	2019-2020 (NSCH)	2020-2021 (NSCH)
0-199% of poverty level	70.6%*	60.5%*
200-299% of poverty level	68.7%*	66.1%*
300-399% of poverty level	75.1%*	63.2%*
400% or more of poverty level	83.2%	77.6%

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year by health insurance type & year		
	2019-2020 (NSCH)	2020-2021 (NSCH)
Public only	79.5%*	65.4%*
Private only	75.3%	71.0%
Public and Private	X	X
Uninsured	X	43.9%*

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Mental Health Treatment: Percent of adolescents, ages 12 through 17, who are reported by a parent to have received treatment or counseling from a mental health professional during the past 12 months 2022-2023 (NSCH)			
	ND	Region 8	United States
Received needed treatment or counseling	89.5%	79.5%	82.5%
Needed treatment or counseling but did not receive it	10.5%*	20.5%	17.5%

North Dakota totals (NSCH)

Percent of adolescents, ages 12 through 17, who received needed mental health treatment or counseling by child race/ethnicity & year			
	2020-2021 (NSCH)	2021-2022 (NSCH)	2022-2023 (NSCH)
Hispanic	X	X	X
Black	X	X	X
White	91.6%	88.1%*	88.9%
Other or multiple races	X	X	X

Percent of adolescents, ages 12 through 17, who received needed mental health treatment or counseling by highest level of education of adult in the household & year			
	2020-2021 (NSCH)	2021-2022 (NSCH)	2022-2023 (NSCH)
Less than high school	X	X	X
High school or GED	X	X	X
Some college or technical school	84.3%*	X	X
College degree or higher	76.6%*	89.7%*	95.8%

Percent of adolescents, ages 12 through 17, who received needed mental health treatment or counseling by household structure & year			
	2020-2021 (NSCH)	2021-2022 (NSCH)	2022-2023 (NSCH)
Two parents, currently married	82.7%*	96.3%	96.9%
Two parents, not currently married	X	X	X
Single parent (mother or father)	X	X	X

Percent of adolescents, ages 12 through 17, who received needed mental health treatment or counseling by percent of poverty level (SCHIP) & year			
	2020-2021 (NSCH)	2021-2022 (NSCH)	2022-2023 (NSCH)
0-199% of poverty level	74.7%*	74.8%*	X
200-299% of poverty level	X	X	X
300-399% of poverty level	X	X	X
400% or more of poverty level	88.2%	94.1%	91.8%

Percent of adolescents, ages 12 through 17, who received needed mental health treatment or counseling by health insurance type & year			
	2020-2021 (NSCH)	2021-2022 (NSCH)	2022-2023 (NSCH)
Public only	X	X	X
Private only	87.8%*	93.7%	93.2%
Public and Private	X	X	X
Uninsured	X	X	X

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Tobacco Use: Percent of adolescents in grades 9 through 12 who reported any use of tobacco products (electronic vapor products, cigarettes, cigars, or smokeless tobacco) in the past 30 days (YRBSS)				
	2017	2019	2021	2023
North Dakota	27.0%	34.7%	23.0%	19.6%
United States	17.7%	33.3%	18.7%	17.9%

North Dakota totals (YRBSS)

Percent of adolescents, grades 9 through 12, who currently use tobacco products by age (2023)			
	Total	Male	Female
15 or younger	13.0%	18.0%	21.2%
16 or 17	23.3%	21.6%	24.8%
18 or older	22.8%	18.1%	28.4%

Percent of adolescents, grades 9 through 12, who currently use tobacco products by grade (2023)			
	Total	Male	Female
9th grade	12.1%	12.0%	12.2%
10th grade	17.5%	17.1%	17.4%
11th grade	26.7%	22.6%	30.6%
12th grade	23.6%	21.5%	26.1%

Percent of adolescents, grades 9 through 12, who currently use tobacco products by race/ethnicity (2023)			
	Total	Male	Female
Hispanic	25.2%	15.3%	33.5%
Native American	30.8%	27.6%	33.6%
Asian	5.5%	X	X
Black	10.6%	8.9%	12.1%
White	18.4%	17.6%	19.2%
Multiple races	21.1%	19.3%	22.7%

X = Fewer than 20 students in this subgroup

Adult Mentor: Percent of adolescents, ages 12 through 17, who are reported by a parent to have at least one other adult in their school, neighborhood, or community who knows them well and who they can rely on for advice or guidance 2022-2023 (NSCH)		
ND 93.9%	Region 8 93.6%	United States 86.8%

North Dakota totals (NSCH)

Percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance by child race/ethnicity & year		
	2021-2022 (NSCH)	2022-2023 (NSCH)
Hispanic	X	X
Black	X	X
White	94.5%	95.7%
Other or multiple races	84.5%*	X

Percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance by highest level of education of adult in the household & year		
	2021-2022 (NSCH)	2022-2023 (NSCH)
Less than high school	X	X
High school or GED	98.7%	98.7%
Some college or technical school	85.1%*	86.3%*
College degree or higher	93.1%	96.7%

Percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance by household structure & year		
	2021-2022 (NSCH)	2022-2023 (NSCH)
Two parents, currently married	92.8%	96.2%
Two parents, not currently married	X	X
Single parent (mother or father)	94.1%	88.4%*

Percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance by percent of poverty level (SCHIP) & year		
	2021-2022 (NSCH)	2022-2023 (NSCH)
0-199% of poverty level	91.2%	91.6%
200-299% of poverty level	85.8%*	88.6%*
300-399% of poverty level	94.7%	95.5%
400% or more of poverty level	95.3%	97.1%

Percent of adolescents, ages 12 through 17, who have one or more adults outside the home who they can rely on for advice or guidance by health insurance type & year		
	2021-2022 (NSCH)	2022-2023 (NSCH)
Public only	93.8%	95.2%
Private only	92.8%	95.3%
Public and Private	X	X
Uninsured	X	X

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Medical Home - Overall: Percent of children with and without special health care needs, ages 0 through 17, who are reported by a parent to meet the criteria for having a medical home (personal doctor or nurse, usual source for care, family-centered care, referrals if needed, and care coordination if needed) 2022-2023 (NSCH)			
	ND	Region 8	United States
All Children	55.2%	51.5%	45.3%
Children with Special Health Care Needs	49.8%	44.0%	39.7%

Percent of children with and without special health care needs, ages 0 through 17, who have a medical home by age 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
0 through 5 years old	54.0%	52.1%*
6 through 11 years old	54.5%	45.9%*
12 through 17 years old	57.3%	51.9%*

Percent of children with and without special health care needs, ages 0 through 17, who have a medical home by child race/ethnicity 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Hispanic	39.4%*	X
Black	58.2%	X
White	47.8%*	55.1%
Other or multiple races	49.3%	42.7%*

Percent of children with and without special health care needs, ages 0 through 17, who have a medical home by highest level of education of adult in the household 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Less than high school	X	X
High school or GED	52.8%	50.5%*
Some college or technical school	50.3%	38.9%*
College degree or higher	58.6%	56.0%

Percent of children with and without special health care needs, ages 0 through 17, who have a medical home by household structure 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Two parents, currently married	56.5%	53.7%
Two parents, not currently married	51.3%*	X
Single parent (mother or father)	54.3%	39.5%*

Percent of children with and without special health care needs, ages 0 through 17, who have a medical home by percent of poverty level (SCHIP) 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
0-199% of poverty level	45.0%	43.1%*
200-299% of poverty level	63.2%	62.2%*
300-399% of poverty level	53.5%	44.2%*
400% or more of poverty level	60.0%	52.4%*

Percent of children with and without special health care needs, ages 0 through 17, who have a medical home by health insurance type 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Public only	52.5%*	51.7%*
Private only	57.9%	49.8%
Public and Private	59.7%*	50.5%*
Uninsured	16.1%*	X

Due to low counts or large standard error (SE), some data may be unreliable. We bring attention to these data by representing it with an asterisk (*). Data points that have an unweighted denominator less than 30 are not reportable and have been omitted, noted with an X.

Medical Home – Personal Doctor: Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse 2022-2023 (NSCH)			
	ND	Region 8	United States
All Children	74.3%	74.9%	71.8%
Children with Special Health Care Needs	76.8%	80.8%	78.3%

Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse by age 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
0 through 5 years old	75.1%	80.3%*
6 through 11 years old	71.4%	70.1%*
12 through 17 years old	76.6%	80.5%

Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse by child race/ethnicity 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Hispanic	65.9%*	X
Black	76.1%	X
White	80.9%*	83.5%
Other or multiple races	67.0%*	66.1%*

Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse by highest level of education of adult in the household 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Less than high school	X	X
High school or GED	74.8%	77.5%*
Some college or technical school	69.7%	71.7%*
College degree or higher	77.4%	82.7%

Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse by household structure 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Two parents, currently married	76.2%	82.1%
Two parents, not currently married	62.0%*	X
Single parent (mother or father)	72.8%	69.7%*

Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse by percent of poverty level (SCHIP) 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
0-199% of poverty level	65.8%	68.5%*
200-299% of poverty level	79.1%	82.1%*
300-399% of poverty level	72.4%	80.4%*
400% or more of poverty level	79.5%	81.7%*

Percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse by health insurance type 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Public only	76.8%	72.8%*
Private only	76.0%	79.6%
Public and Private	84.7%*	83.8%*
Uninsured	31.9%*	X

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Medical Home – Usual Source of Sick Care: Percent of children with and without special health care needs, ages 0 through 17, who are reported by a parent to have a place they usually go when the child is sick or needs advice about their health (excluding the hospital emergency room) 2022-2023 (NSCH)			
	ND	Region 8	United States
All Children	82.6%	82.7%	75.7%
Children with Special Health Care Needs	88.6%	87.6%	82.4%

Percent of children with and without special health care needs, ages 0 through 17, who have a usual source of sick care by age 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
0 through 5 years old	78.0%	80.8%*
6 through 11 years old	85.0%	91.5%
12 through 17 years old	84.6%	89.3%

Percent of children with and without special health care needs, ages 0 through 17, who have a usual source of sick care by child race/ethnicity 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Hispanic	74.3%*	X
Black	69.4%*	X
White	85.0%	91.7%
Other or multiple races	78.0%	91.1%*

Percent of children with and without special health care needs, ages 0 through 17, who have a usual source of sick care by highest level of education of adult in the household 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Less than high school	X	X
High school or GED	77.3%	87.5%*
Some college or technical school	76.9%	89.2%
College degree or higher	87.4%	92.7%

Percent of children with and without special health care needs, ages 0 through 17, who have a usual source of sick care by household structure 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Two parents, currently married	86.1%	93.6%
Two parents, not currently married	79.4%*	X
Single parent (mother or father)	74.9%	73.6%*

Percent of children with and without special health care needs, ages 0 through 17, who have a usual source of sick care by percent of poverty level (SCHIP) 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
0-199% of poverty level	73.2%	80.8%*
200-299% of poverty level	83.7%	96.8%
300-399% of poverty level	89.5%	95.3%
400% or more of poverty level	86.4%	89.3%

Percent of children with and without special health care needs, ages 0 through 17, who have a usual source of sick care by health insurance type 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Public only	76.5%	82.3%*
Private only	86.7%	92.9%
Public and Private	87.5%	93.2%
Uninsured	43.7%*	X

Due to low counts or large standard error (SE), some data may be unreliable. We bring attention to these data by representing it with an asterisk (*). Data points that have an unweighted denominator less than 30 are not reportable and have been omitted, noted with an X.

Medical Home – Family Centered Care: Percent of children with and without special health care needs, ages 0 through 17, who are reported by a parent that the child's doctor or other health care provider always/usually 1) spent enough time with the child, 2) listened carefully to the child, 3) showed sensitivity to family values, 4) provided the specific information needed concerning the child, and 5) helped the family feel like a partner in the child's care (excluding the hospital emergency room) 2022-2023 (NSCH)			
	ND	Region 8	United States
All Children	91.4%	88.0%	84.3%
Children with Special Health Care Needs	91.4%	84.5%	81.6%

Percent of children with and without special health care needs, ages 0 through 17, who have family centered care by age 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
0 through 5 years old	90.3%	87.2%
6 through 11 years old	90.8%	87.6%
12 through 17 years old	93.2%	95.8%

Percent of children with and without special health care needs, ages 0 through 17, who have family centered care by child race/ethnicity 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Hispanic	83.2%*	X
Black	82.7%*	X
White	93.1%	92.8%
Other or multiple races	87.7%	88.3%*

Percent of children with and without special health care needs, ages 0 through 17, who have family centered care by highest level of education of adult in the household 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Less than high school	X	X
High school or GED	84.2%	90.1%
Some college or technical school	91.6%	91.8%
College degree or higher	93.4%	91.3%

Percent of children with and without special health care needs, ages 0 through 17, who have family centered care by household structure 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Two parents, currently married	92.1%	90.9%
Two parents, not currently married	93.9%	X
Single parent (mother or father)	91.0%	88.6%

Percent of children with and without special health care needs, ages 0 through 17, who have family centered care by percent of poverty level (SCHIP) 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
0-199% of poverty level	86.1%	92.0%
200-299% of poverty level	94.4%	93.6%
300-399% of poverty level	91.0%	91.4%
400% or more of poverty level	93.9%	89.3%*

Percent of children with and without special health care needs, ages 0 through 17, who have family centered care by health insurance type 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Public only	84.3%	89.9%
Private only	92.4%	89.9%
Public and Private	96.4%	94.4%
Uninsured	84.6%*	X

Due to low counts or large standard error (SE), some data may be unreliable. We bring attention to these data by representing it with an asterisk (*). Data points that have an unweighted denominator less than 30 are not reportable and have been omitted, noted with an X.

Medical Home – Referrals: Percent of children with and without special health care needs, ages 0 through 17, who are reported by a parent to have no problem getting needed referrals 2022-2023 (NSCH)			
	ND	Region 8	United States
All Children	80.1%	76.6%	77.8%
Children with Special Health Care Needs	74.4%	70.4%	70.0%

Percent of children with and without special health care needs, ages 0 through 17, who receive needed referrals by age 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
0 through 5 years old	82.3%	81.3%*
6 through 11 years old	74.7%*	71.6%*
12 through 17 years old	81.7%*	73.2%*

Percent of children with and without special health care needs, ages 0 through 17, who receive needed referrals by child race/ethnicity 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Hispanic	X	X
Black	X	X
White	83.0%	76.0%*
Other or multiple races	79.3%*	X

Percent of children with and without special health care needs, ages 0 through 17, who receive needed referrals by highest level of education of adult in the household 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Less than high school	X	X
High school or GED	95.7%	X
Some college or technical school	66.5%*	51.5%*
College degree or higher	81.0%	80.1%*

Percent of children with and without special health care needs, ages 0 through 17, who receive needed referrals by household structure 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Two parents, currently married	81.1%	80.4%
Two parents, not currently married	X	X
Single parent (mother or father)	86.4%	X

Percent of children with and without special health care needs, ages 0 through 17, who receive needed referrals by percent of poverty level (SCHIP) 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
0-199% of poverty level	73.1%*	68.5%*
200-299% of poverty level	86.8%	87.1%*
300-399% of poverty level	78.0%	X
400% or more of poverty level	83.0%	71.6%*

Percent of children with and without special health care needs, ages 0 through 17, who receive needed referrals by health insurance type 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Public only	72.6%*	X
Private only	79.8%	70.2%*
Public and Private	85.8%*	82.5%*
Uninsured	X	X

Due to low counts or large standard error (SE), some data may be unreliable. We bring attention to these data by representing it with an asterisk (*). Data points that have an unweighted denominator less than 30 are not reportable and have been omitted, noted with an X.

Medical Home – Care Coordination: Percent of children with and without special health care needs, ages 0 through 17, who are reported by a parent to have received all needed help with care coordination 2022-2023 (NSCH)			
	ND	Region 8	United States
All Children	74.9%	67.0%	66.6%
Children with Special Health Care Needs	62.7%	54.4%	53.3%

Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination by age 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
0 through 5 years old	76.8%	76.6%*
6 through 11 years old	71.7%	54.1%*
12 through 17 years old	75.7%	63.2%*

Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination by child race/ethnicity 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Hispanic	74.2%*	X
Black	X	X
White	76.5%	65.4%
Other or multiple races	66.2%*	56.3%*

Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination by highest level of education of adult in the household 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Less than high school	X	X
High school or GED	76.1%*	61.1%*
Some college or technical school	74.2%	56.0%*
College degree or higher	74.3%	65.1%

Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination by household structure 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Two parents, currently married	74.4%	64.2%
Two parents, not currently married	59.4%*	X
Single parent (mother or father)	80.9%	65.5%*

Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination by percent of poverty level (SCHIP) 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
0-199% of poverty level	74.7%	60.4%*
200-299% of poverty level	81.5%	74.0%*
300-399% of poverty level	71.5%	59.7%*
400% or more of poverty level	73.7%	59.4%*

Percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination by health insurance type 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Public only	73.3%*	56.3%*
Private only	75.0%	61.3%
Public and Private	76.2%*	68.5%*
Uninsured	X	X

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Transition: Percent of adolescents with and without special health care needs, ages 12 through 17, who are reported by a parent to have received services to prepare for the transition to adult health care (time alone with a health care provider, active work to gain skills to manage health/health care or understand changes in health care at age 18, discussed shift to adult providers if needed) 2022-2023 (NSCH)			
	ND	Region 8	United States
All Children	24.7%	21.2%	18.1%
Children with Special Health Care Needs	31.8%	26.6%	22.3%

Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care by child race/ethnicity 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Hispanic	X	X
Black	X	X
White	25.9%	33.1%
Other or multiple races	X	X

Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care by highest level of education of adult in the household 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Less than high school	X	X
High school or GED	16.2%*	X
Some college or technical school	28.0%*	39.1%*
College degree or higher	24.9%	34.4%*

Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care by household structure 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Two parents, currently married	24.1%	34.4%*
Two parents, not currently married	X	X
Single parent (mother or father)	24.6%*	X

Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care by percent of poverty level (SCHIP) 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
0-199% of poverty level	25.6%*	35.4%*
200-299% of poverty level	20.1%*	X
300-399% of poverty level	24.9%*	X
400% or more of poverty level	25.9%	36.9%*

Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care by health insurance type 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Public only	16.4%*	X
Private only	27.4%	37.0%*
Public and Private	X	X
Uninsured	X	X

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Bullying – Bully Others: Percent of adolescents, ages 12 through 17, with and without special health care needs, who are reported by a parent to have bullied others in the past year 2022-2023 (NSCH)			
	ND	Region 8	United States
All Children	17.1%	18.6%	11.7%
Children with Special Health Care Needs	32.6%*	25.7%	19.4%

Percent of adolescents, with and without special health care needs, ages 12 through 17, who bully others by child race/ethnicity 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Hispanic	X	X
Black	X	X
White	17.0%	30.7%
Other or multiple races	X	X

Percent of adolescents, with and without special health care needs, ages 12 through 17, who bully others by highest level of education of adult in the household 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Less than high school	X	X
High school or GED	14.7%*	X
Some college or technical school	17.2%	29.3%*
College degree or higher	18.7%	33.9%*

Percent of adolescents, with and without special health care needs, ages 12 through 17, who bully others by household structure 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Two parents, currently married	15.0%	30.9%*
Two parents, not currently married	X	X
Single parent (mother or father)	23.2%*	X

Percent of adolescents, with and without special health care needs, ages 12 through 17, who bully others by percent of poverty level (SCHIP) 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
0-199% of poverty level	17.7%	26.8%*
200-299% of poverty level	22.1%*	X
300-399% of poverty level	14.2%*	X
400% or more of poverty level	15.7%	28.2%*

Percent of adolescents, with and without special health care needs, ages 12 through 17, who bully others by health insurance type 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Public only	16.6%*	X
Private only	16.5%	33.2%*
Public and Private	X	X
Uninsured	X	X

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Bullying – Who are Bullied: Percent of adolescents, ages 12 through 17, with and without special health care needs, who are reported by a parent to have been bullied in the past year 2022-2023 (NSCH)			
	ND	Region 8	United States
All Children	39.8%	44.0%	33.2%
Children with Special Health Care Needs	63.3%*	62.6%	51.3%

Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied by child race/ethnicity 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Hispanic	X	X
Black	X	X
White	40.4%	64.3%
Other or multiple races	X	X

Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied by highest level of education of adult in the household 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Less than high school	X	X
High school or GED	33.6%*	X
Some college or technical school	43.4%*	66.0%*
College degree or higher	42.2%	64.6%*

Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied by household structure 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Two parents, currently married	40.3%	65.2%*
Two parents, not currently married	X	X
Single parent (mother or father)	33.3%*	X

Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied by percent of poverty level (SCHIP) 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
0-199% of poverty level	40.2%*	64.4%*
200-299% of poverty level	39.6%*	X
300-399% of poverty level	36.9%*	X
400% or more of poverty level	40.6%	60.0%*

Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied by health insurance type 2022-2023 (NSCH)		
	All Children	Children with Special Health Care Needs
Public only	41.2%*	X
Private only	39.2%	62.4%*
Public and Private	X	X
Uninsured	X	X

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