North Dakota Maternal, Infant, and Early Childhood Home Visiting Program

Statewide Needs Assessment Update 2020

Prevent Child Abuse North Dakota™

North Dakota Maternal, Infant, and Early Childhood Home Visiting (MIECHV)
Statewide Needs Assessment Update

Introduction

North Dakota (ND) Maternal, Infant, and Early Childhood Home Visiting (MIECHV) is administered by Prevent Child Abuse North Dakota (PCAND) and supported by federal MIECHV funds through the federal Health Resources and Services Administration (HRSA). The purpose of the MIECHV program is to "support the delivery of coordinated and comprehensive high-quality and voluntary early childhood home visiting services to eligible families." The goals of home visiting, according to HRSA, are to

- Improve maternal and child health;
- Prevent child abuse and neglect;
- Encourage positive parenting; and
- Promote child development and school readiness.

The goals of the MIECHV program are more specific, including to

- Strengthen and improve the programs and activities carried out under Title V of the Social Security Act;
- Improve coordination of services for at-risk communities; and
- Identify and provide comprehensive services to improve outcomes for families.

Home visiting is a key component in the continuum of care services to support children and families. It is a two-generation strategy to improve health and well-being; research has demonstrated that home visits conducted by a trained professional during pregnancy and through the first years of a child's life improves outcomes for children and their parents. Home visitors help parents and guardians improve their understanding of child development, learn positive parenting practices, promote early literacy and school readiness, and navigate systems of care to achieve more positive health outcomes.

MIECHV was reauthorized through the Bipartisan Budget Act of 2018, which states in section 50603 that states are required to conduct a statewide needs assessment. The last MIECHV needs assessment was conducted in 2013 by North Dakota State University (NDSU) and determined the three highest-risk counties to be Rolette, Benson, and Williams Counties. The current MIECHV needs assessment is also a condition of receiving Title V Maternal and Child Health (MCH) Block Grant funding. The North Dakota Department of Health, staff of which recently completed the statutorily required Title V statewide needs assessment, administers the Title V program.

Needs Assessment Purpose. A needs assessment is key to determining which communities and areas in the state of North Dakota are "at-risk," or, which communities, due to gaps in services or needs of families, could benefit from improved access to services, better coordination of existing services, or the development of new services. Needs assessment data allows administering agencies to make data-driven, better informed decisions to ensure that MIECHV programs are implemented in areas of high need. HRSA has noted that MIECHV awardees may use needs assessment updates to:

- Understand the current needs of families and children, and at-risk communities;
- Target home visiting services to at-risk communities with evidence-based and promising approach home visiting models that meet community needs;
- Support statewide planning to develop and implement a continuum of home visiting services for eligible families and children prenatally through kindergarten entry;

- Inform public and private stakeholders about the unmet need for home visiting and other services in the state;
- Identify opportunities for collaboration with state and local partners to establish appropriate linkages and referral networks to other community resources and supports, and strengthen early childhood systems; and
- Direct technical assistance resources to enhance home visiting service delivery and improve coordination of services in at-risk communities.

PCAND's aims for the needs assessment are very much in line with HRSA's expectations: to ensure MIECHV-funded local implementing agencies (LIAs) serve communities of high need, to better understand the needs of families and gaps in services in these communities, and to support the strengthening of systems that exist to serve children and families.

There are, as of the time of publication, two MIECHV-funded LIAs in ND. The first is administered by the Turtle Mountain Band of Chippewa Indians (TMBCI) and serves Rolette County, which includes the entirety of the TMBCI reservation. This LIA, which is referred to as Turtle Mountain (TM), utilizes the Parents as Teachers evidence-based home visiting model. The program includes five staff, including one supervisor, three full-time home visitors, and a lead home visitor, who carries half a full-time home visitor caseload and completes administrative and managerial duties in support of the supervisor. Custer Health, a local public health agency located in Morton County, administers the second LIA, Nurse-Family Partnership of Missouri Valley (NFP-MV). Custer Health works in coordination with Bismarck-Burleigh Public Health, another local public health entity, to staff this home visiting program, which serves Burleigh, Morton, Mercer, Oliver, Grant, and Sioux Counties using the Nurse-Family Partnership evidence-based home visiting model. Staff for NFP-MV include a half-time supervisor, one full-time nurse home visitor (NHV), and three half-time NHVs.

Currently, each of these sites coordinates a local advisory committee comprised of program partners and stakeholders. Each LIA is also tasked with maintaining and updating memoranda of understanding (MOUs) with relevant partner organizations. However, on a state level, while there is strong work and collaboration done in various areas of the early childhood and maternal and child health systems, there is an overall lack of cohesiveness and coordination between programs within those systems. Therefore, in addition to using needs assessment results to ensure home visiting services are targeted, appropriate, and equitable in communities of need, PCAND anticipates using findings from this needs assessment to work toward the development of a greater, comprehensive children-and-family health and wellness system in North Dakota.

Planning Process and Coordination with Program Partners. ND MIECHV staff within PCAND began meeting with Title V staff at the North Dakota Department of Health in October 2018 to develop project timelines, discuss data needs and scheduling, and discuss collaborations between the Title V and MIECHV needs assessment. During these initial meetings, the required needs assessments of other programs, such as Head Start, were discussed. In November 2018, a Work-as-One collaborative needs assessment group was brought together. During this meeting, the following organizations presented on planned needs assessments, data needs, or data collection activities:

- North Dakota Department of Public Instruction
- Prevent Child Abuse North Dakota
- North Dakota Department of Health (Title V, Family Planning, Office of Primary Care, Division of Disease Control, Office of Health Systems and Performance)
- North Dakota State University (NDSU)

- North Dakota Center for Persons with Disabilities
- University of North Dakota Center for Rural Health
- American Heart Association

After this meeting, all program representatives (including those who did not present) were instructed to complete a survey asking if participating in a needs assessment working group would be beneficial for their organization. Those who responded positively were invited to participate in future meetings.

Over the next year, the group met regularly to discuss individual organization progress and any collaborative efforts. The Work-as-One group also requested and facilitated meetings with other states, including Maine, Utah, Colorado, and Ohio, to discuss their collaborative processes and framework for assessments.

As these meetings became less frequent throughout 2019, while individual programs were completing their separate assessments, PCAND focused efforts on planning and implementing the ND MIECHV needs assessment. A full-time, temporary Needs Assessment Specialist was hired in October 2019. Danni Pinnick, MPH, filled this position and began work in early November 2019. In spring of 2020, a master's practicum student in the NDSU Department of Public Health, Murphy Anderson, joined the team to assist with needs assessment activities. The ND MIECHV needs assessment team within PCAND was thus:

- Elizabeth Pihlaja, ND MIECHV Program Director
- Jacob Davis, Tribal Programming Director
- Danni Pinnick, Needs Assessment Specialist
- Murphy Anderson, NDSU practicum student

PCAND's Executive Director, Sandy Tibke, provided oversight and support as necessary.

The first action item for the ND MIECHV team was to develop an advisory board that would help ensure activities were appropriate, made progress toward goals and objectives, promoted equity, and were done in conjunction with the needs assessments conducted by Title V, Head Start, and the Child Abuse Prevention and Treatment Act (CAPTA) (which is administered by the North Dakota Department of Human Services, Children and Family Services Division). An invitation letter to participate (see Appendix A) was sent to representatives of various early childhood and maternal and child programs across the state. Those who accepted the invitation were:

- Tracy Miller – ND Department of Human Services, Family Preservation and Administrator
- Alicia Gourd-Mackin – Indigenous Birth and Breastfeeding Coalition of North Dakota; Spirit Lake Nation enrolled member, resident of Standing Rock Nation reservation
- Amy Gourneau – Turtle Mountain Home Visiting Program, Site Supervisor; Turtle Mountain Band of Chippewa Indians enrolled member
- Chelsey Trebas – Custer Health, Nurse-Family Partnership of Missouri Valley nurse home visitor
- Missi Baranko – Lutheran Social Services of North Dakota, Healthy Families Team Lead; Right Track, Region 8 Coordinator
- Kim Mertz – ND Department of Health, Healthy and Safe Communities Section Chief, Title V Coordinator
- Grace Njau – ND Department of Health, Epidemiologist; Principal Investigator, ND PRAMS
- Ruth Buffalo – ND State Representative; Mandan-Hidatsa-Arikara (MHA) Nation enrolled member

- Kathy Anderson – ND Chapter of the American Academy of Pediatrics, President; Nurturing Wellness Pediatrics
- Tara Fuhrer – ND Department of Public Instruction, Office of Early Learning Director
- Donene Feist – Family Voices of North Dakota, Executive Director

Beginning in December 2019, this group was convened monthly to discuss project updates, review data, and support project activities. The advisory group reviewed and provided feedback on the quantitative data process and results, qualitative data process tools (survey, interview, and focus group questions), the capacity of existing children and family service programs in North Dakota, and identification of community members and at-risk communities.

Identification of At-Risk Counties with Concentrations of Risk

Through the needs assessment process, MIECHV grantees are required to develop a list of communities with concentrations of risk, including premature birth, low birthweight infants, infant mortality (including infant death due to neglect), or other indicators of at-risk perinatal, newborn, or child health; poverty; crime; domestic violence, high rates of high school dropouts; substance misuse; unemployment; or child maltreatment.

HRSA is clear in the agency's guidance for the needs assessment that, for the purpose of this update, the term "community" is used to mean "county"; however, awardees are free to further explore areas of need and high concentration of risk and break the each identified county into smaller, targeted areas as necessary. Due to small population numbers, and the resulting complications of analyzing small datasets, ND MIECHV has left the designation of "community" to mean county. This also ensures consistency with current ND MIECHV practices, which support LIAs serving entire counties.

Quantitative Data Analysis, Phases One and Two. To decrease the data collection and analysis burden on MIECHV grantees, HRSA provided a summary of nationally available, county level data to each state awardee. HRSA also developed a methodology, termed the "simplified method," for each grantee to use. The simplified method is based on five domains of potential risk: low socioeconomic status, adverse perinatal outcomes, child maltreatment, crime, and substance use disorder. Domains and indicators are listed in the table below.

Domain	Indicator	Indicator Definition	Data Year
Population	2017 Population	# of people living in an area	2017
Socioeconomic Status	Poverty	% of population living below 100% federal poverty level (FPL)	2017
	Unemployment	Unemployed percent of the civilian workforce	2017
	High School Dropout Rate	% of 16-19 year olds not enrolled in school with no high school diploma – one year estimate	2017
		% of 16-19 year olds not enrolled in school with no high school diploma – five year estimate	2013-2017
		% of 16-19 year olds not enrolled in school with no high school diploma – one year or five year estimate	2013-2017 OR 2017
	Income Inequality	Gini coefficient* – one year estimate	2017

		Gini coefficient – five year estimate	2013-2017
		Gini coefficient – one year or five year estimate	2013-2017 OR 2017
Adverse Perinatal Outcomes	Preterm Birth	% of births <37 weeks	2013-2017
	Low Birthweight	% of live births <2500 g	2013-2017
Substance Use Disorder	Alcohol	Prevalence rate: binge alcohol use in past month	2012-2014
	Marijuana	Prevalence rate: marijuana use in past month	2014-2016
	Illicit Drugs	Prevalence rate: use of illicit drugs (excluding marijuana) in past month	2012-2014
	Pain Relievers	Prevalence rate: Nonmedical use of pain medication in past year	2012-2014
Crime	Crime Reports	# crimes/1000 residents	2016
	Juvenile Arrests	# of crime arrests ages 0-17/100,000 juveniles ages 0-17	2016
Child Maltreatment	Child Maltreatment	Rate of maltreatment victims aged <1-17 per 1,000 child (aged <1-17) residents	2016

**The Gini coefficient is intended to represent the income inequality within a group of people.*

This methodology defines a county as at-risk if at least half the indicators within at least two of the above domains have z-scores greater than, or equal to, one standard deviation higher than the mean of all counties in the state. The counties identified by HRSA's simplified method as being at risk include the following counties, which all scored two flagged domains:

County	At-Risk Domains	Indicators Within At-Risk Domains
Benson	Socioeconomic Status	Poverty
		Income Inequality
	Adverse Perinatal Outcomes	Preterm Birth
Grand Forks	Substance Use Disorder	Alcohol
		Marijuana
		Illicit Drugs
		Pain Relievers
	Crime	Juvenile Arrests
Grant	Adverse Perinatal Outcomes	Preterm Birth
	Child Maltreatment	Child Maltreatment
Ramsey	Adverse Perinatal Outcomes	Preterm Birth
		Low Birthweight
	Crime	Crime Reports
		Juvenile Arrests
Rolette	Socioeconomic Status	Poverty
		Unemployment
		High School Dropout Rate
		Income Inequality
	Adverse Perinatal Outcomes	Preterm Birth
Sioux	Socioeconomic Status	Poverty
		High School Dropout Rate
		Income Inequality
	Adverse Perinatal Outcomes	Preterm Birth

Walsh	Substance Use Disorder	Alcohol
		Marijuana
		Illicit Drugs
		Pain Relievers
	Crime	Juvenile Arrests

In addition to the simplified method, PCAND analyzed additional substance-use disorder data, using the "Supplemental Data NORTH DAKOTA" spreadsheet, to identify if counties' risk status changed, based upon the new data parameters, to determine whether this more accurately captured substance used disorder in North Dakota. Following suggestion three (adding an additional domain) would add the following counties to the "at-risk" list:

- Pembina County
- Nelson County

However, PCAND staff determined that adding this additional information would not be beneficial, as the measurements were not discrete sets. While it might be appropriate to replace the domain with the updated information, staff compared the two measurements for substance use disorder and determined that the updated data collection parameters would not change the level of risk in that domain. Therefore, Pembina and Nelson Counties were not added to the list of at-risk counties due to this additional information.

In addition to these identified counties, PCAND staff elected to examine data for additional counties known or thought to have high concentrations of risk, even if they were not initially identified as the highest risk counties by the simplified method. These were counties that had one at-risk simplified method domain, a land boundary within a tribal nation, or are currently MIECHV home visiting service areas, as well as being in the upper quartile of the following arenas:

- Home visiting need estimate (provided by HRSA);
- County population;
- Indigenous (American Indian/Alaska Native) population;
- Foreign-born resident population;
- Population increase from 2010-2019; or
- Percent of population less than five years old.

These counties included the following:

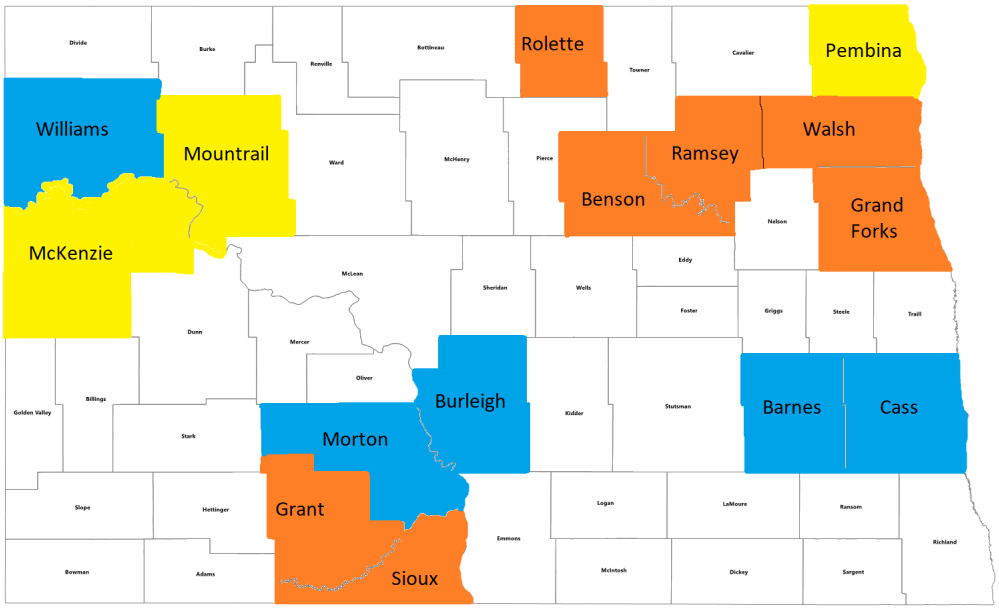
County	Validation Indicators
Barnes	Simplified method at-risk domain (Crime)
	Estimated home visiting need (55)
	2019 population (10,542)
Burleigh	Simplified method at-risk domain (Crime)
	Currently served by MIECHV LIA
	Estimated home visiting need (1,142)
	2019 population (95,273)
	Ten-year population increase (17.2%)
	Indigenous population (4.2%)
Cass	Simplified method at-risk domain (Crime)
	Estimated home visiting need (371)
	2019 population (181,516)

	Ten-year population increase (21.2%)
	Foreign-born population (7.2%)
McKenzie	Simplified method at-risk domain (Crime)
	Shares boundary with MHA Nation
	Includes Trenton Indian Health Service Area
	Estimated home visiting need (53)
	2019 population (13,632)
	Ten-year population increase (114.4%)
	Indigenous population (10.0%)
	Population under five (9.9%)
Morton	Simplified method at-risk domain (Crime)
	Currently served by MIECHV LIA
	Estimated home visiting need (372)
	2019 population (31,095)
	Ten-year population increase (13.2%)
	Population under five (7.2%)
Mountrail	Shares boundary with MHA Nation
	Ten-year population increase (33.3%)
	Indigenous population (30.3%)
	Population under five (8.5%)
Pembina	Simplified method at-risk domain (Substance Use Disorder)
	Identification of substance use disorder domain using supplemental data
	Estimated home visiting need (32)
	Foreign-born population (4.2%)
Williams	Simplified method at-risk domain (Crime)
	Estimated home visiting need (144)
	2019 population (35,350)
	Ten-year population increase (57.8%)
	Indigenous population (4.3%)
	Population under five (9.6%)

The counties determined to be at-risk based upon the simplified method were validated using data that closely aligned with statutory definitions, as well as with the data presented in the North Dakota Assessment Data Summary provided by HRSA. The aim was not to change the list of at-risk counties, but to determine whether the data provided by the simplified method would be similar to data collected from another source. These data were obtained from the Annie E. Casey Foundation KIDS COUNT website. Because descriptive statistics for these target populations and their data subsets were not available, value standardization was not possible. Following methodology used by needs assessment in other states, as well as that performed by KIDS COUNT data county rankings, counties were scored with a value of 1 if they ranked in the upper or lower quartile (depending on the indicator) and 0 if it appeared in another quartile. Counties were then assigned a composite score, which were compared to the composite score assigned by the Simplified Method. A comparison between the validation composite score and the simplified method score are included in the table on the following page:

County	Validation Composite Score	Simplified Method Score
Benson	2	2
Grand Forks (County)	3	2
Grant	2	2
Ramsey	3	2
Rolette	2	2
Sioux	3	2
Walsh	1	2
Barnes	1	1
Burleigh	3	1
Cass	3	1
McKenzie	0	1
Morton	2	1
Mountrail	0	0
Pembina	0	1
Williams	2	1

The counties identified by the simplified method and verified by PCAND as accurately representing concentrated areas of risk according to the flagged indicators – the highest priority "at-risk" areas – are displayed below in orange. Additional counties with a validation composite score of at least 1 are displayed in blue – these are medium priority areas. The counties that were analyzed but scored low (zero validation composite and 1 or 0 for the simplified method score), and are still designated "at-risk" but are lower priority, are yellow. The map template was sourced from www.usboundary.com.



Qualitative Data Collection. In order to better assess areas of need and risk throughout the state, PCAND conducted outreach and qualitative data collection statewide. These activities include:

- Interviews with community "champions" – With assistance from the needs assessment advisory board, PCAND staff identified individuals in each flagged county who represented various early

childhood and maternal and child health sectors. These individuals were then contacted and asked to participate in an interview about the populations they serve, the goals of the services they provide, and ideas for improvement (Appendix B). Across all counties, eleven individuals participated in these interviews. Interviews were recorded, transcribed, and coded for themes. The themes that emerged were used to develop the subsequent focus group and survey tools.

- Surveys – Two surveys (Professionals survey, Appendix C; Family survey, Appendix D) were conducted to gather information from both service professionals and families. Family surveys were sent specifically to individuals who demonstrated interest in participating in a family focus group, but were unable to do so. Parents who completed a family survey were given a $10 electronic gift card to either Walmart, Target, or Amazon. Children and family services professionals were entered into a drawing for either $100, $50, or $25 gift cards to the same stores (three winners per county of interest). Responses were themed and results will be shared below.
- Family focus groups – Initially, PCAND had planned to hold family focus groups/talking circles and other similar events in each community of interest. With the COVID-19 pandemic changing travel plans for spring and summer 2020, focus groups were moved to a virtual format using WebEx. Participants were recruited through social media, both by targeted ads from PCAND and by asking PCAND's program partners to share information. All family focus group participants were sent an electronic gift card to their choice of store (Walmart, Target, Amazon).
    - All recipients provided their contact information and agreed to not use the gift cards for unallowable purchases, such as alcohol, tobacco, lottery tickets, or firearms. The online stores for all three entities do not sell these items. However, electronic gift cards can be used in the store as well. Target stores in North Dakota do not carry any of the listed items; however, Walmart stores do. Therefore, PCAND made sure to clarify restrictions on gift card purchases prior to sending. Focus group questions are included as Appendix E.

PCAND received IRB approval from NDSU to complete these activities. In addition to this, the North Dakota Indian Affairs Commission provided a letter of support to demonstrate the importance of this data collection for indigenous communities (Appendix F). All PCAND staff on the ND MIECHV needs assessment team have training and experience in developing data collection tools and facilitating focus groups.

Qualitative Data Activity Numbers. Unfortunately, due to the change in venue/delivery of the focus groups, numbers of participants were significantly lower than anticipated. Even in counties with more than ten registered participants, it was more common to have 2-3 people participate.

Activity	County	# of Participants
Survey for children and family services professionals	Sent to service organizations in all at-risk counties	58
Family focus groups	Cass	7
	Grand Forks	3
	Burleigh	3
	Benson	1
	Rolette	4
	Sioux	2
	Mountrail	5
	Morton	1

Survey for parents who could not attend focus groups	Sent to interested parents in all at-risk counties	13

Statewide Family Themes. Overwhelmingly, family participants (both surveys and focus groups) valued connections in their communities. Many reported enjoying their chosen communities/counties because of a small town feel (even in North Dakota's largest cities, Fargo, Bismarck, and Grand Forks) and a sense of community, or everyone being willing to pitch in to help those in need. Many had family in the area or another form of relational connection to the county; some had grown up in the same community or somewhere close. In the larger cities, participants reported moving to their area for college or jobs, then settling down. These same factors that brought families to North Dakota kept them in the state. Additionally, parents in the larger cities reported enjoying access to varied activities for children and families. Throughout many focus groups and survey responses, but especially for those living in more rural areas, participants reported staying in their communities due to a sense of safety.

When reporting on concerns in their communities, parents noted that access to services (PCAND included any service in the community that is intended to support or help children and families, to include WIC, housing assistance, occupational therapy, speech therapy, behavioral health services, and more) was limited or difficult. Both transportation and the availability and awareness of available sources were cited as issues. For participants in rural areas, long distances and scheduling preclude many families from accessing the services their children and families require. Many parents reported not being aware of all the services or supports available to them, and felt it would be helpful to have a comprehensive database of what programs exist in their communities. Two additional areas of concern across the state were substance use disorder and the availability of affordable, safe housing.

In examining available services, the sentiment of most participants was that there is a greater need for services than is always available, due to funding or program staffing. Most parents felt that when services are available, they are helpful. Many parents also felt that service providers largely try to do their best to help those applying for support, and that they are compassionate and understanding. However, some parents did report experiences with program staff who were brusque, unhelpful, or judgmental. These themes were especially prevalent in areas with large indigenous populations, where participants shared stories of frustration and race-based prejudice.

A majority of respondents felt that the system of applying for support (housing, especially) can be difficult to navigate, the experience fraught with excessive paperwork, inconsistent methods of application (in person, mail, online), and lack of help/advocacy in undergoing the process. Major barriers to receiving services included paperwork (finding all the necessary documentation, the overwhelming process), transportation, programs not being centrally located, and scheduling/the time commitment involved in the process. Participants who reported that services had been helpful to their family tended to also report having a program staff person who was willing to help guide them through the process or answer questions. What was reported as being especially valued by parents was having an advocate or staff person who could help coordinate other services or provide referrals to other agencies. Integration of services and coordinated referrals remove several barriers to access, and these were noted as being major points of satisfaction.

To improve services, parent respondents in several counties reported the need for trauma-informed services and a greater understanding, by providers, of the cultures and backgrounds of their service population. Parents felt that trauma-informed practices and cultural responsiveness training would benefit the system. Responsiveness to indigenous beliefs and practices, and better collaboration with tribal

entities, was noted to be something that would increase satisfaction and utilization of services. Additionally, some parents felt there is a gap in services for children with disabilities and their families. A few parents specifically stated that more training and education on adverse childhood experiences (ACEs) for both families and service providers would be beneficial.

Best and most appreciated practices were reported to be programs being centrally located, to ease transportation and scheduling burdens, having program staff who are culturally responsive and willing to help advocate for family needs, and greater collaboration/coordination between programs. Discussions around collaboration included developing a coordinated intake and referral system, either regionally or statewide, as well as education around the services available to families in each community. Additionally, families reported that most programs had moved to accepting online or emailed applications for services, which was greatly appreciated.

Children and Family Service Provider Survey Themes. Service providers reported very similar positive or appreciated things about their communities as parents did: a sense of community unity and tight-knit connections in their areas. Service providers also reported that collaborations with other organizations tend to be strong and providers work well together. Diversity and acceptance in communities across the state were felt to be a positive part of living in North Dakota, and service providers also lauded educational systems across the state. Similarly, when asked about concerns for families in their communities, surveyed professionals reported that substance abuse disorder, difficulty accessing services (limited/lacking services), transportation, housing, and poverty were primary areas of concern. These align with the responses of parents.

Children and family service providers largely reported that access to services is a tremendous concern. From transportation and availability of service, to rigid income guidelines, surveyed professionals worried that families are not able to receive the support they need. Additionally, they too noted that the paperwork involved can be burdensome and overwhelming for parents. And while most providers felt that collaboration with other programs occurs, this does not always result in program staff assisting families with coordinating services and referrals, which, as stated above, is something parents feel is key to success.

Responses regarding cultural responsiveness were mixed, as they were in the family activities. While some reported collaborating with tribal entities and that differing cultures are respected, others felt that cultural responsiveness training would be beneficial – that culture is not considered when providing services.

In order to improve services, responding professionals noted that collaboration with other programs could be strengthened and improved, especially with regard to coordinating intakes and referrals to reduce the burden on families. They also noted that safe, affordable housing is desperately needed for families and that children and family support professionals would benefit from mandated reporter training. As most programs require the state-developed mandated reporter training, which is available online, it is not clear whether programs are not aware of this resource or if they are desiring additional support and training.

At-Risk Counties Reflecting Risk in North Dakota; North Dakota General Profile. The counties identified by the simplified method accurately reflect the level of risk in North Dakota. Domains that were flagged included substance use, which is a substantial concern in the state, and crime, largely in the same areas in which substance use disorder has been identified as a risk factor; as demonstrated in the section to follow, these are concerns statewide. Nearly all counties in which socioeconomic status, and its associated indicators, was flagged are home to tribal reservations (Rolette, Benson, Sioux), which are

unfortunately areas with high levels of unemployment, poverty, and paucity of resources. All these factors, plus genetic components, can lead to adverse perinatal outcomes.

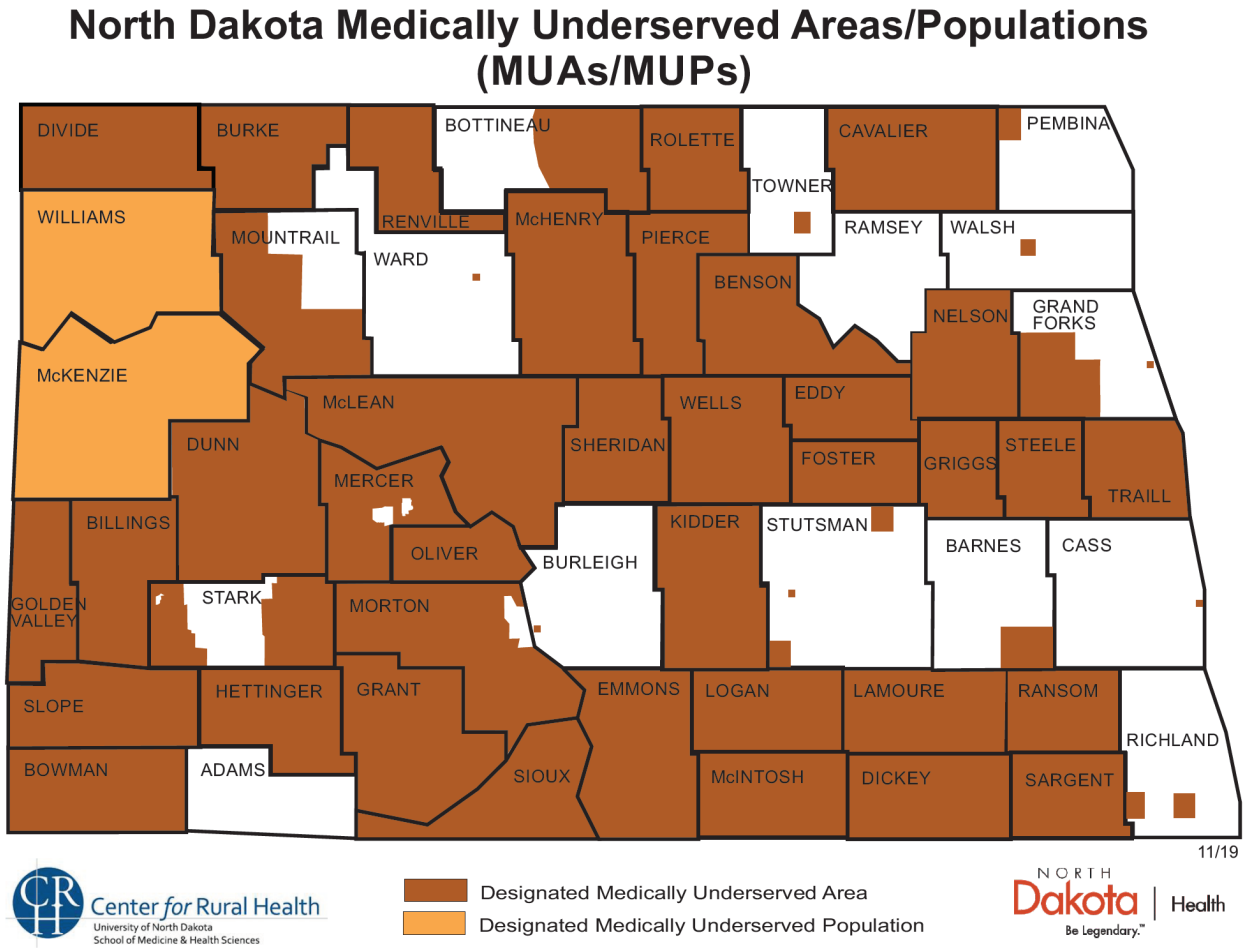
The state of North Dakota is largely rural or frontier, with a total population of 762,062. Nearly one-quarter of the population (23.6%) is under 18 years of age.[1] According to the U.S. Census, North Dakota is the fourth youngest state in the country, and the only state with a median age drop from 2010 to 2018 (from 37 to 35.2).[2] The population is largely white (86.9%), though North Dakota is growing more ethnically and racially diverse; in 2000, 92% of the state's population was white and non-Hispanic. Since then, populations Black, Latino, Asian, and mixed-race residents have increased, while populations of Indigenous peoples (American Indian and Alaska Native) has slightly decreased.[3] Census population estimates as of 2019 show 3.4% of the population as Black, 5.6% as Indigenous, 4.1% as Hispanic or Latino, 1.7% as Asian, and 2.3% identifying as two or more races. 3.9% of the population reports to be foreign-born.[1] There are five federally recognized tribes located at least partially in North Dakota: Spirit Lake Nation, the Turtle Mountain Band of Chippewa Indians, the Mandan-Hidatsa-Arikara (MHA) Nation, the Standing Rock Sioux (the reservation lies in both North and South Dakota), and the Sisseton Wahpeton Oyate of the Lake Traverse Reservation (the reservation lies in both North and South Dakota, but no major population center is in North Dakota).

A large majority of the population has graduated high school (92.5%), and nearly one-third (29.5%) have a Bachelor's degree. Nearly two-thirds of the population lives in a home they own (62.7%) and a similar percentage (69.2%) of the civilian population over the age of 16 is in the workforce (including 64.8% of women over the age of 16).[1] Of the population under 65 years of age, 7.1% of people have a disability and 8.1% do not have health insurance. 10.6% of North Dakotans live in poverty.[1]

As previously noted, North Dakota is relatively sparsely populated, with large populations of people living in rural or frontier-designated areas (in 2017, 38 of the 53 counties in the state were designated as frontier, with a population of fewer than seven people per square mile).[4] The population per square mile in 2010 was 9.7 people.[1] This can lead to barriers to accessing services, including behavioral health and medical care. About 58% of people who have health insurance coverage through the expansion of Medicaid live in rural or frontier areas in North Dakota.[5] The majority of the state's hospitals (36/42, or 85.7%) are critical access hospitals (CAHs).[5] CAHs have 25 or fewer acute care inpatient beds, are located at least 35 miles from another hospital, and provide 24/7 emergency care services.[6] Over half the

[1] United States Census QuickFacts, estimate as of June 2019. https://www.census.gov/quickfacts/ND
[2] State of North Dakota News Release, 2019. "U.S. Census: North Dakota Only State to Get Younger." https://www.nd.gov/news/us-census-north-dakota-only-state-get-younger
[3] North Dakota Census Office, August 2017. "Growing ND by the Numbers." https://www.commerce.nd.gov/uploads/26/CensusNewsletterAug2017.pdf
[4] University of North Dakota Center for Rural Health. "North Dakota Frontier Counties." https://ruralhealth.und.edu/maps
[5] University of North Dakota Center for Rural Health. "Key Points: Rural Health and Health Reform in North Dakota." https://ruralhealth.und.edu/assets/232-405/key-points-rural-health-reform-nd.pdf
[6] Rural Health Information Hub. "Critical Access Hospitals." https://www.ruralhealthinfo.org/topics/critical-access-hospitals

state is considered a medically underserved area.[7] A map displaying the state's medically underserved areas can be viewed below.



In addition to this, North Dakota has demonstrably high rates of substance misuse and binge drinking. In 2019, 22.8% of North Dakotans over the age of 18 reported binge drinking (four or more [women] or five or more [men] drinks on one occasion in the past 30 days) or chronic drinking (eight or more [women] or 15 or more [men] drinks per week), compared to 18.2% of the U.S. adult population.[8] North Dakota ranks fourth in the U.S. for binge drinking among adults, nearly one-quarter of adult arrests in North Dakota are for driving under the influence (DUI), nearly half (43.2%) of fatal car crashes in North Dakota are alcohol related, 41% of new domestic violence cases involve alcohol, and three-quarters of the North Dakota inmate population has a substance use disorder diagnosis.[9]

[7] University of North Dakota Center for Rural Health. "North Dakota Medically Underserved Areas/Populations (MUAs/MUPs)." https://ruralhealth.und.edu/assets/2783-12675/nd-mua.pdf
[8] United Health Foundation, America's Health Rankings. "Annual Report: Excessive Drinking." https://www.americashealthrankings.org/explore/annual/measure/ExcessDrink/state/ND
[9] North Dakota Department of Human Services, Prevention Resource and Media Center. "Substance Use in North Dakota Data Book, 2017." https://prevention.nd.gov/sites/default/files/pdf/DataBook2017.pdf

While relatively few individuals report using marijuana, over half (53%) of drug violations in North Dakota in 2015 were marijuana-related, and nine in ten (91%) of adolescents receiving substance use disorder treatment services at a regional human services center report using marijuana.[9] Additionally, the number of overdose deaths due to prescription pain relievers has increased over 300% from 2013 to 2015.[9]

Crime in North Dakota has decreased slightly over the past several years. The state's 2019 crime rate of 6,281.8 per 100,000 population is down slightly from the 2018 crime rate of 6,339.9. This rate includes the following categories: "Crimes Against Persons" (such as murder/non-negligent manslaughter, rapes, assaults), "Crimes Against Property" (robbery, burglary, theft, shoplifting, and motor vehicle theft), and "Crimes Against Society" (drug violations, prostitution, animal cruelty). Unfortunately, some areas of crime did increase: there was a 2.2% increase in crime against persons and homicide rates increased from 2018 (26 homicides v. 17 in 2018). Ten persons were killed by homicide in domestic violence cases, including two infants.[10]

Property crimes make up nearly half (49.9%) of all Group A offenses, with 23,868 property crimes reported (an 0.1% increase from 2018). Arson increased 118.4% from 2018 (83 reports in 2019, compared to 38 in 2018). And while substance use disorder is a demonstrated concern in the state, drug and narcotic violation offenses decreased 6.4% from 2018's rates. The primary drugs seized by law enforcement were marijuana, methamphetamine, and heroin. Animal cruelty crimes also increased (100 offenses in 2019 v. 82 in 2018).[10]

In the state, about one in ten people (10.6%) live in poverty.[1] This is significantly lower than the national average (14.6%). However, different races experience varying rates of poverty.[11]

White	Black	Asian	Indigenous	Latino
8.0%	21.2%	23.6%	33.8%	15.3%

Unfortunately, reservation areas in North Dakota experience poverty at a much higher rate than non-reservation areas, especially for families with children 0-17.[12]

Reservation	ND Counties Included	Poverty Rate – Families with Children 0-17	State Poverty Rate – Families with Children 0-17
MHA Nation	Dunn, McKenzie, McLean, Mercer, Mountrail, Ward	27.4%	12.4%
Spirit Lake Nation	Benson, Ramsey, Eddy, Nelson	59.7%	
Turtle Mountain Band of Chippewa Indians	Rolette	49.2%	
Standing Rock Sioux	Sioux	47.9%	

[10] North Dakota Attorney General. "2019 North Dakota Crime Report." https://attorneygeneral.nd.gov/sites/ag/files/documents/2019-CrimeReport.pdf

[11] Talk Poverty. "Poverty by State: North Dakota, 2018." https://talkpoverty.org/state-year-report/north-dakota-2018-report/

[12] ND Kids Count (Annie E. Casey Family Foundation). "North Dakota Tribal Reservation Supplement, 2018." https://www.ndkidscount.org/publications/factbook/TribalSupplement/2019/NDKCFB_2019_RESERVATIONSUPPLEMENT.pdf

Individuals living in reservation areas also tend to have adverse perinatal experiences and late or no prenatal care, which can exacerbate existing risk factors.[12] The following tables list counties that account for the primary population of a reservation.

Accessing Prenatal Care After the First Trimester[12]

County	Rate	State Rate
Benson	42.4%	13.7%
Dunn	15.9%	
McKenzie	NA	
Mountrail	31.0%	
Ramsey	11.2%	
Rolette	53.0%	
Sioux	59.0%	

Births to Mothers Who Smoke[12]

County	Rate	State Rate
Benson	27.9%	10.2%
Dunn	9.6%	
McKenzie	NA	
Mountrail	11.8%	
Ramsey	24.0%	
Rolette	34.8%	
Sioux	20.6%	

Low Birthweight[12]

County	Rate	State Rate
Benson	7.9%	6.8%
Dunn	NA	
McKenzie	NA	
Mountrail	6.7%	
Ramsey	4.1%	
Rolette	10.4%	
Sioux	13.2%	

Another major concern in North Dakota is health equity and access to services. As previously noted, and as demonstrated by the map above, the rural nature of North Dakota (plus a shortage of qualified medical professionals) has left the majority of the state medically underserved. In addition to this, the health status of one of the largest minority groups in the state, Indigenous residents, is often compromised due to racism, historical trauma, and lack of access to appropriate services. The literature around the prevalence of adverse childhood experiences (ACEs), and the importance of researching neuroscience, epigenetics, ACEs, and resilience (NEAR) science, among American Indians (AI) is growing. Data for AI children in ND showed that 28% of children 0-9 and 74% of children 10-17 had experienced 2+ adverse childhood and family experiences (ACFEs); 1/4 of children 0-17 had experienced at least four. The study demonstrated that rates of ACFEs for AI children are considerably higher than white children in the state,

which underscores the need to focus efforts on the development of culturally-based programs in order to reduce significant health disparities.[13]

Quality and Capacity of Existing Home Visiting Services

Several home visiting services exist in North Dakota. According to HRSA:

"For purposes of this needs assessment, 'early childhood home visitation services' or 'home visiting programs' are programs that use home visiting as a primary intervention strategy for providing services to pregnant women and/or children from birth to kindergarten entry. These phrases, for purposes of the MIECHV program and this needs assessment, exclude programs with few or infrequent visits or where home visiting is supplemental to other services.'

Therefore, only programs that provide regular and consistent home visits for a sustained period of time were included in the capacity assessment. A list of home visiting programs throughout the state is included in the table below. The table also includes the number of families served by the program (provided by the program wherever possible, estimated based on model fidelity guidelines if no response received), as well as a column of families estimated to be in need of home visiting services in that service area. This information was provided by HRSA and describes need by a county level.

Program/Model	Agency	Service Area	Service Population	Families Served*	Families in Need
Early Head Start	Community Action Partnership	Dickinson and surrounding area (Stark County)	Low-income pregnant women and children with families birth-3	32*	131
	Fort Yates Early Head Start	Standing Rock reservation/Sioux County		46*	19¥
	Bismarck Public School District	Bismarck and surrounding area (Burleigh County)		10*	1,142
	Minot Public School District	Minot and surrounding area (Ward County)		11*	295
	TGU School District #60	Towner, Anamoose, Harvey, Devils Lake (McHenry and Ramsey Counties)		22*	83
	Cankdeska Cikana Community College	Spirit Lake reservation (Eddy, Nelson, Benson, and		38*	119^^

[13] Danielson R, Kenney MK, Muccatira D, "Adverse Childhood and Family Experiences Among American Indian Children in North Dakota: Analysis of 2011/12 National Survey of Children's Health Data," 2015. https://www.ndhealth.gov/cshs/docs/APHA-DanielsonPoster-NSCH-102915rev.pdf

		Ramsey Counties)			
	Mayville State University	Hillsboro, Mayville (Traill County)		14*	37
	Community Action Region VI	Jamestown, Valley City (Stutsman and Barnes Counties)		20	161
	Three Affiliated Tribes	Dunn County		35	18
Head Start	Community Action Partnership	Dickinson and surrounding area (Stark County)	Low-income families with children birth-5	5*	131
	Community Action Region VI	Jamestown, Valley City (Stutsman and Barnes Counties)		4	161
	Three Affiliated Tribes	Dunn County		5	18
Nurse-Family Partnership	Fargo Cass Public Health	Fargo (Cass County)	Low-income, pregnant (<28 weeks) first-time mothers	158	371
	NFP of Missouri Valley	Burleigh, Morton, Mercer, Oliver, Grant, and Sioux Counties		43	1,587
Parents as Teachers	Turtle Mountain Home Visiting – State MIECHV	Rolette County	MIECHV priority populations	56	74°
	Turtle Mountain Home Visiting – Tribal MIECHV	Turtle Mountain Band of Chippewa Indians reservation (Rolette County)	MIECHV priority populations among enrolled tribal members	58	74°
	United Tribes Technical College (FACE)	Burleigh County	Tribal members whose children will attend tribal schools	48	1,142
	Tate Topa Elementary School (FACE)	Spirit Lake Nation reservation (Eddy, Nelson, Benson, and		48	119^^

		Ramsey Counties)			
	Dunseith Elementary School (FACE)	Rolette County		48	74[°]
Healthy Families North Dakota	Lutheran Social Services of North Dakota	McKenzie, Billings, Dunn, Stark, Hettinger, Burleigh, Morton, Grand Forks, Nelson, Walsh and Pembina Counties	Mothers who are pregnant/expecting a baby; Has recently had a baby and the infant 3 months old or younger; Is connected to the child welfare system and the youngest child in the family is under 24 months old; Is incarcerated and pregnant; Is incarcerated and has a child under the age of 12 months.	205	2,152
Healthy Start^ (Family Spirit)	Great Plains Tribal Chairman's Health Board	Spirit Lake Nation, Turtle Mountain Band of Chippewa Indians, Standing Rock Sioux reservations	Families with women of child-bearing age (support fathers as well), as well as those with children up to 18 months	60-75*	212[¥,^^,°]
MHA Nation Infant and Toddler Program	MHA Nation/Three Affiliated Tribes	MHA Nation reservation (McKenzie, McLean, Ward, Mountrail, Dunn, and Mercer Counties)	Tribal members with children 0-5	---[+]	486[€]
Public Health High Priority Infants	First District Health Unit	Bottineau, Burke, McHenry, McLean, Renville, Sheridan, and Ward Counties	All infants are eligible; have served some children up to 3	30	421
Early Intervention & Right Track	All regional human service centers	Statewide	Early Intervention: children birth-2 with a developmental delay and found eligible through evaluation process; Right Track: any North Dakota child birth-3	1,195[†]	4,032[£]

**For the last program year. If program did not provide numbers of families served in the most recent program year, the program's maximum capacity will be listed. All entries referring to maximum capacity or caseload will be denoted with an asterisk.*

^Despite repeated requests, the needs assessment team could not get in touch with program representatives at either the individual sites or the administering agency. The provided caseload number is based on the expected caseload of 20-25 families per full-time home visitor under the Family Spirit model. This estimate assumes one full-time home visitor serves each listed area.

[+]This program did not respond to requests for information. According to their website, they have staff vacancies (three of six positions).

[†]There are no official maximum capacities for Right Track and Early Intervention services. These are offered through Part C.

[¥]HRSA did not provide reservation-specific need estimates. The reservation of the Standing Rock Sioux is entirely contained (in North Dakota) by Sioux County; the number of families in need includes those reported for this county. PCAND believes the need on the reservation to be greater than the number reported for the county.

^^HRSA did not provide reservation-specific need estimates. The reservation of the Spirit Lake Nation reaches into four counties (Benson, Ramsey, Eddy, and Nelson); the number of families in need includes those reported for these four counties.

[°]HRSA did not provide reservation-specific need estimates. The reservation of the TMBCI is entirely contained within Benson County; the number of families in need includes those reported for this county. PCAND believes the need on the reservation to be greater than the number reported for the county.

[€]HRSA did not provide reservation-specific need estimates. The reservation of the Three Affiliated Tribes reaches into six counties (Mountrail, McKenzie, Mercer, McLean, Dunn, and Ward); the number of families in need includes those reported for these six counties.

[£]Number may not be entirely accurate; Right Track serves birth to three and HRSA number may include children through the age of 5 (priority population).

The ND MIECHV team's practicum student, Murphy Anderson, contacted programs in the identified at-risk counties to ask about three domains related to quality and availability: staffing, capacity, and population. These questions included the following:

1. How many staff does program have dedicated to home visiting services in each county or center, and how many full time equivalents are dedicated solely to home visiting?
2. Have you had any issues filling vacancies with qualified staff?
3. How many families are you able to serve (max capacity)?
4. How many families did you serve in your last fiscal year? Please indicate the dates of your fiscal year.
5. Is there a waitlist of families? How many?
6. Are your services limited to certain and/or priority populations? If so, which?
7. Do you work with any other programs or organizations? If so, which?
8. What gaps in services and/or barriers for families do you see?
9. Do you use an evidence-based model for HVPs, such as Parents as Teachers, Healthy Families, or Nurse Family Partnership?

From the responses, PCAND found that nearly all programs are adequately staffed according to model or program requirements, and most programs reported no problems finding qualified staff. However, some program representatives did note that simply hiring staff is not an issue, but hiring qualified staff is. Representatives noted that home visiting takes a specialized skill set and dedication. Two Early Head Start programs noted having difficulties filling vacancies with qualified staff, and one rural site noted that it can be difficult to find home visitors with a college degree (which is not required by their model, but recommended). Many programs noted that they have low staff turnover and no difficulties hiring. Ensuring that home visitors are trained in home visiting core competencies, as well as building up the home visiting/maternal and child health workforce throughout the state would better equip communities for implementing quality, sustainable home visiting programs.

Nearly all programs report serving caseloads that are at or very near their maximum capacity (if their site has such a limit), however, only two responding programs noted that they have a waitlist. Many programs serve priority populations – typically low-income families with children three or younger. Additionally, every program representative listed several key community partners and relationships for making and giving referrals, supporting clients/families, and strengthening community systems. In this way, it appears that the communities in North Dakota are well-equipped to provide comprehensive, supportive services to families who desire home visiting. All at-risk counties identified by PCAND are covered by at least one evidence-based home visiting model, which provides the opportunity for families to do so.

Gaps and barriers identified by home visiting program representatives include access to health services (dental, medical, behavioral), transportation, access to social services supportive therapies (occupational, speech, etc.), affordable childcare, long waiting periods for housing assistance, difficulty navigating the application process for services, safe and affordable housing, working with other organizations' or services' referral processes, staff turnover at medical facilities, language barriers, fear of child welfare/child protective services involvement, and lack of services for children with disabilities. Several of these were echoed by those who participated in the MIECHV needs assessment qualitative data process, and it is apparent there are ample opportunities for collaboration and coordination moving forward to cover some of these gaps and mitigate these barriers.

All listed home visiting services are high quality (are either evidence-based and must adhere to model fidelity, and/or undergo regular monitoring of program progress and outcomes). A table of North Dakota's counties, an estimate of families in need of services (provided by HRSA), and the number of families being served by high-quality, evidence-based home visiting services (not including Right Track or Early Intervention, which are not considered evidence based) is below (with "at risk" counties marked with their coordinating color of need). As a note, programs provided information on current caseloads. For the purposes of this report, in instances for which a program serves multiple counties and a representative provided only a service-area or regional caseload, PCAND has split the caseload proportionally based on county population as of 2019 (most recent data available via the US Census estimates). Therefore, the numbers in the table below may not be accurate, though they provide an educated estimate as to the percent of families in need that are served by evidence-based programs.

County	Estimated Families in Need	Number of Families Served	Percent of Families in Need Served
Adams County	10	0	0%
Barnes County	55	8	15%
Benson County	34	31	91%
Billings County	4	1	25%
Bottineau County	33	2	6%
Bowman County	14	0	0%
Burke County	9	1	11%
Burleigh County	1142	198	17%
Cass County	371	158	43%
Cavalier County	18	0	0%
Dickey County	26	0	0%
Divide County	10	0	0%
Dunn County	18	42	233%
Eddy County	12	10	83%
Emmons County	41	0	0%

Foster County	16	0	0%
Golden Valley County	7	0	0%
Grand Forks County	324	31	10%
Grant County	10	0	0%
Griggs County	10	0	0%
Hettinger County	11	1	10%
Kidder County	30	0	0%
LaMoure County	21	0	0%
Logan County	23	0	0%
McHenry County	25	9	36%
McIntosh County	33	0	0%
McKenzie County	53	5	10%
McLean County	41	3	7%
Mercer County	36	1	3%
Morton County	372	45	12%
Mountrail County	43	0	0%
Nelson County	15	15	100%
Oliver County	8	0	0%
Pembina County	32	3	10%
Pierce County	21	0	0%
Ramsey County	58	67	116%
Ransom County	27	0	0%
Renville County	11	1	9%
Richland County	82	0	0%
Rolette County	74	182	246%
Sargent County	19	0	0%
Sheridan County	7	0	0%
Sioux County	19	67	353%
Slope County	4	0	0%
Stark County	131	37	28%
Steele County	9	0	0%
Stutsman County	106	16	15%
Towner County	10	0	0%
Traill County	37	14	38%
Walsh County	50	4	8%
Ward County	295	32	11%
Wells County	21	0	0%
Williams County	144	0	0%

A few items of note, as one concludes reading the above table. First, as noted as above, Right Track and Early Intervention programs – which serve over 1,000 families per year in North Dakota – are not included in the table. While the programs are high quality, and must submit regular reports and progress updates to the state as a contingency of funding, they are not evidence-based according to HRSA/MIECHV standards. These programs are available for infants and toddlers across the state, and serve families in all 53 counties. Second, and also previously noted, the estimates above may be calculated using the county's population to determine a proportion of a program's caseload, so while it appears that 49% of the state's counties do not have any families served by an evidence-based home

visiting program, some of the "zero" counties may include a family or two, who were proportioned to another county due to the estimate calculations.

One program, which serves multiple counties (MHA Nation Infant and Toddler Program; McKenzie, McLean, Mountrail, Ward, Dunn, and Mercer Counties), did not respond to requests for information about the program's capacity or caseload. Therefore, there may be greater numbers of families served in those counties than the table demonstrates.

Finally, while some areas appear to overserve families (Dunn, Ramsey, Rolette, and Sioux Counties all show greater than 100% of families in need being served; other counties are at or near 100%), these are all counties that house or are adjacent to reservation areas. The estimates of families in need were provided by HRSA, and they do not appear to include data for reservation areas, which have demonstrated (see data beginning on page 16) disparities and intensive needs. While the data and its associated table may lead a reader to believe these counties are saturated in terms of home visiting services, PCAND believes that is not the case.

State Capacity for Providing Substance Use Disorder Treatment and Counseling Services

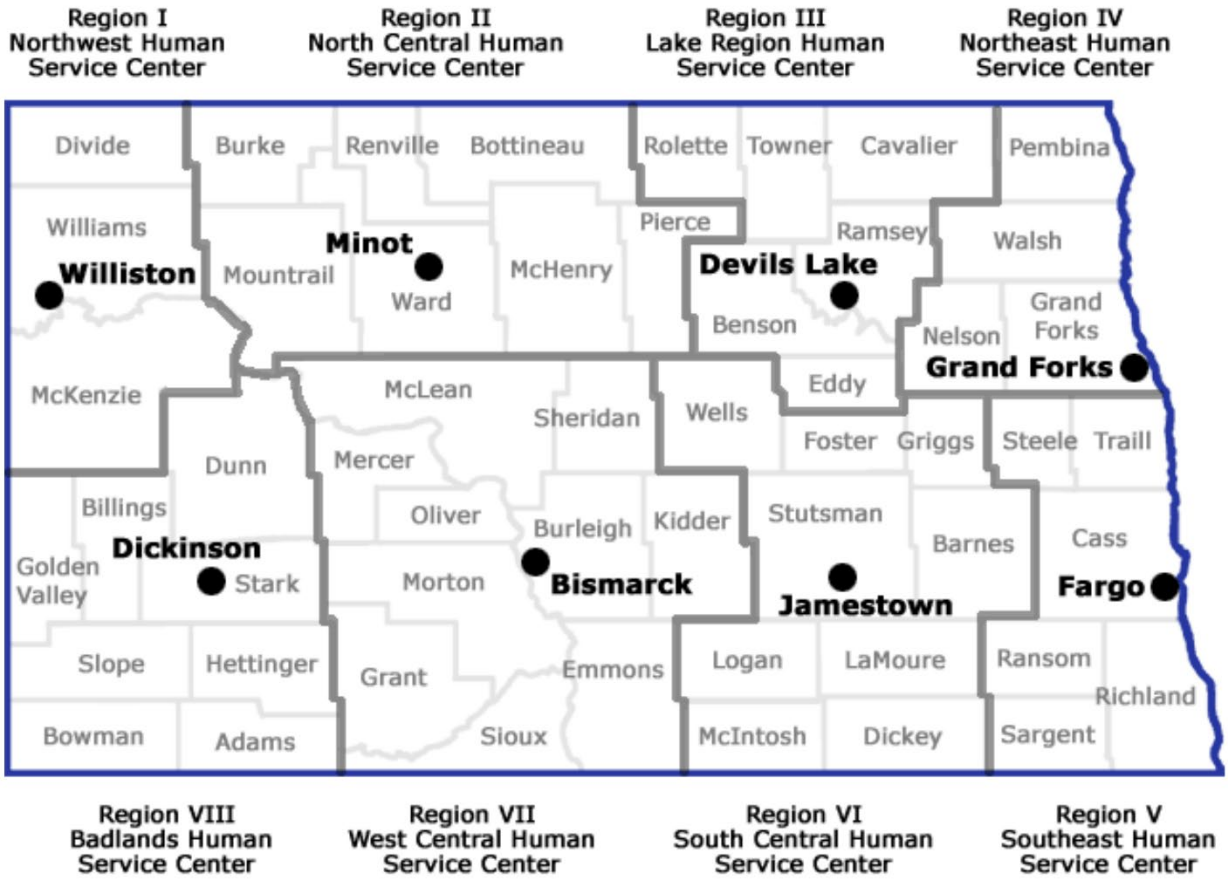
There are a wide range of substance use disorder treatment and counseling services (intervention, treatment, and recovery) available in North Dakota to meet the needs of pregnant women and families with young children who may be eligible for MIECHV services. Initial assessments and services are available at each of the eight regional human service centers, displayed in a map from the North Dakota Department of Human Services on the following page.

Regarding intervention and assessment, these facilities have adopted open access assessment services and each individual seeking an assessment is triaged and screened for pregnancy. Individuals who identify as being pregnant are given priority and assessed that day. If an assessment is not able to be completed that day, policies require an assessment to be completed no later than 48 hours. Services are to begin directly following the assessment.

Some of the regional human service centers offer a "treatment mall" model of services, which embraces the values of increasing self-determination, empowering relationships, developing meaningful roles, and eliminating stigma and discrimination.[14] In these instances, individuals are able to begin services directly following the assessment. If services are not available directly following the assessment, the individual is placed on a prioritized waiting list and offered interim services to include engagement group, case management or referred to education-based programming. Regional human service center directors and clinical directors sign a memorandum of understandings to stipulate priority population requirements are met.[15]

[14] Behavioral Health Executive, 2009. "Building a Treatment Mall." https://www.psychcongress.com/article/building-treatment-mall

[15] North Dakota Department of Human Services. "ND 2020-2021 Block Grant Application." https://www.nd.gov/dhs/info/pubs/docs/mhsa/draft-nd-uniform-application-fy-2020-2021-block-grant-application.pdf



Unfortunately, at this time no residential services in North Dakota exist to provide on-site treatment and recovery options that allow a mother to keep her children with her while undergoing services. There had previously been such an option near Minot, but it was converted to a co-ed facility without children earlier this year. Other residential facilities are available for pregnant women and mothers who are able to procure childcare during the length of treatment (see table on the next page).

Through the capacity mapping process, substance abuse services in each focus county were identified. The SIR statutory requirement number three requires reporting on available substance abuse disorder treatment and counseling services which intend to meet the needs of MIECHV populations. The table below shows licensed substance abuse services by each at-risk county. With the exception of the Human Service Centers, the At-Risk County column indicates the county in which the center is located, however the centers serve families and individuals in surrounding counties. For Human Service Centers, the At-Risk County column indicates at-risk counties within each service area.

The Services Provided column indicates the age group of individuals served, adult (18 years and older) and adolescent (17 years and younger), and treatment services provided. For more information about services provided, refer to *Licensed Addiction Treatment Programs in North Dakota* from the North Dakota Department of Human Services Behavioral Health Division (2020).[16] Because some service centers provide services to at-risk counties, but are located in other counties, there are 21 counties

[16] North Dakota Department of Human Services, 2020. "Licensed Addiction Treatment Programs in North Dakota." http://www.nd.gov/dhs/info/pubs/docs/mhsa/nd-licensed-addiction-treatment-programs.pdf

included in the table below.

Substance Abuse Service Name	At-Risk County	Services Provided
South Central Human Serv ice Center – Region 6	Barnes	Adult; outpatient
Spirit Lake Nation Recovery & Wellness Program	Benson	DUI seminar
A.D.A.P.T Inc (Headquarters)	Burleigh	Adolescent & adult; outpatient; day treatment
Chambers and Blohm Psychological Services, P.C	Burleigh	Adolescent & adult; outpatient
St. Alexius Medical Center/PHP Dual Diagnosis Program	Burleigh	Adolescent & adult; outpatient; day treatment
Heartview Foundation – 23rd Street	Burleigh	Adolescent & adult; outpatient; day treatment; adult low-high residential care; social detox
Dakota Boys & Girls Ranch	Burleigh	Adolescent; outpatient; low and medium intensity residential care
De Coteau Trauma-Informed Care & Practice, PLLC	Burleigh	Adult & adolescent; outpatient
The Village Family Service Center	Burleigh	Adult; outpatient; day treatment
Good Road Recovery Center	Burleigh	adult outpatient, day treatment, low intensity residential care, social detox
New Freedom Center, Inc.	Burleigh	Adult; outpatient; day treatment; low residential care; social detox
Summit Counseling Services	Burleigh	Adult & adolescent; outpatient; day treatment
Heartview Foundation	Burleigh	Adult & adolescent; outpatient, day treatment; adult low to high residential care, social detox, opioid treatment; DUI seminar
Audrey Kazmierczak Counseling Services	Burleigh	Adult & adolescent; outpatient; DUI seminar
Pathways Counseling & Recovery Center	Cass	Adult; DUI seminar
City of Fargo dba Fargo Cass Public Health	Cass	Social detox

Dacotah Foundation - Dacotah Pioneer	Cass	Social detox
First Step Recovery - The Village	Cass	Adolescent & adult; outpatient; day treatment
Dakota Boys & Girls Ranch	Cass	Adolescent; outpatient; low and medium intensity residential care
Simon Chemical Dependency Services	Cass	Adult; outpatient; DUI seminar
ShareHouse Inc	Cass	Adult; outpatient; day treatment; low to high residential care; social detox
Centre, inc.	Cass	Adult; outpatient; low to high intensity residential care
PSJ Acquisitions, LLC d/b/a/Prairie St. John's	Cass	Adult & adolescent; outpatient; residential care; DUI seminar; social detox
Ideal Option	Cass	Adult; outpatient
Southeast Human Service Center – Region 5	Cass	Adult; outpatient
Resolve Behavioral Health	Cass	Adult; outpatient
Willow Tree Counseling PLLC	Cass	Adult; outpatient
Benson Psychological Services, PC	Cass	Adult; outpatient
Discovery Counseling	Cass	Adult; outpatient
Drake Counseling Services	Cass	Adult &adolescent; outpatient; day treatment
Eddie Burl LLC	Cass	Adult; DUI seminar
GOODclover LLC	Cass	Adult & adolescent; outpatient; DUI seminar
Community Medical Services	Cass	Adult; opioid treatment
Fargo VA Healthcare System	Cass	Adult, veteran; outpatient
A.D.A.P.T Inc (Satellite Office)	Cass	Adolescent & adult; outpatient; day treatment
Badlands Human Service Center – Region 8	Dunn	Adult & adolescent; outpatient; day treatment; low intensity residential care

A.D.A.P.T Inc (Satellite Office)	Grand Forks	Adolescent & adult; outpatient; day treatment
Red River Behavioral Health System	Grand Forks	Adult & adolescent; outpatient; day treatment; medium and high intensity residential care
Centre, inc.	Grand Forks	Adult; outpatient; low to high intensity residential care
City of Grand Forks	Grand Forks	Adult; outpatient; social detox
Drake Counseling Services	Grand Forks	Adult & adolescent; outpatient
Spectra Health	Grand Forks	Adult; outpatient
Agassiz Associates PLLC	Grand Forks	Adult; outpatient
Carol Torgerson Counseling LLC	Grand Forks	Adult; outpatient
Northeast Human Service Center – Region 4	Grand Forks, Nelson, Pembina, Walsh	Adult; outpatient
Summit Counseling Services (Prairie Site)	Grant	Adolescent; outpatient; day treatment
Prairie Learning Center	Grant	Adolescent; residential care
West Central Human Service Center – Region 7	Burleigh, Grant, Mercer, Morton, Oliver, Sioux	Adult; outpatient
Summit Silver Creek	McKenzie	Adult; outpatient; day treatment, social detox, high intensity residential care
Empowered Therapy by Tara Lorenz, PLLC	McKenzie	Adult; outpatient
Circle of Life Alcohol Program	Mountrail	Adult; outpatient; day treatment
Parshall Resource Center	Mountrail	Adult; outpatient; low intensity residential care
A.D.A.P.T Inc (Satellite Office)	Ramsey	Adolescent & adult; outpatient; day treatment
Aspiring Hope Therapy	Ramsey	Adult; outpatient
Lake Region Human Service Center – Region 3	Ramsey, Benson, Rolette	Adult & adolescent; outpatient; adult day treatment; low to high intensity residential care; social detox

Spotted Eagle & Holy Otter Women 16 Hour DUI Class	Rolette	Adult; outpatient
Patty Allery DUI Seminar Program	Rolette	Adult; DUI seminar
5th Generation	Rolette	Adult; day treatment; low intensity residential care
Cornerstone II - Dunseith	Rolette	Adult; outpatient
Quinn DUI/MIP Evaluations	Walsh	Adult; outpatient
Trinity Health Hospitals	Ward	Adolescent and adult day treatment; low, medium, high intensity inpatient care, social detox, intensive/high intensity inpatient care
Dakota Boys & Girls Ranch Association	Ward	Adolescent; outpatient; low and medium intensity residential care
Community Medical Services	Ward	Adult; outpatient; opioid treatment
Growing Together Inc. - Hope's House, New Hope	Ward	Adult; day treatment; low intensity residential care
Goodman Addiction Services	Ward	Adult & adolescent; outpatient
Bob Hayes Addiction Services	Ward	Adult; outpatient
Cornerstone Addiction Services	Ward	Adult; outpatient
A.D.A.P.T Inc (Satellite Office)	Ward	Adolescent & adult; outpatient; day treatment
North Central Human Service Center – Region 2	Ward, Mountrail	Adult & adolescent; outpatient; adult day treatment; adult low to high intensity residential care; social detox
A.D.A.P.T Inc (Satellite Office)	Williams	Adolescent & adult; outpatient; day treatment
The Fred and Clara Eckert Foundation for Children	Williams	Adolescent; outpatient; day treatment; low intensity residential care
Weishoff Alcohol & Drug	Williams	Adult & adolescent; outpatient
Native American Resource Center	Williams	Adult & adolescent; outpatient
Summit Counseling Services	Williams	Adult & adolescent; outpatient; day treatment

Montgomery Counseling Services	Williams	Adult; outpatient
Choice Recovery Counseling	Williams	Adult; outpatient
Northwest Human Service Center – Region 1	Williams, Divide, McKenzie	Adult & adolescent; outpatient; adult day treatment
78 Services	**Serving 21 At-Risk Counties**	**Varies**

Barriers to Receipt of Behavioral Health and Substance Use Treatment Services. Barriers to these services are similar to the barriers preventing access to medical and preventative health care – there are relatively few treatment slots available, a lack of providers, weak coordination of programs and systems, and issues relating to long distances, weather, and difficulty traveling (due to the very rural/frontier nature of North Dakota).The North Dakota Behavioral Health System has been examined at length due to reports of difficult access, limited number of treatment slots, and more. In 2017, the Behavioral Health Division commissioned a study of the system, which was conducted by the Human Services Research Institute (HSRI). This study found several gaps in the North Dakota system.

Aside from the issues around access and availability, the gaps found primarily concern the lack of preventative measures, as well as the inadequacy of crisis response services (especially for children and youth, and the population outside the Fargo area). From Medicaid data, it is apparent that there is a need for more proactive community response services – rates of behavioral health-related emergency department and ambulance utilization are high. However, parents that participated in PCAND's focus groups reported that even when services are available, scheduling and travel make accessing services difficult. Additionally, greater support for parents whose children are at risk of out-of-home placement and justice involvement is needed.

Another gap identified by the study was the lack of coordination between the behavioral health system and other systems that serve children and families, especially the public school system. Because of this, the Department of Human Services aims to expand programming options for school-based mental health and substance use disorder treatment services for children and youth. The Department also aims to work toward the development of a community system of care for children and youth in North Dakota, a goal that is shared by PCAND/ND MIECHV and key partners, so this is a prime opportunity to collaborate and include home visiting services. Better coordination of systems and greater collaboration between the public school system and behavioral health system – up to and including public schools becoming hubs of services and care for children – will remove access barriers and potentially reduce any stigma around receiving behavioral health care or support for children and adolescents.

The study also found that the state should expand funding and accessibility for telehealth services, especially for children and youth, as well as indigenous communities. Telehealth services would help individuals and families who struggle due to transportation issues, long travel distances, scheduling difficulties, and weather concerns. While programs have expanded services to include more telehealth options due to the COVID-19 pandemic, these options have not traditionally been funded by the state at levels in accordance with need. Additionally, parents who participated in focus groups and surveys reported that the ability to apply for and access services online would be beneficial, as it could reduce the barriers of long travel distances, procuring transportation, and submitting extensive paperwork via mail or in-person. Better coordination of systems, a more efficient intake process, and more options for those who

wish to access care online would remove several barriers (time, travel, cost, safety, availability) from those who require services.

Coordinating with Other Programs' Needs Assessments

As previously described at the beginning of this report, PCAND has been supported and guided by an advisory committee including representatives of the programs developing the Title V MCH Block Grant program needs assessment, the community-wide strategic planning and needs assessments conducted in accordance with section 640(g)(1)(C) of the Head Start Act, and the inventory of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect (as well as other family resource services operating in the state, required under section 205(3) of Title II of CAPTA. Additionally, as part of the Work-as-One needs assessment planning group, PCAND participated in several meetings with statewide stakeholders, including the aforementioned programs, during which shared data, activities, and dissemination efforts were discussed and planned.

Several similarities between identified gaps for CAPTA, MCH priorities, and MIECHV findings were discovered. The Head Start needs assessment detailed the need for improved collaboration with other organizations in the early childhood system, as well as needs regarding data quality, sharing, and exchange. These were items that were identified through MIECHV focus groups. Parents reported that increased coordination of programs, especially around sharing information for intakes, assessments, and referrals, would benefit families in North Dakota.

Similarly, two identified MCH priorities align with MIECHV initiatives. The first priority is improving well-woman care, with an emphasis on minority women, to reduce maternal morbidity and mortality, low birthweight infants, preterm birth, and infant mortality. A key component of this priority is increasing the percentage of women who receive a yearly preventative visit. Counties that border or include reservation areas were identified as being at-risk partially due to high rates of adverse perinatal outcomes, including preterm birth or low birthweight. Home visitors can help mothers navigate systems and encourage them to make preventative care visits, as they would for their children. The second MCH priority that meets MIECHV initiatives, if not directly the areas of risk identified in key counties, is increasing breastfeeding rates among Indigenous mothers. Statewide, 83% of new mothers initiate breastfeeding. For Indigenous mothers, that rate is 53%. Breastfeeding can have a positive impact on both maternal and infant health, including infant mortality and the occurrence of Sudden Unexplained Infant Death (SUID).

Gaps identified by CAPTA include several items that were also noted during parent focus groups. These include barriers around transportation and scheduling (parents have difficulty finding time to attend groups or classes), isolation of parents and families, long distances to receive services, cultural responsiveness, poverty, parents with substance use disorder or addiction, the need for more licensed child care providers, and more support and resources for parents and children affected by ACEs, especially foster parents. These were all echoed by parents participating in focus groups, as well as children and family service professionals who responded to PCAND's survey.

From the beginning of the grant period for which needs assessment funds were made available (fall 2018), PCAND was actively involved in planning meetings and discussions with other key programs conducting needs assessments. The Work-as-One group developed lists of potential data sources, including those that might be shared by multiple groups for analysis or synthesis of results, opportunities to collect qualitative data, and previously conducted needs assessments and gap analyses. These documents, along with the State Health Improvement Plan and State Health Assessment tools, were hosted on a collaborative Sharepoint site, so all could access and use as necessary.

Because the MIECHV needs assessment was the "final" assessment of the group, with the latest due date, many organizations moved ahead to complete their own data collection activities and analysis prior to MIECHV qualitative data collection. However, as representatives from relevant organizations sat on the MIECHV needs assessment advisory board, there were continued conversations and suggestions about the incorporation of relevant questions and information from partner agencies. During monthly meetings, the advisory group would discuss progress toward completing needs assessment activities and goals, as well as the identification of service gaps, duplication of services, and challenges or barriers to receipt of services that had been identified by both the MIECHV data collection activities and those organizations' needs assessments. Again, as the MIECHV needs assessment fell "last" in the order of required assessments, in order to avoid duplication of data collection efforts, questions included in the qualitative data collection tools primarily concerned MIECHV-related populations and referral services.

Moving forward, PCAND plans to continue convening the needs assessment advisory group as it transitions to be representative of an early childhood comprehensive systems advisory group. Through the continued meeting and facilitation of discussions, as well as the dissemination of assessment results and findings, stakeholders will be able to engage in the contextualization of the MIECHV needs assessment findings. Because findings so closely align with the gaps and priorities of partner agencies, it is likely that cohesive, coordinated strategies for collaboration will be identified.

Conclusion

The North Dakota MIECHV needs assessment found the following:

- Substance use disorder is a pervasive issue in North Dakota, especially in the northeast section of the state.
- Reservation areas demonstrate poorer health outcomes, especially with regard to perinatal health, than do other areas of the state.
- Minority populations are much more likely to live in poverty than white residents.
- Parents struggle to navigate complicated and sometimes burdensome systems.
- Families would benefit from better coordination between programs, especially to reduce the burden of paperwork, transportation, and documentation, as well as to receive quicker referrals.
- More outreach around what programs are available in each community would be helpful for families.
- Providers would benefit from receiving training on being trauma-informed and culturally responsive.
- There are ongoing concerns from minority groups, especially Indigenous peoples, around race related prejudices.
- Health equity, especially for minority groups and rural residents, should be a priority for all systems.
- There are plentiful opportunities for collaboration between organizations and systems to improve family health and well-being in North Dakota.
- While there are many great home visiting programs in the state, including evidence-based models, there is still a substantial need for additional funding and support for these programs.

Three tiers of at-risk counties were developed based on the simplified method and additional validation attempts. These are listed in the table on page 33.

High-Priority	Medium-Priority	Lower-Priority
Benson Ramsey Rolette Grand Forks Walsh Sioux Grant	Cass Barnes Burleigh Morton Williams	Pembina McKenzie Mountrail

There were some limitations to the data collected by PCAND and provided by HRSA. First, those who participated in qualitative data activities were volunteers and self-selected themselves to participate, which may mean they had particularly strong feelings about services they had received; their responses may not be representative of others in their communities or organizations. Secondly, due to restrictions in place because of COVID-19, focus groups were held virtually instead of in person, which potentially limited the number of participants (who needed a strong internet connection and device capable of accessing the internet to participate). Some organizations who were asked to provide capacity information did not respond to requests from PCAND. This could be due to concerns about the process, the requesting organization, or other reasons – staff hypothesized there may be some concerns about a new home visiting program moving into the area, despite repeated explanations of the needs assessment purpose. However, it is also possible that because of COVID-19, program staff were overextended, continually out of the office, or did not have access to the appropriate data.

Finally, the data initially provided by HRSA did not come from datasets that are inclusive of tribal data. This is not due to any fault of individual program staff or in fact any intentions of HRSA to exclude that data. There have been longstanding and continuing abuses of Indigenous peoples, programs, and data, leading to a mistrust of research and related activities in some of these communities. Therefore, it is excessively difficult to obtain certain data, such as child welfare data, especially when considering that there are hundreds of federally recognized tribes in the United States and each individual community and/or state may have different agreements or arrangements for providing that data to funders and researchers. The simplified method did identify counties that are in high need of services in North Dakota, and PCAND has also encountered incredible difficulty in accessing certain tribal data sets. However, the team felt it was important to note that this is a concerning issue when considering the comprehensiveness and equity of the data provided to grantees.

Regarding dissemination of needs assessment findings, the ND MIECHV team plans to continue convening meetings with the advisory board as it transitions to an early childhood comprehensive systems group. This will allow PCAND to continue working with partners on coordinating efforts to address identified gaps and needs throughout the state. Additionally, there are typically events offered through the state that will allow for PCAND to share findings, such as the Dakota Conference for Rural and Public Health, the statewide Indigenous Maternal and Child Health Conference, and the annual Government-to-Government event hosted by the Indian Affairs Commission. PCAND is also working to develop community briefs for each region with identified, at-risk counties, as well as a more easily accessible, community-facing state brief. These will be shared with all participants of the state qualitative data activities, the advisory board, program partners, as well as being hosted on the PCAND website. A sample community brief has been included as Appendix G.

The required nonprofit documentation, a letter from the state Title V agency, has been attached as Appendix H.

Prevent Child Abuse
North Dakota™

November 12, 2019

Dear valued partner,

Warmest greetings as we enter another cold holiday season! As you may know, Prevent Child Abuse North Dakota (PCAND) administers the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant for our state. This grant funds two home visiting sites in North Dakota – a Parents as Teachers program in Rolette County, and a Nurse-Family Partnership program, serving Burleigh, Morton, Mercer, Oliver, Grant, and Sioux Counties. As a requirement of the reauthorization of our federal funding, PCAND is conducting a needs assessment of maternal and child health needs in our state. The needs assessment will include the collection and analysis of both quantitative and qualitative data and must be completed by October 1, 2020.

As our organization begins the process of developing tools and processes for collecting qualitative data, we are seeking input from our partners across the state. We would be grateful if you, or an appointed representative from your organization, would be willing to serve on our MIECHV Needs Assessment Advisory Board. Expectations of participants are as follows:

- Attend monthly online meetings, and review shared resources, for a total monthly time commitment of roughly five hours per month, from December 2019 through September 2020;
- Provide feedback on shared resources and proposed documents, in a manner determined by the group;
- Assist in the identification of community champions in regions identified as being "high needs" by our quantitative data analysis;
- In collaboration with PCAND and our partners, develop and test questions for the needs assessment process (to include community surveys, key informant interviews, and focus group discussions); and
- Market and promote, as appropriate, needs assessment and data collection activities.

Our goal for this endeavor is to produce a comprehensive report based on high-quality data. Findings from this assessment will be shared statewide, so our organization and partners can determine gaps in existing systems and work together to ensure women, children, and families in North Dakota are provided access to the best health and human services possible. By appointing a representative to this advisory board, your organization will gain firsthand access to this information, strengthen existing ties and relationships to community partners, and help ensure the methods and tools we develop are reflective of, and respectful to, the populations you serve.

If you are willing to serve or designate a colleague from your agency to participate on our advisory board, please contact Elizabeth Pihlaja at epihlaja@pcand.org by November 22. A scheduling poll will be sent via email to all participants shortly thereafter to schedule a December (online) meeting.

Thank you for your consideration. Please contact Elizabeth with any questions or concerns.

Sincerely,

Sandra Tibke

Sandra Tibke
PCAND Executive Director

Elizabeth Pihlaja
ND MIECHV Program Director

1. Getting to know interviewee
    a. ***Tell me about yourself:***
        i. Where are you from, originally? (Tribal affiliation, if applicable)
        ii. How long have you lived in ND/your current community?
    b. ***Tell me about your work:***
        i. what is your current role, organization, and set of responsibilities?
        ii. Do you belong to any personal or professional organizations?
2. Target population of services
    a. ***Within your position of [professional title], who do you provide services to, directly?***
        i. Primary – mothers and children
        ii. Secondard – fathers/secondary care-givers
        iii. Tertiary – other care givers of children, such as aunts, uncles, and grandparents
3. Goal of services
    a. ***How does your work/program/organization benefit young children and families?***
4. Ideas for improvement
    a. ***In what ways could these services be improved?***
        i. Types of support
    b. ***If you could "wave a magic wand" and solve one problem to make lives better, for the clients and communities that you serve, what would that be?***
5. Closing statement
    a. ***Thank you for your time and feedback! Your interview is invaluable to this process and will help us develop questions to be asked, in our upcoming focus groups of maternal and child health service professionals. What is one question you would suggest we include, during these focus groups?***

Children and Family Services Personnel Survey

Thank you for your time. This 20 question survey is intended for ***Children and Family Service*** staff. This includes anyone who provides services to children, mothers, fathers, families, parents, guardians/caregivers, foster families, etc.

This survey is being conducted by Prevent Child Abuse North Dakota (PCAND) as a requirement of receiving federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program funding.

The purpose of this survey is to learn from professionals about your experiences working with families and communities in North Dakota.

If you agree to participate, this survey will take approximately ten (10) minutes of your time. Participation will mean answering a variety of questions about your personal and professional experiences and opinions.

There are no known risks to this survey. Data obtained may be beneficial to PCAND, as well as your organization and community.

For completing this survey, you will be entered to win one of three electronic Amazon, Walmart, or Target gift cards, in the amount of $25, $50, or $100, per county of interest. Recipients will be selected randomly by county and notified via email. Recipients will be required to submit a signed document acknowledging participation in the survey and receipt of the gift card.

Most of the data obtained in this survey will be reported in aggregate format and will not be reported individually. Only the PCAND research team will have access to individual responses. If individual quotes are used, for reports, these will be de-identified.

Participation in this survey is completely voluntary. You have the right to withdraw participation at any time by closing your internet browser.

If you have any questions about this survey, please contact Danielle Pinnick at dpinnick@pcand.org.

You may also contact the NDSU IRB:
e-mail: ndsu.irb@ndsu.edu
phone: 1-855-800-6717
mail: NDSU HRPP Office
NDSU Dept 4000
PO Box 6050
Fargo, ND 58108-6050

* 1. Please provide your contact information and any credentials/licensures you hold. We are requesting your email address so we can contact you if you are selected to receive a gift card. PCAND will not use your email address for any other reason. You may choose to complete this survey anonymously, but will not be entered for the gift card drawing.

Name

Organization

Job Title

Credential(s)

City/Town

ZIP/Postal Code

Email Address

2. Which of the following best describes the sector in which you work?

Other (please specify)

* 3. Please indicate the North Dakota counties, zones, and/or region in which your organization provides services.

- [ ] Statewide
- [ ] Adams County
- [ ] Barnes County
- [ ] Benson County
- [ ] Billings County
- [ ] Bottineau County
- [ ] Bowman County
- [ ] Burke County
- [ ] Burleigh County
- [ ] Cass County
- [ ] Cavalier County
- [ ] Dickey County
- [ ] Divide County
- [ ] Dunn County
- [ ] Eddy County

- [ ] Emmons County
- [ ] Foster County
- [ ] Golden Valley County
- [ ] Grand Forks County
- [ ] Grant County
- [ ] Griggs County
- [ ] Hettinger County
- [ ] Kidder County
- [ ] LaMoure County
- [ ] Logan County
- [ ] McHenry County
- [ ] McIntosh County
- [ ] McKenzie County
- [ ] McLean County
- [ ] Mercer County
- [ ] Morton County
- [ ] Mountrail County
- [ ] Nelson County
- [ ] Oliver County
- [ ] Pembina County
- [ ] Pierce County
- [ ] Ramsey County
- [ ] Ransom County
- [ ] Renville County
- [ ] Richland County
- [ ] Rolette County
- [ ] Sargent County
- [ ] Sheridan County
- [ ] Sioux County
- [ ] Slope County
- [ ] Stark County
- [ ] Steele County

- [ ] Stutsman County
- [ ] Towner County
- [ ] Traill County
- [ ] Walsh County
- [ ] Ward County
- [ ] Wells County
- [ ] Williams County
- [ ] Other (please specify)

* 4. How long have you worked in the ***Children and Family Services*** field?

- ○ Fewer than 2 years
- ○ 2-5 years
- ○ 5-10 years
- ○ 10-15 years
- ○ 15-20 years
- ○ More than 20 years
- ○ I don't work in the ***Children and Family Services*** field

* 5. How long have you worked at your current organization?

- ○ Fewer than 2 years
- ○ 2-5 years
- ○ 5-10 years
- ○ Other (please specify)
- ○ 10-15 years
- ○ 15-20 years
- ○ More than 20 years

* 6. The following list includes a number of issues which are of great concern, throughout the state. Please select the top <u>three (3)</u> which are, in your opinion, of greatest concern in *your* community.

- [ ] Substance abuse
- [ ] Mental health care access
- [ ] Food insecurity/access to proper nutrition
- [ ] Lack of primary care
- [ ] Unemployment/underemployment
- [ ] Lack of transportation
- [ ] Lack of childcare affordable and/or accessible childcare
- [ ] Family/domestic violence
- [ ] Child maltreatment
- [ ] Poverty
- [ ] Racism or social inequity

Children and Family Services Personnel Survey

Please indicate the extent to which you disagree or agree with the following statements:

* 7. I believe our organization is able to serve all of the clients who are in need of the services we provide.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	N/A
○	○	○	○	○	○

8. Please provide any comments or specific examples:

Children and Family Services Personnel Survey

Please indicate the extent to which you disagree or agree with the following statements:

* 9. In the community I serve, ***Children and Family Service*** Programs work well with other programs that serve the same population.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	N/A
○	○	○	○	○	○

10. Please provide any comments or specific examples:

Children and Family Services Personnel Survey

Please indicate the extent to which you disagree or agree with the following statements:

* 11. In the community I serve, ***Children and Family Service*** providers are respectful and mindful of clients' cultural backgrounds and beliefs.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	N/A
○	○	○	○	○	○

12. Please provide any comments or specific examples:

Children and Family Services Personnel Survey

Please indicate the extent to which you disagree or agree with the following statements:

* 13. At my organization, I believe the client responsibilities, to receive services, are reasonable.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	N/A
○	○	○	○	○	○

14. Please provide any comments or specific examples:

Children and Family Services Personnel Survey

Please indicate the extent to which you disagree or agree with the following statements:

* 15. At my organization, I believe the eligibility requirements to receive services are reasonable.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	N/A
○	○	○	○	○	○

16. Please provide any comments or specific examples:

Children and Family Services Personnel Survey

Please indicate the extent to which you disagree or agree with the following statements:

* 17. In the community I serve, ***Children and Family Service*** Programs collaborate well with health care providers.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	N/A
○	○	○	○	○	○

18. Please provide any comments or specific examples:

Children and Family Services Personnel Survey

* 19. In your opinion, what is your community's biggest strength?

* 20. In your opinion, what is the most pressing challenge facing your community?

21. Use this space to provide any additional feedback.

Thank you for your time and your responses. If you have any questions, please contact Danni Pinnick at dpinnick@pcand.org

Family Survey MIECHV Needs Assessment

2020 HRSA Maternal and Infant Early Childhood Home Visiting Needs Assessment

Dear Participant,

My name is Danielle Pinnick, and I am a Needs Assessment Specialist at Prevent Child Abuse North Dakota (PCAND) and Research Assistant, at North Dakota State University (NDSU). Our organization, PCAND, facilitates Maternal and Child Home Visiting Programs, throughout the state, for new parents. We are currently conducting a Needs Assessment, on behalf of the Health Resources and Services Administration, to determine which areas of the state would benefit the most from these programs, and to assess if current home visiting programs are meeting needs, in the state.

We appreciate that you would like to participate in the survey portion of our study. You will be one of approximately 50-100 people who will participate in this portion of the study. We are happy to answer any questions you have about our preliminary data analysis or other parts of our project. You will be asked questions about your personal and professional experiences, related to maternal, child, and family health, as well as home visiting services, and related social services.

For participating in this survey, you will be offered a $10 gift card to your choice of one of three vendors (Amazon, Target, or Walmart.) To receive this incentive, you will have to answer each of the questions below, with as much detail as possible, and provide information to us to comply with our federal reporting standards. If you have already participated in one of our family focus groups, you are ineligible to receive a separate incentive, for this activity.

The responses you give are invaluable, as they will help inform our report to HRSA and will ultimately direct where funds and resources are allocated, in the coming years of the MIECHV programs. If you feel uncomfortable in any way, during this session, you have the right to end your participation by exiting the survey.

This survey will be included in our data, but no names or identifying information will be used. All survey responses are protected and will only be seen by the core research team.

If you have questions or complaints about this research, you may contact the researchers, listed below, or the NDSU IRB, by email, at: ndsu.irb@ndsu.edu, phone at 1-855-800-6717, or mail: NDSU HRPP Office, NDSU Dept 4000, PO Box 6050, Fargo, ND 58108-6050

Thank you for your time and participation.

Sincerely,

Danielle Pinnick, MPH

dpinnick@pcand.org
Needs Assessment Specialist

Prevent Child Abuse North Dakota

danielle.pinnick@ndsu.edu
Research Assistant
North Dakota State University Dept of Public Health

* 1. Do you have any children (may include biological, adopted, foster)?

- Yes
- No

* 2. Do you currently have any children at home who are between ages 0-5?

- Yes
- No

3. Are you currently pregnant/with a partner who is pregnant?

- Yes
- No
- I'm not sure or would rather not say

* 4. Please take a minute to introduce yourself – your name, anything you want to share about your children.

* 5. In which ND county do you reside? (Due to the results of our preliminary data analysis, we are only looking for responses, from the following counties.)

- ○ Williams
- ○ Mountrail
- ○ Grant
- ○ Barnes
- ○ Cass
- ○ Morton
- ○ Benson
- ○ Pembina
- ○ Rolette
- ○ Burleigh
- ○ Walsh
- ○ McKenzie
- ○ Grand Forks
- ○ Sioux

* 6. In the last five years, have you utilized any of the following services in the county you currently reside? Please check all that apply. If you have not, please check "None" at the bottom of the list.

- ☐ SNAP (supplemental nutrition assistance program or food stamps)
- ☐ WIC
- ☐ Public Health (immunization clinics, car seat checks, breastfeeding support)
- ☐ Social services or child protective services/child welfare
- ☐ Head Start
- ☐ Child care
- ☐ Home Visiting (a trained home visitor who regularly visits your home to provide parenting support)
- ☐ None
- ☐ Other (please specify)

* 7. How long have you lived in your community?

* 8. Why do you choose to live in this community?

* 9. What is the biggest strength of your community?

* 10. What is your biggest concern about your community?

* 11. What do you think is the biggest challenge for families in this community?

* 12. In thinking about services you have accessed in your community – this might include WIC, home visiting, Head Start, housing assistance – what is one short phrase or sentence you could use to describe them?

* 13. If you have participated in these services before, what were the requirements and responsibilities on your end?

* 14. Of the services you've accessed, what unique value has it had on you and your family?

* 15. Do you feel like service providers are or have been respectful and mindful of your background, needs, and beliefs?

* 16. What would help providers understand you and your family better?

* 17. Can you think of a time when services worked well together or not well together? Explain.

* 18. How could the programs you've been part of help make your life easier?

* 19. Is there anything else you'd like us to know in regard to the community services provided in your community?

* 20. Please select one of the following options for an electronic gift card ($10). These will be sent to the email you provide, at the end of the survey. You can use these online or, for Walmart or Target, in store.

- ◯ Walmart
- ◯ Target
- ◯ Amazon

* 21. Due to restrictions on the use of federal funding, funds on these gift cards cannot be used to purchase alcohol, tobacco products, firearms, or lottery tickets. We are also required to keep records of the purchase of these gift cards. By providing your name and address below, you signify your agreement with the restrictions on gift card purchases.

Name	
Address	
Address 2	
City/Town	
State/Province	
ZIP/Postal Code	
Email Address	

You should receive an email with your chosen electronic gift card within a few days. Please contact dpinnick@pcand.org, with any questions.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,207,045 with zero percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Family Focus Group Questions

Please take a minute to introduce yourself – your name, anything you want to share about your children.

How long have you lived in your community? Why do you choose to live here?

What is the biggest strength of your community?

What is your biggest concern about your community? What do you think is the biggest challenge for families in this community?

In thinking about services you have accessed in your community – this might include WIC, home visiting, Head Start, housing assistance – what is one short phrase or sentence you could use to describe them?

If you have participated in these services before, what were the requirements and responsibilities on your end?

Of the services you've accessed, what positive impact have they had on you and your family?

Do you feel like service providers are or have been respectful and mindful of your background, needs, and beliefs? What would help providers understand you and your family better?

Can you think of a time when services worked well together or not well together? Explain.

How could the programs you've been part of help make your life easier?

Is there anything else you'd like us to know in regard to the community services provided in your community?

NORTH DAKOTA
INDIAN AFFAIRS COMMISSION

600 East Boulevard • 1st Floor Judicial Wing
Bismarck ND 58505-0300
Phone (701) 328-2428 • Fax (701) 328-1537
Webpage: www.nd.gov/indianaffairs

Governor Doug Burgum
Chairman

Scott J. Davis
Commissioner

May 22, 2020

Sandra Tibke
Prevent Child Abuse North Dakota
418 E. Broadway Ave. Suite 70
Bismarck, North Dakota 58501-1213

Dear Ms. Tibke,

North Dakota is home to several Indigenous communities, each with its own unique culture and traditions. While Indigenous peoples have demonstrated continued resilience and strength in the face of trauma, these communities still face many disparities and health challenges, such as poverty, substance use, and poor perinatal outcomes. These adversities can lead to poor health outcomes and adverse childhood experiences. Unfortunately, these experiences are not always reflected in the health data that is collected by state and federal entities, making it difficult to know the true breadth and depth of the issues in our local communities.

Prevent Child Abuse North Dakota (PCAND) is currently conducting a statewide needs assessment as a requirement of its Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant. Needs assessment activities have included secondary data analysis of county-level data and interviews with key informants across the state (including tribal community members and representatives). PCAND is also proposing to facilitate focus groups across the state; this work will allow first-hand accounts of parents, community members, public health workers, and early childhood education professionals to supplement the original data analysis. After the conclusion of data collection and analysis, PCAND will develop and share community profiles with stakeholders statewide and in each community.

The North Dakota Indian Affairs Commission would like to offer this letter of support to accompany the MIECHV needs assessment activities that are being conducted throughout the state of North Dakota. We are confident that this work will benefit the state at large and will specifically benefit our tribal communities. The North Dakota Indian Affairs Commission will be pleased to offer additional support as needed.

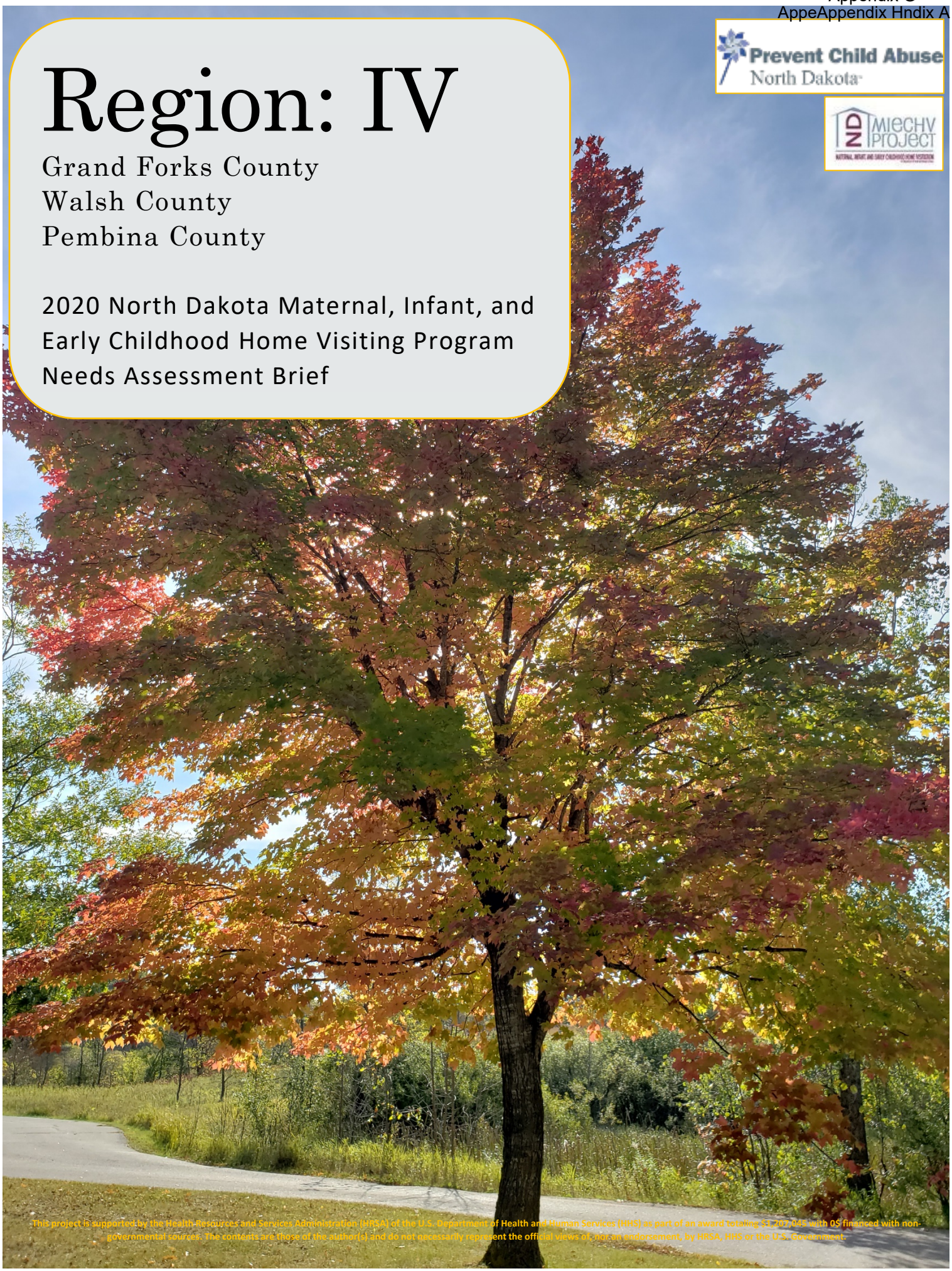
Sincerely,

Scott J. Davis
Executive Director
North Dakota Indian Affairs Commission

Region: IV

Grand Forks County
Walsh County
Pembina County

2020 North Dakota Maternal, Infant, and Early Childhood Home Visiting Program Needs Assessment Brief



This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,207,045 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

A LITTLE BIT ABOUT US

Maternal, Infant and Early Childhood Home Visiting (MIECHV)

Maternal, Infant, and Early Childhood Home Visiting (MIECHV) is a federal program administered by the Health Resources and Services Administration (HRSA). MIECHV funding supports evidence-based home visiting services that benefit children and families. In North Dakota, MIECHV funds two home visiting sites – one in Rolette County and one that serves Burleigh, Morton, Mercer, Oliver, Grant, and Sioux Counties. MIECHV-funded sites in North Dakota work closely with other home visiting programs, family support agencies, and early childhood education professionals to maintain a continuum of care for families.

Prevent Child Abuse North Dakota (PCAND)

Prevent Child Abuse North Dakota is a 501(c)(3) nonprofit agency that aims to prevent abuse and neglect of children in our state through primary prevention. Primary prevention is a strategy that aims to stop abuse and neglect before it occurs. For PCAND, that looks like supporting hospitals and social services in providing education on shaken baby syndrome/abusive head trauma, working with schools and law enforcement to support children whose families are involved in incidents requiring police intervention, investing in perinatal and early childhood home visiting, and more. These activities help strengthen guardians' positive parenting practices, knowledge of child development, and self-sufficiency, which reduce abuse and neglect rates.

Needs Assessment

As a requirement of MIECHV funding, PCAND conducted a statewide needs assessment of child and family education and support services across the state, with a focus on home visiting capacity and the availability of substance use treatment for pregnant women and families. Our team analyzed data provided by HRSA, looking at things like crime, economic stability, and perinatal health, to determine a list of counties that could potentially benefit from increased access to home visiting services. In addition to this work, our team facilitated focus groups with parents in our high-risk counties, while implementing both a family-focused survey and a survey for professionals who work with children and families. These qualitative data activities allowed individuals in our state to provide their perspectives and concerns.

Home Visiting

Home visiting is an important strategy in improving the health and wellbeing of children and families. Trained professionals work closely with parents or guardians and their children, during pregnancy and beyond, to navigate the stressful work of being a parent! Home visitors help families navigate larger social support systems and are able to answer questions and concerns about their children. Home visiting programs are always voluntary for parents, and nearly always free of costs. The North Dakota Home Visiting Coalition is a professional group consisting of home visitors, supervisors, and administrators from across the state.

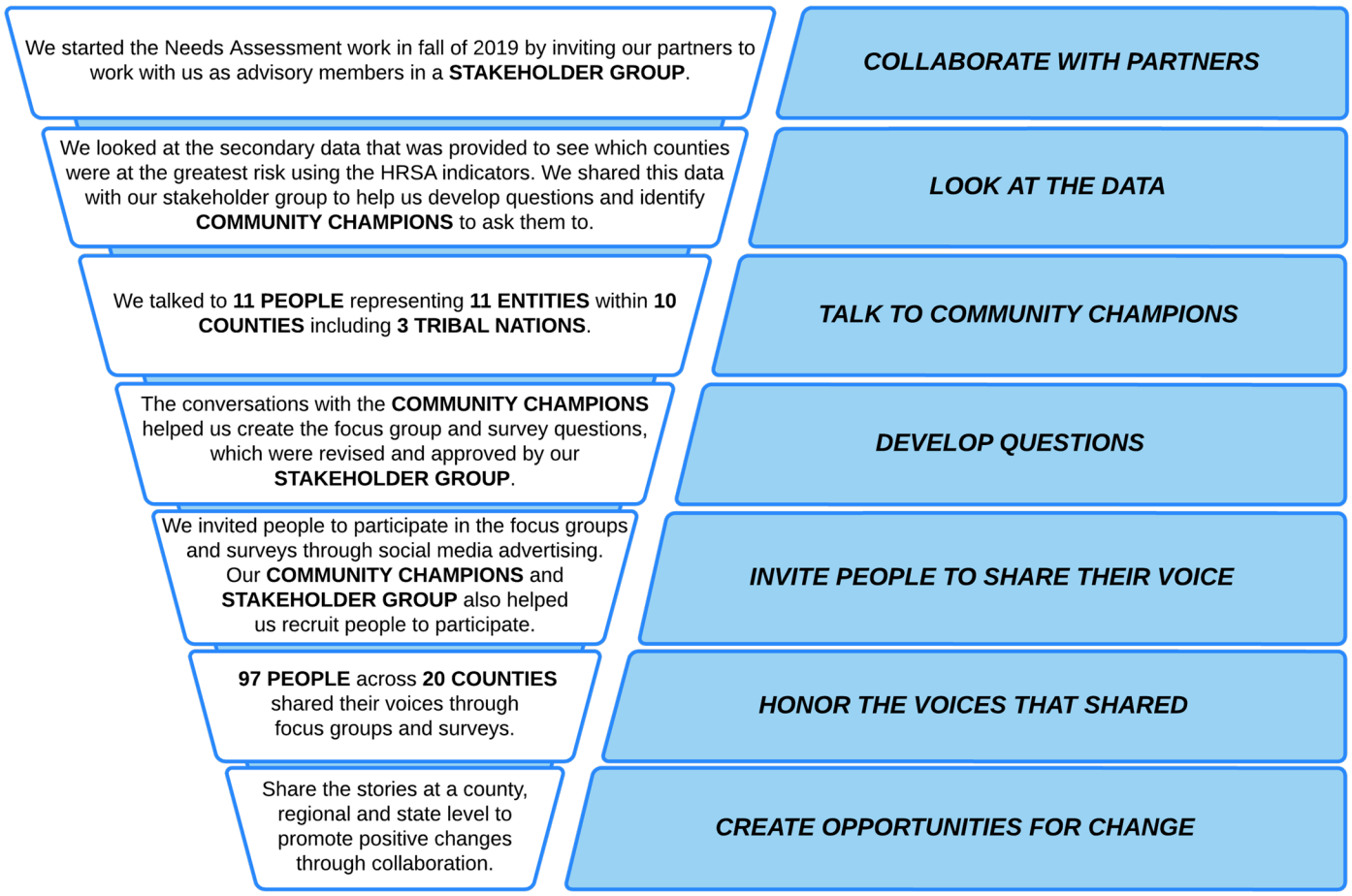
WHAT WE DID

Our Needs Assessment journey began with the formation our **STAKEHOLDER GROUP** which included **11 PEOPLE** representing **11 PROGRAMS** within **9 ENTITIES**.

STAKEHOLDER	PROGRAM	ENTITY
Alicia Gourd-Mackin	Social Work	Sitting Bull Community College
Amy Gourneau	Turtle Mountain Home Visiting	Turtle Mountain Band of Chippewa Indians
Chelsey Trebas	Nurse-Family Patnership Home Visiting	Custer Health
Donene Feist	Family Voices of North Dakota	Family Voices
Grace Njau	North Dakota PRAMS	North Dakota Department of Health
Dr. Kathy Anderson	Pediatrics	CHI St. Alexius
Kim Mertz	Healthy and Safe Communities	North Dakota Department of Health
Missi Baranko	Healthy Families Home Visiting	Lutheran Social Services
Tracy Miller	Epidemiology	North Dakota Department of Health
Tara Fuhrer	Early Learning	North Dakota Department of Public Instruction
Ruth Buffalo	Legislator	North Dakota House of Representatives

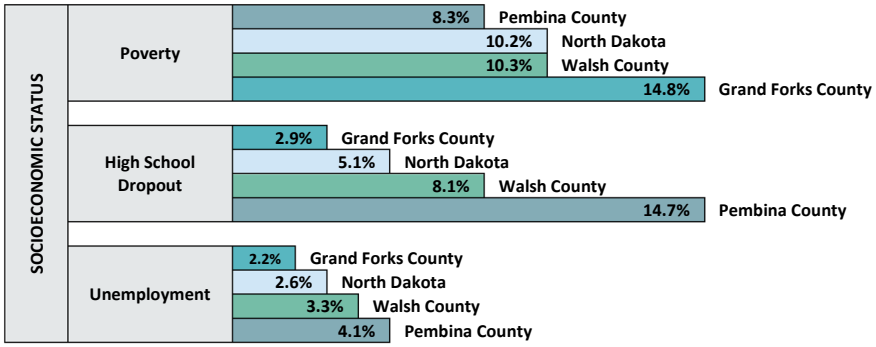
The **STAKEHOLDER GROUP** played an instrumental part in developing our process and refining our questions.

Their support was the **KEY TO OUR SUCCESS**.

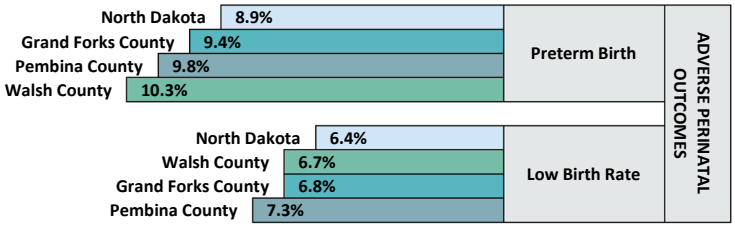


BY THE NUMBERS

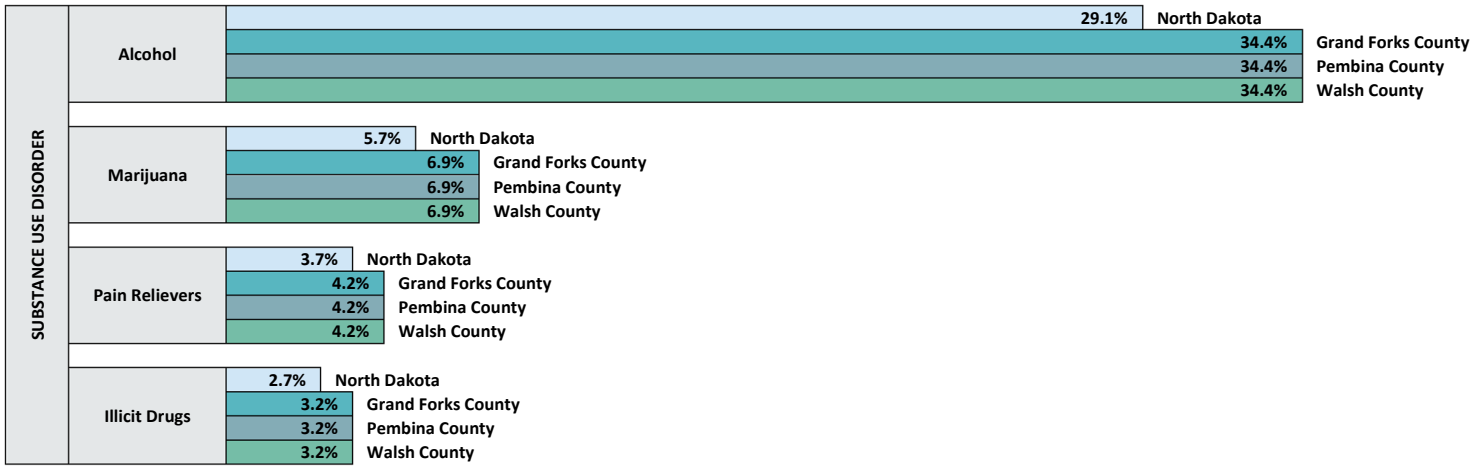
In late 2019 we looked at the North Dakota county level data that was provided by the Health Resources and Services Administration. This data included information on **socioeconomic status**, **adverse perinatal outcomes**, **substance use disorder**, **crime** and **child maltreatment** and showed **Grand Forks County** as being a potential **at-risk** county. The data can be seen below and includes the surrounding counties of Pembina and Walsh as well as the state for comparison.



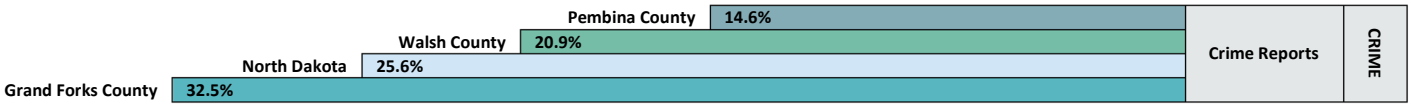
Poverty = percentage of people living below 100% federal poverty level (2017 Census Small Area Income and Poverty Estimates)
High School Dropout = percentage of 16-19-year-olds not enrolled in school with no high school diploma - 5-year Estimate (2013-2017 American Community Survey)
Unemployment = unemployed percent of the civilian labor force (2017 Bureau of Labor Statistics)



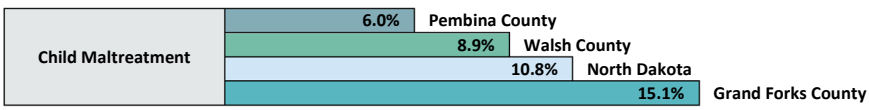
Preterm Birth = percentage of live births less than 37 weeks (2013-2017 NVSS Raw Natality File)
Low Birth Rate = percentage of live births less than 2500 grams (2013-2017 NVSS Raw Natality File)



Alcohol = prevalence rate: binge alcohol use in past month (2012-2014 SAMHSA National Survey of Drug Use and Health)
Marijuana = prevalence rate: marijuana use in past month (2014-2016 SAMHSA National Survey of Drug Use and Health)
Pain Relievers = prevalence rate: nonmedical use of pain medication in past year (2012-2014 SAMHSA National Survey of Drug Use and Health)
Illicit Drugs = prevalence rate: use of illicit drugs, excluding marijuana, in past month (2012-2014 SAMHSA National Survey of Drug Use and Health)



Crime Reports = number of reported crimes per 1000 residents (2016 Institute for Social Research - National Archive of Criminal Justice Data)



Child Maltreatment = rate of maltreatment victims aged 0-17 per 1000 children aged 0-17 residents (2016 ACF)

COMMUNITY VOICES

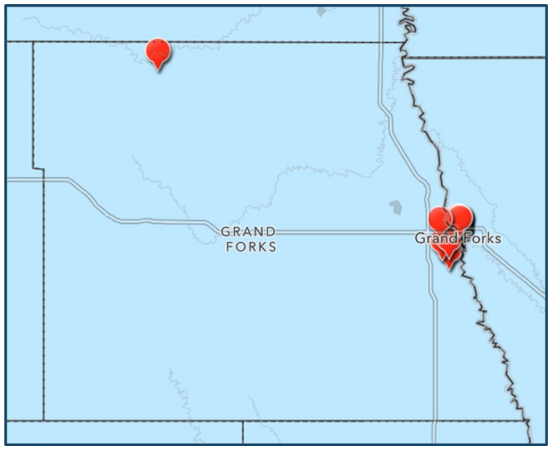
In the summer of 2020 we held a virtual **FOCUS GROUP** in Grand Forks County and had **3 FAMILIES** participate. We also had **2 FAMILIES** fill out a **FAMILY SURVEY** and **24 SERVICE PROVIDERS** fill out a **CHILDREN AND FAMILY SERVICES SURVEY**.

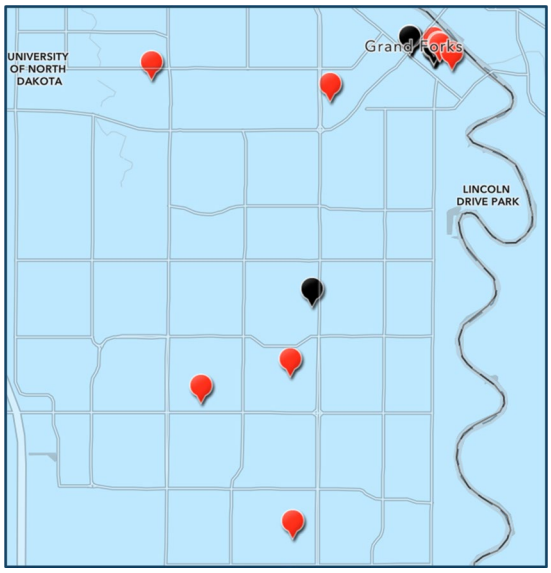
Why People Live Here

Why Families Value Services

	FAMILY VOICES	SERVICE PROVIDER VOICES
STRENGTHS	Community Support Small Town Feel Family Activities Connections to Friends	Community Support Great School System Tight Knit Community Diversity and Acceptance Collaboration between Services
CHALLENGES	Access to Childcare Asking for Help Awareness of Resources Access to Housing Navigating Insurance Cost of Insurance Employment with Good Wages Income Disparities Transportation Paperwork is Overwhelming Waitlist for Services Services are not Centrally Located Time Commitment to Receive Services	Access to Childcare Judgmental Service Providers Awareness of Resources Access to Housing Substance Use Disorder Providing Services to Rural Communities Poverty Rigid Income Guideline Requirements Transportation Cost of Accessing Services
OPPORTUNITIES	Trauma Informed Care Training Improve Communication between Services More One on One Interactions in Services Centralized Location for Services Improve Process to Unburden Paperwork	Increase Housing Improve Collaboration between Services Mandatory Reporter Training

COUNTY LEVEL SERVICES





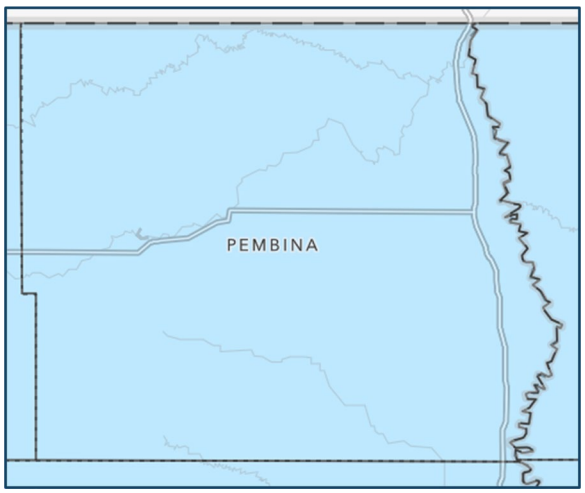
WALSH COUNTY CHILD HOME VISITING

Northeast Human Service Center-Early Intervention/Right Track

Lutheran Social Services-Healthy Families America

WALSH COUNTY SUBSTANCE ABUSE SERVICES

Quinn DUI/MIP Evaluations



GRAND FORKS COUNTY HOME VISITING

Northeast Human Service Center- Early Intervention/Right Track

Grand Forks Public Healthy-Prenatal/Newborn Home Visits

Lutheran Social Services-Healthy Families America

Mayville State University Child Development Programs

GRAND FORKS COUNTY BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES

A.D.A.P.T. Inc.

Agassiz Associates, PLLC

Carol Torgerson Counseling, LLC

Centre, Inc.

City of Grand Forks

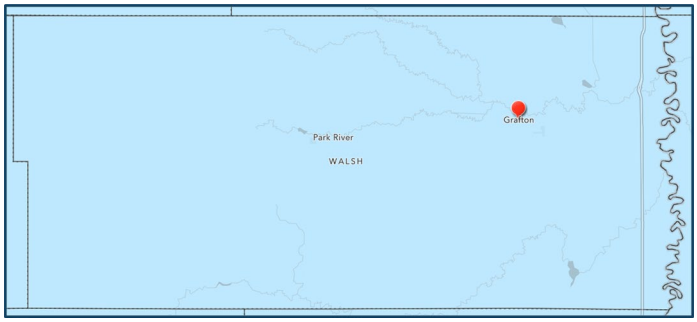
Drake Counseling Services

Red River Behavioral Health System

Spectra Health

UND Counseling Center Substance Abuse Program

Northeast Human Service Center



PEMBINA COUNTY HOME VISITING

Northeast Human Service Center-Early Intervention/Right Track

Lutheran Social Services-Healthy Families America

PEMBINA COUNTY BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES

No Services Identified

ACKNOWLEDGEMENTS

SPECIAL THANKS TO DR. RAMONA DANIELSON FOR THE USE OF HER AMAZING PHOTOS

Prevent Child Abuse North Dakota would like to extend our thanks to everyone that made this project possible.

PCAND	STAKEHOLDERS	COMMUNITY CHAMPIONS	FOCUS GROUP PARTICIPANTS	SURVEY RESPONDENTS
Elizabeth Pihlaja Jacob Davis Danielle Pinnick Murphy Anderson	Alicia Gourd-Mackin Amy Gourneau Chelsey Trebas Donene Feist Grace Njau Dr. Kathy Anderson Kim Mertz Missi Baranko Tracy Miller Tara Fuhrer Ruth Buffalo	The 11 wonderful people that we had the opportunity to learn from.	The 26 families that were courageous enough to share their experiences with us.	The 71 people that took the time to share their voices.

FOR MORE INFORMATION PLEASE CONTACT

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Email: epihlaja@pcand.org
Website: www.pcand.org

Jacob Davis
Tribal Programming Director
Phone: (701) 477-2824
Email: jacobdavis@pcand.org
Website: www.pcand.org

NORTH Dakota | Health
Be Legendary.™

October 1, 2020

Alicia Norris Heim, MPH
Health Resources and Services Administration
Maternal & Child Health Bureau
Division of Home Visiting and Early Childhood Systems
Region VIII (CO, MT, ND, SD, UT, WY)

Dear Ms. Heim,

This letter serves as the state of North Dakota's authorization for Prevent Child Abuse North Dakota (PCAND) to complete and submit the state's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program needs assessment. The North Dakota Title V program has coordinated needs assessment efforts with PCAND during this grant period, and staff have also served on the PCAND North Dakota MIECHV Needs Assessment advisory board. I am confident that PCAND, as the administering agency of MIECHV funds in North Dakota, will submit a thorough and comprehensive MIECHV needs assessment.

Sincerely,

Kim Mertz, Chief, Healthy and Safe Communities Section
Title V Maternal and Child Health Program Director

HEALTHY & SAFE COMMUNITIES | 600 East Boulevard Avenue, Dept. 301 | Bismarck, ND 58505-0200
701-328-2367 | TTY 800-366-6888 | health.nd.gov

COMMUNITY & HEALTH SYSTEMS	FAMILY HEALTH & NUTRITION	HEALTH PROMOTION	INJURY & VIOLENCE PREVENTION	SPECIAL HEALTH SERVICES	SYSTEMS & PERFORMANCE	HEALTH EQUITY & MATERNAL CHILD HEALTH
701-328-3398	701-328-2496	701-328-2356	701-328-4536	701-328-2436	701-328-2367	701-328-2228