Maternal and Child Health Services Title V Block Grant

South Dakota

FY 2024 Application/ FY 2022 Annual Report

Created on 7/17/2023 at 11:13 AM

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I. General Requirements

I.A. Letter of Transmittal

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SOUTH DAKOTA DEPARTMENT OF HEALTH

Division of Family and Community Health
Child and Family Services
Chronic Disease Prevention and Health Promotion
Disease Prevention Services
State Epidemiologist

July 14, 2023

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

Dear Director:

I am pleased to submit the FY 2024 South Dakota Maternal and Child Health Block Grant application and annual report. Should you have any questions concerning this application, please contact Whitney Brunner at 605.773.4749.

Sincerely,

Katelyn Strasser

Katelyn Strasser
Administrator
Office of Child and Family Services
South Dakota Department of Health

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

South Dakota maternal and child health needs mirror many of the same challenges faced by rural and frontier states. Access to healthcare services, including the ability to travel to these services, and social needs like housing and food were identified throughout the Needs Assessment. Other challenges include access to mental health and substance misuse resources and services, parenting education and support, and affordable health insurance. Paying for medical services and care coordination challenges like difficulty scheduling or long waits for appointments were identified needs for the CYSHCN population.

The seven priority needs and their corresponding NPMs and SPMs are listed in the table below.

Priority	MCH Population Domain	NPM or SPM
Mental health/Substance misuse	Women/Maternal Health	NPM 1 Well-Woman Visit
Safe sleep	Perinatal/Infant Health	NPM 5 Safe Sleep
Parenting education and support	Child Health	NPM 6 Developmental Screening
Mental health/Suicide prevention	Adolescent Health	NPM 7.2 Injury Hospitalization
Access to care and services	CYSHCN	NPM 11 Medical Home
Healthy relationships	Adolescent Health	SPM 1
Data sharing and collaboration	Cross-Cutting	SPM 2* SPM 3

*SPM 2 was discontinued after FY21 due to changing focus and measurement and replaced with SPM 3 in FY22.

The South Dakota Department of Health (DOH) Office of Child and Family Services (OCFS) completed a statewide needs assessment of Maternal and Child Health (MCH) populations across South Dakota (SD) to understand health and well-being issues that impact them. The needs assessment was driven by two key frameworks, the Life Course Theory and Health Equity Model. The focus was to understand the social determinants of health and health inequities that impact health outcomes throughout the life course. Utilization of these frameworks emphasized understanding the factors that shape the health and well-being of SD families.

Seven guiding principles informed the needs assessment, including: 1) evidence-based decision making; 2) health equity lens; 3) respond to emerging issues and trends that affect families and individuals in SD; 4) social determinants of health; 5) input from diverse stakeholders and partners; 6) do not reinvent the wheel; and 7) setting realistic priorities and performance measures.

The needs assessment was carried out between September 2018 and May 2020. Targeted planning was conducted between September and December 2018 in collaboration with OCFS staff, Needs Assessment Project Team, Advisory Committee, MCH Impact Team, partner agencies, and an external consultant to inform the process design and implementation. Implementation of the needs assessment occurred between January 2019 and May 2020

including data collection, community engagement, program planning and performance reporting.

A collaborative approach that engaged OCFS staff and multi-sector partners across SD through quantitative and qualitative data collection methods, priority setting, and program planning was integral in carrying out the needs assessment. New and existing partners were engaged throughout the process, focused on ensuring transparency and fostering sustainable partnerships. Input was elicited from families and individuals across the state who represent broad perspectives and MCH populations served through surveys and focus groups with targeted outreach to ensure representation from diverse SD geographies and underserved populations.

Program planning and development of action plans occurred in collaboration with key partners focused on issues that impact each MCH domain served. Action plans address priority issues including safe sleep, healthy relationships, mental health and substance misuse, parenting education and support, access to care and services, and a cross-cutting priority for data sharing and collaboration. The action plans will inform strategies and activities outlined to address priority health issues implemented in collaboration with MCH partners. MCH domain leaders will build on the training provided by John Richards and additional data support and capacity to engage in evidence-based practice and monitoring of performance measures.

Strategic planning for the next needs assessment will begin in the summer of 2023 with planned implementation from January 2024 through May 2025. An external public health consultant will help guide this process.

Role of State Title V

The OCFS administers the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), community health nursing, the Bright Start Maternal, Infant and Early Childhood Home Visiting (MIECHV) program, Family Planning, and the MCH block grant among others. While OCFS has a huge service delivery and outreach presence, it is just one piece of the efforts to serve the maternal and child population. Its partnerships with other DOH programs, state agencies, and local entities supplement the capacity to meet the needs of SD's MCH population. MCH domain leaders, funded through the MCH Block Grant, serve as the backbone for collaboration with interagency partners and with external community-based or research organizations. The domain leaders facilitate multi-sector workgroups and utilize the Wilder Collaboration Index to assess the effectiveness of these workgroups in keeping partners engaged in carrying out MCH priorities. In addition, each domain leader has received training in program evaluation and CQI and prioritizes strategies that are informed by data and address health inequities.

Partnerships

The 2021-2025 needs assessment process assisted in furthering the development of long-standing partnerships and provided an opportunity to identify and engage emerging partners. Partnerships have always played a significant role in implementing SD MCH programs and initiatives through the Title V block grant.

Historically, MCH program leaders have focused their efforts on supporting and expanding the work of SD's public health system, which includes a centralized organizational structure where the DOH directly governs the state's 74 local community health offices. This focus has led to strong interagency partnerships, like the WIC program and Office of Rural Health to ultimately address a dire need for healthcare access, delivery of case management services for the MCH population and development of the MCH workforce. Program planning has been prioritized and cultivated throughout the needs assessment process in collaboration with interagency partnerships, such as the Department of Social Services (DSS). Specifically, DSS expands the reach of Title V by addressing social needs and access to healthcare that are persistent issues in SD. Engagement of partners beyond state government is being leveraged to expand programming and reach to underserved MCH populations. Community and faith-based partners, such as Lutheran Social Services (LSS), were identified during the needs assessment as partners who extend into communities at risk for health disparities, including refugee, new American and American Indian (AI)

communities. In 2022, the MCH program began offering mini grant opportunities to further engage local and community organizations across domains. Actions continue to cultivate partnerships and innovative programming with the major healthcare systems in SD for children and youth with special health care needs (CYSHCN).

While the MCH program has been successful in cultivating multi-sector partnerships to deliver services to our MCH population, significant need for more intentional outreach and engagement with the nine sovereign native nations within the SD border is essential to better support American Indian populations across the state. In addition, the program also recognizes a need for more intentional engagement with families and family-based organizations and has recently drafted policy to guide our efforts in establishing a culture that values family engagement. Staff participated in family and community engagement training in summer 2023 in preparation for the upcoming needs assessment.

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

The DOH provides services through the Title V MCH Block Grant that reflect the commitment that SD has to improve the health and well-being of mothers, infants, children, adolescents and young adults including children with special health care needs. MCH services are delivered through a network of field offices located in nearly every county of the state, and enhance outreach services provided by WIC, Title X Family Planning, and Nurse Home Visiting services that occur in SD. With Title V MCH funding, the MCH program is able to provide the following services that include but are not limited to: infant safe sleep education; health and safety information; immunizations; growth and development screening; and case management for high risk pregnancy, postpartum care and prenatal education. Title V MCH funds also allow the DOH to provide support services to families with CYSHCN such as respite care, newborn screening, parent support, and genetic/specialty consultation. Using Title V funding, the DOH is able to leverage resources and provide evaluation, epidemiology and media services to DOH Child & Family Services programs to ensure that data driven decisions are made and program improvement is sustained. Title V funds support new and existing partnerships that allow for expanded service delivery to our MCH population across the state. Without Title V MCH Block Grant funding, the DOH would be forced to make significant cuts to the services and education provided to South Dakota citizens.

III.A.3. MCH Success Story

The South Dakota Early Hearing Detection Intervention (EHDI) Collaborative with the University of South Dakota (USD) and NBS (SD Newborn Screening Program) has worked diligently to improve the process of newborn hearing screening follow up and is piloting a newborn hearing screening follow up program. Out-of-hospital births were identified as a low rate of EHDI adherence to initial screening, along with the rate of newborns that were missing rescreening after a non-passing birthing center screening. Low rates of audiology follow up with two non-passing screens was identified and low referrals to birth-to-three (Bto3) early intervention for diagnosed children with hearing loss.

The NBS partnered with the Certified Professional Midwives and Certified Nurse Midwives to identify roadblocks, barriers, and solutions. An educational overview of newborn hearing was presented at the biannual certified professional midwife meeting. Educational materials were developed toward specific populations that utilize these professionals providing out of hospital births. The NBS used MCH funds to purchase and distribute hearing screeners and supplies on loan to high volume midwife providers. The NBS provides yearly maintenance for the screeners which can be costly to a midwife provider. A hearing screener share program was created for the lower volume midwives. Outreach to birthing hospitals and midwives for missing rescreens is provided. Newly developed reporting forms and process were given to our birthing partners. Monthly missed or not screened reports are now being sent to the identified facility newborn hearing champion and midwives, providing the names and results of the newborns. The champions and midwives are asked to contact the families for follow up and primary care provider (PCP) outreach. The NBS asks for new results or what has been done to reach the children identified as missing a first screen or not passed first screen. This information provides direction for the Newborn Hearing Screening Program staff for further follow up with the child's PCP or pediatrician to avoid lost to follow up. The NBS worked with our Vital Record System administration to improve information recording from birthing facilities and providers. This ensures adequate contact information for both the parents and primary care providers is available to the NBS follow up staff. A partnership has been made with the School for the Deaf and Bto3 programs to provide direct referrals to both agencies for services by our follow up staff if indicated. All program improvements have proven to be a success with data confirmation.

- Missed hearing screens has decreased by 88.2%.
- Total passed by 1 month has increased by 4.56% and after 1 month by 161%
- Total passed increased by 5.78% due to more children being screened/ rescreened
- Total passed as an outpatient with no inpatient screening increased to 22% related to PCP outreach and midwife participation
- No outpatient screening or rescreening decreased by 80%
- Unknown screening status decreased by 65.68%

III.B. Overview of the State

Demographics, Geography, Economy

South Dakota traverses over 75,000 square miles in the upper Midwest and is one of the United States' most rural and frontier geographic areas. SD is home to diverse landscape that is divided into east and west by the Missouri River. As of 2022, there are an estimated 909,824 people living in SD with an average population density of 11.7 people per square mile. Of SD's 66 counties, 30 are rural and 34 are frontier (less than 6 people per sq. mile). The states' two most populated counties are located on opposite sides of the state. There are nine federally recognized American Indian tribes within the SD borders.

The state's population by race and Hispanic origin as of 2022 is 84.2% White, 9% American Indian (AI), 2.5% Black, 1.7% Asian, 2.6% Two or More Races and 4.6% Hispanic or Latino. The population by sex is 49.2% female and 50.8% male. Just under 25% of the state's population are persons under the age of 18, with 6.6% of persons under 5 years of age. Approximately 37% of the state's female population is of childbearing age, 15 through 44.

South Dakota's 2021 median household income was $63,920. Nearly 13% of SD households live below 100% of the Federal Poverty Level (FPL), with the 10 poorest counties either part of or adjacent to SD's AI reservations. Reservations experience significantly higher poverty levels ranging from 22.3%-48.6%. 11.4% of persons under 65 years of age lack health insurance. In addition, 92.5% of persons aged 25 years and older are high school graduates or higher and 30% have a bachelor's degree or higher. Key industries that shape SD's economy include agriculture, mining, finance, healthcare, manufacturing, and tourism.

The state of SD has administrative rules for services provided within the Children's Special Health Services (CSHS) program, the state's recognized name for the CYSHCN program. The rules outline eligibility requirements including income level and the chronic conditions that may or may not be covered. They also outline the types of treatment services that may be financially covered and the process by which the CSHS program reimburses families and healthcare providers for these services. South Dakota Codified Law 34-24-17 to 34-24-25 mandates newborn screening and while Administrative Rules of SD 44:19 specifies what diseases and conditions are required for screening.

Strengths and Challenges

South Dakota possesses unique strengths and challenges that impact the health status of its MCH population. Specifically, SD is home to a growing healthcare industry that supports its MCH population. The states healthcare industry is projected to be among the largest growth industries from 2012-2022. This industry is projected to add 7,305 workers to SD's economy (from a level of 52,875 in 2012 to a level of 60,180 in 2022). The rate of growth is projected to be 13.8%, nearly double the 7.0% growth projected in total employment for all industries.

This growth in the healthcare industry is significant because as baby boomers retire and leave the healthcare workforce, they are subsequently aging, requiring additional healthcare services. A focus has been placed on high school graduates who can replace the retirees in the workforce and continue to provide quality healthcare services across the state. The SD Departments of Education, Health, Labor and Regulation, and the SD Board of Regents have created a program to address this critical need for healthcare workers. Health Occupations for Today and Tomorrow focuses on health career information and opportunities for SD students at all grade levels. The South Dakota Healthcare Workforce Center established within the Office of Rural Health (ORH) functions as a clearinghouse for healthcare workforce-related data and information. The Center is also designed to develop and implement programs and projects that assist individuals, agencies, and facilities in their efforts to address current

and projected workforce needs. ORH also works to improve the delivery of health services to rural and medically underserved communities, emphasizing access.

Despite the growth in the healthcare industry and strategies to address the healthcare workforce, SD residents are challenged by the limited access to healthcare. Over two-thirds of the state is designated by the federal government as a Health Professional Shortage Area (HPSA). Health care provider shortages exist in primary care, dental health, and mental health. There are also 71 Medically Underserved Areas/Populations (MUA/P), including a shortage of primary care health services across the state. As of June 2022, there were 5613 licensed physicians and 736 physician assistants licensed in SD. In addition, in 2022 there were 1,964 actively licensed nurse practitioners and 52 actively licensed certified nurse midwives.

Another challenge facing SD's MCH population is a lack of transportation to access services and resources. This is compounded by factors such as poverty and geographic isolation. For some, this means traveling great distances (over 50 miles) to see a primary care provider and even further to see a specialist. Most healthcare specialists and the state's lone children's hospital is located on the eastern side of the state. This adds additional travel and expense for families of children in the central and western regions of the state which can be as much as 400 miles away. Access to services and resources is further complicated on AI reservations by the lack of a reliable transportation system.

The MCH program continues to identify strategies to address these challenges such as marketing program services to reach all eligible populations, utilizing tele-health services where appropriate and available, recruiting and retaining adequately trained/prepared individuals to meet workforce needs (especially in remote counties and reservation communities), being responsive to populations with different cultures and beliefs, and improving access to dental and mental health services.

Roles, Responsibilities and Targeted Interests of State Health Agency

In December 2019, the DOH released its 2020-2025 Strategic Plan. The strategic plan provides a road map for the future and helps staff work together as a department to achieve meaningful outcomes. The plan is not designed to be a compilation of all DOH programs and services but instead helps identify new things to be accomplished as well as reflect key strategic initiatives the DOH is doing today and will continue in the future.

The DOH's 2020-2025 Strategic Plan envisions "every South Dakotan healthy and strong", with the mission of "working together to promote, protect, and improve health". The guiding principles of the DOH include serve with integrity, respect and compassion; focus on evidence-based prevention and outcomes; support data-driven innovation; achieve health equity in all communities; demonstrate proactive leadership and strengthen partnerships; and exhibit transparency and accountability. The Strategic Plan is reviewed and updated regularly.

The strategic plan addresses the following goals:

- Goal 1: Enhance the accessibility, quality, and effective use of health resources.
- Goal 2: Provide services to improve public health.
- Goal 3: Plan, prepare, and respond to public health threats.
- Goal 4: Maximize partnerships to address underlying factors that determine overall health.
- Goal 5: Strengthen and support a qualified workforce.

Each goal has objectives and key strategies to help guide DOH activities. There are also 13 key performance indicators that will be tracked to allow the DOH to monitor progress towards these goals. More information about the plan can be found at http://doh.sd.gov/strategicplan/.

The DOH also remains committed to providing comprehensive public health services and programs for and with underserved populations and communities throughout the state. Much of the state is designated as a HPSA and is therefore underserved.

The DOH's centralized organizational structure delivers public health services across the state through 74 local community health offices. Previously there were 76, but two offices consolidated with others in 2021 and 2022 due to very small caseloads and staffing.

To fill the gaps, OCFS has purchased three mobile units that will be equipped to provide satellite public health services including WIC, Immunizations, Fluoride Varnish, Pregnancy Care support, and other public health programs. Trained OCFS staff will take services "on the road" to areas that have been identified as underserved. Initially, the primary focus will be on services for the MCH population. Communities that will be targeted include those without an acceptable location for a permanent site or a caseload too small to support one, and areas with transportation challenges prevent families from accessing services to which they are entitled. The office is currently working on logistics for the mobile units, including creation of a vehicle manual, scheduling, and equipment checklists. The goal is to have the units operational by summer 2023.

In addition, the MCH program has partnered with the WIC program to launch a telehealth platform, doxy.me, to be utilized by WIC nurses and dieticians. The goal of this platform is to prioritize and increase face to face visits, whether in person or virtual, and limit telephone calls with clients. The platform will help increase face to face visits when distance and transportation create a hardship to come to a community health office.

A wide array of public health services are provided in the state's community health offices including interpreter services, direct services, and outreach services provided by WIC, Title X Family Planning, and the Bright Start Home Visiting program. Due to funding limitations, the Bright Start Home Visiting Program has only been available at select sites, however, the program was approved for additional funding during the 2022 legislative session that will allow the program to expand and reach all eligible mothers statewide. Community health staff provide infant safe sleep education, health and safety information, growth and development screening, prenatal education, immunizations, school nurse services, modified case management for high-risk pregnant moms, postpartum care and support services for families with funding from and coordination with the MCH block grant. These offices are under the leadership of the Title V administrator and provide an avenue to gather input in program development as well as during program evaluation. A few examples of the communities that community health offices serve include the 54 Hutterite colonies throughout the state, the refugee resettlement of the Burmese Karen populations in the Huron and Aberdeen areas, and the expanding urbanization of Sioux Falls.

The DOH remains committed to fostering relationships with both Indian Health Service (IHS) staff and statewide tribal government/tribal health to identify opportunities to support MCH services on SD Indian reservations. The DOH has supported several tribal initiatives, such as the Project LAUNCH grant and Tribal MIECHV grants, by providing letters of support and community advisory board commitments. These partnerships are in place with the Sisseton Wahpeton Oyate MCH program, as well as Great Plains Tribal Leaders' Health Board on behalf of the Rosebud Sioux Tribe and Sisseton Wahpeton Oyate. The DOH participated in the Region VIII Tribal Relations Community of Practice to increase knowledge, skills, strategies, cultural responsiveness, and engagement with Tribal populations. Safe sleep outreach to Tribes has expanded in 2023 as infant mortality rates continue to rise.

South Dakota Systems of Care

According to SDDOH vital statistics, U.S. Census, and other federally available data, the MCH Block Grant in SD aims to serve approximately 437,000 women of child-bearing age including 11,000 pregnant women, 12,000 infants, 253,000 children and adolescents age 1 through 21, and 37,957 children and youth with special health care needs. SD has 49 general community hospitals, of which 38 are critical access hospitals and 9 offer labor and deliver and obstetrics services. There are fifty-one federally qualified health centers (FQHCs) and fifty-eight rural health clinics. There are also five IHS hospitals in SD, of which only two provide routine obstetrical services. SD has one children's hospital located on the East side of the state and 125 general pediatricians and approximately 75 subspecialists to

serve the MCH population.

The Departments of Health and Social Services continue to prioritize and focus on social needs and behavioral health services integration. The OCFS is the outreach arm and community presence of the DOH and works closely with DSS programs that support health, social needs and behavioral health including Medicaid, Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP). These programs work directly with the community health offices that administer WIC program and the Bright Start home visiting program. These programs are also forging new partnerships and services to address behavioral health needs as an emerging issue within the state.

In state fiscal year 2022 153,826 South Dakotans participated in Medicaid for their healthcare. The vast majority, 64%, are children. Half of the children born in SD each year will be on Medicaid during their first year of life and 36.7% of all Medicaid recipients are American Indian (SD Medicaid). Medicaid eligibility for FY20 includes pregnant women at 138% FPL; children under 6 at 182% FPL, children aged 6-19 at 116% FPL, parent/caregiver/relatives of low-income children at 46% FPL; CHIP (Children's Health Insurance Program) at 209% FPL.

III.C. Needs Assessment
FY 2024 Application/FY 2022 Annual Report Update

Needs Assessment Update

The South Dakota MCH and CYSHCN Programs completed their statewide five-year needs assessment in May 2020 but continue to carry out ongoing needs assessment activities.

Ongoing Data Collection and Needs Assessment Activities

As part of the ongoing needs assessment, the Office of Child and Family Services (OCFS) data team compiles the Special Supplemental Nutrition Assistance Program for Women, Infants, and Children needs assessments. This WIC needs assessment is completed yearly in the community health offices statewide, and results were looked at collectively over the last year to identify statewide needs, assets, and weaknesses. Strengths and weaknesses were identified, but more importantly, the need to improve the process and utilization of these needs assessments was recognized. This process led to the development of the Strategic Community Outreach and Outcomes Plan (SCOOP), being implemented in the community health offices statewide.

The Sanford Patient Navigation Program surveys families of children with special healthcare needs as well as their affiliated professionals to gain ongoing perspective of the needs faced by this population and the professionals that provide services to them. This information is used by the CYSHCN Program to continue shaping the Patient Navigation Program to fill gaps in services and improve outcomes for these children and their families. In 2022, the program began to evaluate the impact of adding a nurse practitioner to the program on health outcomes for patients as well as the mental health of their caregivers. Post surveys were completed in August 2022 and presented a new challenge in program evaluation. As the program grows and evolves, participation has become more fluid, making it difficult to capture participant responses as a cohort, as some had been in the program much longer than others. In addition, the level of involvement of participants is also becoming more fluid as the program grows and services are tailored to meet the needs of each individual patient. The program is also seeing a new demand for cost-savings data as we look for ways to make the program financially sustainable long-term. Following the second cohort surveys, the decision was made to move away from surveys, and conduct final, in-person interviews of no more than twelve volunteer families who had been in the program a minimum of one year. The interviews will take place in spring 2023. Following completion of the interviews, a final report on family perceptions will be provided. The program will continue to collect data through the Care Coordination Management Tool filled out by the program's care team to document day to day services provided and outcomes achieved through these services.

The South Dakota Newborn Screening Advisory Committee provides support and recommendations to the South Dakota Department of Health (SD DOH) Newborn Screening Program regarding programmatic decisions. The group convenes on an annual basis to receive updates on the status of the newborn screening program and to discuss the addition of new disorders to the South Dakota panel of disorders. The advisory committee consists of newborn screening stakeholders and partners, including pediatric specialists, laboratory personnel, nurses, pediatricians, and family and community members interested in learning about newborn screening. In 2023, a need was recognized to create a formal process to nominate new conditions to be added to the state's Newborn Screening panel. The Newborn Screening Coordinator worked with other states and the SD DOH Communications Team to create an online form that can be used to nominate a condition for addition to the panel. A subcommittee is also being formed to review nominations and recommend or deny a nomination based on established criteria. The subcommittee has representation from medical and laboratory professionals and specialists, Medicaid, Department of Health, Statewide Family Engagement Center Birth to Five pillar, and parent representatives.

South Dakota DOH began reviewing child deaths from age 1 up to age 13 in 2020. Prior to this, only post birth hospitalization infant deaths (all cause, all manner) were reviewed statewide. Child Death Review's (CDR) two

multidisciplinary teams located on the east and west side of the state use a common data collection tool, the National Center for Fatality Review and Prevention's Case Reporting System. Findings, including risk and protective factors and Social Determinants of Health (SDoH) are documented for each death reviewed which inform upstream prevention recommendations. CDR data is shared with state partners and disseminated within their networks.

The SD DOH formed a Maternal Mortality Review Committee (MMRC) in 2021 to review maternal death cases and determine leading causes of maternal mortality in South Dakota. A maternal mortality abstractor was hired and has access to the necessary medical records from the three major health systems in the state. In addition, the abstractor can analyze data collected from the health information exchange, vital records, WIC, and Medicaid. The first case review meeting was held in October 2021. The SD MMRC is also participating in the Texas Discrimination and Social Determinants of Health (DASH) pilot study to assess discrimination and social determinants of health as a factor in maternal deaths.

The SD DOH launched a new electronic health record (EHR) in January 2022. The record hosts data from family planning, community health, and nurse home visiting. Additional data linkages with WIC data, the Health Information Exchange, and the SD Immunization Registry will also be possible through this EHR. The MCH epi has been involved with the creation of questions for the EHR that address social determinants of health.

In early 2023, following an RFP process, the OCFS contracted SLM Consulting, LLC to coordinate the 2025 MCH statewide needs assessment. SLM Consulting is a public health consulting firm located in Sioux Falls, SD and has experience working with OCFS and co-lead the 2020 MCH needs assessment. Through initial conversations with SLM Consulting, the MCH Program has laid out a broad timeline for the 2025 needs assessment. Planning will take place in late summer/early fall 2023, full implementation in 2024, and data analysis/priority setting in 2025.

Noted Changes in Health Status

In May 2023, the Public Health Emergency relating to the Covid 19 pandemic ended. MCH staff had been mostly pulled from Covid work in mid-2022 due to declining Covid cases and data collection and monitoring was turned over to Infectious Disease staff as DOH Epidemiology. The DOH website page dedicated to Covid has since been paired down and the dashboard is now updated monthly as opposed to weekly. The covid.sd.gov page was removed entirely.

The SD Department of Health continues to monitor the state's severe rise in syphilis cases. As of spring 2023, syphilis cases have increased over 1713% above the five-year median. Congenital syphilis cases are also on the rise in South Dakota, increasing 2200% over the five-year median. Due to the sharp rise, the MCH Program has been partnering with the DOH Office of Disease Prevention to launch a media campaign to raise awareness of congenital syphilis and direct the public to available resources. The campaign is geared toward both males and females aged 25-39, with an emphasis on women of child-bearing age. Efforts are focused on the counties with the highest numbers of cases and include a mix of social media, radio, and signage.

South Dakota has also seen a sharp rise in suicide cases. Provisional data from South Dakota Suicide Prevention (SDSP) shows suicides in the state have been on the rise since 2011, with 2021 showing the highest recorded number of suicides since tracking has been in place. SDSP data shows suicide is the leading cause of death in SD among ages 10 to 19. The data also shows the SD American Indian suicide rate is 2.5 times higher than the SD White suicide rate for 2011-2020. The MCH adolescent domain has made mental health and suicide prevention one of their top priorities. The adolescent domain leader leads a workgroup comprised of stakeholders in the areas of medical consultation, Helpline Center, Department of Social Services, DOH Injury Prevention, University of South Dakota, and Lutheran Social Services. The group promotes evidence-based programs and practices that

increase protection from suicide risk, promote positive youth development, and develop and disseminate equitable and accessible Suicide Prevention education material, resources, and messaging. The women's domain is also focused on mental health and substance misuse and provides depression screening in the community health offices.

The 2022 infant formula shortage brought leadership from WIC, MCH, and Community Health together weekly to discuss changes and updates to the situation. The WIC team also created an emergency channel on Microsoft Teams to communicate updates in real time. The community health staff was integral in keeping leadership updated on what they were hearing from the families in the clinic and communicated the needs expressed by families as well as locations where families were able to locate formula throughout the shortage. They also communicated misinformation they were hearing in the clinic, prompting the DOH to create social media posts to address misunderstandings and provide accurate information.

Title V Program Capacity

The MCH Title V Program has made recent efforts to expand internal staffing, so each domain leader can focus on one domain population. The goal of this change is to expand the capacity of each domain leader to address MCH priorities and emerging health issues for their domain through strategic partnerships, networking, and oversight. These efforts have continued into 2023 as the program continually reviews and evaluates staffing capacity. There are currently vacancies within the Title V Program, including key leadership vacancies in the women's health and child health domains. The MCH and CYSHCN Directors have been working on a restructure to fill these positions, as well as create new positions to increase capacity to address emerging needs as they arise.

A noted change in SD's broader MCH service delivery began in November of 2019, when the Office of Child and Family Services (OCFS) embarked on a process to assess its structure and staffing to identify opportunities to better meet client needs and deliver services more efficiently across the state. This includes gaining a better understanding of the public health services and supports most needed in communities across South Dakota and identifying and evaluating the viability of current service delivery models. To guide this project, OCFS worked with several consultants from Health Management Associates (HMA), and a project team comprised of OCFS and division leadership, central office staff members, and regional manager representatives. As a result of this assessment, several changes were proposed.

Implementation of the proposed changes to the organization and structure of the OCFS began in 2021. These changes include moving from a seven-region structure for local services to a four-region structure. Within each region, a leadership team was assembled including nurse, dietitian and billing/operations leads who work collaboratively with the Public Health Manager to implement both OCFS and region wide strategies.

The goal of this reorganization was to:

- Deliver the right care at the right time - staff each working at highest scope of practice
- Build capacity and autonomy for regional and local responsiveness
- Prioritize and lean into the "gap-filling" function of OCFS
- Reduce overall costs of service delivery model
- Develop and commit to an OCFS-wide long-term strategy with the tribes, and other specific populations, to address health inequities

Following implementation of the new structure, challenges with service delivery continued to be noted across the state. OCFS leadership worked to identify the context of these challenges by reviewing data, looking at client feedback, and asking for staff perspective in meetings and through an OCFS staff survey. Primary challenges noted were staff workload, lack of adequate communication, and need for additional education, training, and development opportunities.

To address the ongoing challenges, the decision was made in 2023 to redesign the WIC and Community Health Services (CHS) to provide for adequate staffing and supervision, by removing WIC service delivery staff from CHS and relocating them under WIC central leadership. Previously, nurses were providing both WIC services and CHS services. The two programs will continue to share spaces but will carry out different duties and report to their respective leadership. This change allows CHS staff to focus on public health nursing, expand current services, and embrace new opportunities as they arise. The OCFS restructure will move toward a hub and spoke model for both WIC and CHS that maximizes resources at 11 hubs in the state and allows for designated areas of outreach using mobile units.

The CHS offices will focus on a case management model, reaching eligible populations for services, allowing for flexibility in how work is conducted, and enabling accountability for performance. The four regions created in the previous restructure will be condensed to three service areas, Northeast, Southeast, and West-Central. Core services provided will be MCH, immunizations, and school health services. This change allows the MCH program to provide increased training and development opportunities to CHS staff, as well as incorporate new services for the MCH population.

Title V Partnerships and Collaborations

Title V programs have built strong partnerships both within and outside the DOH to collaborate on key programs and initiatives that impact priority populations. The physical presence of the OCFS 74 community health offices serves as a major asset throughout the state. These offices carry out coordinated programs, services, and outreach that are funded through a variety of federal, state, and local public health funding streams. These offices serve as the "local" health department and in many rural and underserved communities this "staying" power builds trust and partnerships.

Opportunities to strengthen partnerships lie with three groups: community-based and faith-based organizations that are directly supporting priority populations; nine American Indian tribes within the borders of SD; and family engagement organizations to expand the reach of Title V investments which aim to improve health and wellbeing of SD families. Strategies will be developed and prioritized in the action plans for the coming year to sustain or cultivate engagement. Specific health equity partnership development strategies will be assessed on utility and feasibility.

Throughout the needs assessment process, 27 long standing partners were identified representing all sectors including tribal health systems and programs. Most of these partnerships are defined as "formal" meaning they have a contract, MOU or historical working relationship with the DOH. The MCH team also identified 17 emerging partners, the vast majority of whom were informal (meaning non-typical) partners that represent emerging needs. These partners tended to represent the infants, children, and adolescent domains.

Maternal Child Health Bureau Investments: Bright Start Home Visitation Program includes OCFS as both grantee and implementing agency for the MIECHV program. Bright Start uses the Nurse Family Partnership (NFP) model in fifteen sites covering all 66 counties in SD. The Bright Start Home Visitation Project Director will be actively engaged with the workgroup implementing strategies under NPM 1 and NPM 5.

The State Systems Development Initiative (SSDI) grant has awarded a new five year grant cycle in 2022 to SD that coordinates with and directly supports the work of the MCH Title V Block Grant. SD's SSDI grant supports an epidemiologist focused on maternal and child health, the South Dakota PRAMS, and facilitation of the identified SPM to better coordinate and disseminate data.

Other Federal Investments Administered in the DOH OCFS: South Dakota MCH populations are also supported, and SD's MCH Block Grant reach is expanded through additional grants within the broader OCFS.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) serves participants through 74 community health offices across the state. The program works cooperatively with the Cheyenne River, Rosebud Sioux and Standing Rock tribal reservations to ensure every county in South Dakota has access to WIC services. From October 2021 to September 2022, WIC served an average of 13,736 participants per month

Rape Prevention Education Grant (RPE) aims to decrease sexual violence by funding community-based organizations who use the public health approach to decrease sexual violence risk factors and increase sexual violence protective factors. The Sexual Violence Project Specialist for the South Dakota Network Against Family

Violence and Sexual Assault will engage as an active partner on SPM 1 workgroup.

Office for Victims of Crime Rural Sexual Assault Nurse Examiners (SANE) is utilized statewide to increase the opportunity for victims of sexual assault across rural SD to receive services in their communities and increase awareness of law enforcement services. The project director for both RPE and SANE grants will be actively engaged on the work group implementing strategies under NPM 1 and SPM 1.

State Personal Responsibility Education Program (PREP) is delivered through a partnership with Lutheran Social Services. PREP is being utilized statewide to educate young people on abstinence and use of contraception to prevent pregnancy and sexually transmitted infections, including HIV/AIDS. SD's program goals are to lower both Chlamydia rates and teen birth rates among young people. The LSS Project Director for PREP will engage as an active partner on the SPM 1 workgroup.

Title V Sexual Risk Avoidance Education (SRAE) is administered through a partnership with LSS and Boys & Girls Club, SRAE is utilized statewide to educate young people on sexual risk avoidance and teaches youth to voluntarily refrain from non-marital sexual activity. The target population is 10 – 13-year-old who are considered vulnerable youth. The goals of this program are to lower both Chlamydia rates and teen birth rates among young people in SD. The LSS Project Director and Boys and Girls Club Program Coordinator will engage as an active partner on the SPM 1 workgroup.

SD Family Planning Program (SDFP) delivers statewide services through a network of 21 sites and provides services to low-income individuals to increase healthy maternal/infant outcomes. The Title X Project Director will be actively engaged with the workgroup implementing strategies under NPM 1.

Major Health Systems: Sanford Health, Avera and Monument Health, partner with MCH program staff to provide a variety of services including coordinated case management services and genetic counseling. Sanford Health provides the one children's specialty clinic in the state and works closely with the State's Newborn Screening Coordinator to coordinate newborn screening follow up and case management services. These health systems have representation on workgroup implementing strategies to address NPM 5 and NPM 11.

Other State Government Agencies: South Dakota Department of Social Services DOH has an MOU with SD Medicaid to provide direct healthcare services and modified case management within the 74 community health offices. The DOH and Medicaid have also established an interagency collaborative over the last year. The focus of this partnership is across all MCH domains. DSS Behavioral Health and the DOH began working together to merge resources on suicide prevention and promoting DSS' youth suicide prevention campaign - BeThe1SD. They will engage as a new active partner on NPM 7.2 workgroup. South Dakota's Office of Emergency Management partners with DOH's Office of Public Health Preparedness and Response (PHPR) and OCFS in providing emergency response efforts across the state. OCFS field staff in community health offices are assigned to a Point of Dispensing (POD) site to dispense emergency pharmaceuticals in the event of a public health emergency.

Other Programs Within the DOH: Child Death Review (CDR) Through a Memorandum of Agreement (MOA) between DOH and member agencies, volunteer professionals across the state conduct CDR. Two regional teams, East and West River, are made up of members from law enforcement, DSS Child Protection Services, public health, hospital staff (Pediatricians, DNPs, nurses, and social workers) Emergency Medical Services (EMS), Forensic Pathology, Division of Criminal Investigation (DCI), FBI, Bureau of Indian Affairs (BIA), Indian Health System, and the States Attorney's offices. DOH's Office of Health Statistics and Vital Records provides data for the review process. CDR is funded exclusively by MCH dollars.

Tribes, Tribal Organization and Urban Indian Organization: Maternal and child health services are provided in a variety of ways. A few of those include partnerships with DOH; dedicated staff within a tribe; and through a partnership with the Great Plains Tribal Leaders Health Board. Tribal MCH Programs are informal, but long-standing. Partnerships with Rosebud IHS and Tribal MCH and Cheyenne River Sioux Tribal MCH are in place to provide safe sleep environments to American Indian families in need each year. The needs assessment team also noted an emerging partnership with the Sisseton Wahpeton Oyate MCH staff, who will serve on the workgroup addressing NPM 1.

Great Plains Tribal Leaders Health Board (GPTLHB) advocates for its constituents to have access to health resources available in the areas of research, education, assistance, prevention, and outreach. This organization will be part of the workgroup addressing SPM 3.

Public Health and Health Professional Education Programs/Universities: SDSU Population Health Center is a formal, long-standing partner that provides technical assistance to the MCH team to develop, monitor and evaluate the program's overall objectives. They assisted with the development, execution, and evaluation of the Needs Assessment and will continue to provide technical expertise but will also serve on the workgroup that will direct State Performance Measure 3.

USD Sanford School of Medicine (SSOM) and the MCH program have fostered a partnership as a formal and emerging partner who now leads the state's Early Hearing Detection and Intervention collaborative. Previously the DOH led this grant. USD also houses the state's medical school and along with SDSU jointly houses the state's only public health program.

Community-Based Organizations: The HelpLine Center is a nonprofit organization that offers youth suicide prevention education and activities throughout the state. With this partnership the following activities are offered: 24/7 statewide crisis line – updating the database of mental health providers and emergency services in order to provide quality referrals. They will engage as an active partner on the NPM 7.2 workgroup.

Operationalization of Needs Assessment Findings

The state's MCH leaders have taken steps to operationalize its five-year needs assessment process and findings. The seven priority needs identified in the five-year needs assessment and their corresponding NPMs and SPMs are listed in the table below.

Priority	MCH Population Domain	NPM or SPM
Mental health/Substance misuse	Women/Maternal Health	NPM 1 Well-Woman Visit
Infant safe sleep	Perinatal/Infant Health	NPM 5 Safe Sleep
Parenting education and support	Child Health	NPM 6 Developmental Screening
Mental health/Suicide prevention	Adolescent Health	NPM 7.2 Injury Hospitalization
Access to care and services	CYSHCN	NPM 11 Medical Home
Healthy relationships	Adolescent Health	SPM 1
Data sharing and collaboration	Cross-Cutting	SPM 2*

**SPM 2 has since been replaced with SPM 3.*

The MCH domain leaders have formed diverse workgroups that meet quarterly to inform and help carry out the

activities in the domain action plans. Domain leaders also track their collaboration efforts utilizing the Wilder Collaboration Index and carry out ongoing evaluations of their programs. They continue to evaluate the needs of the populations they serve through surveys and data analysis.

Organizational Structure and Leadership

The OCFS provides leadership and technical assistance to assure systems are promoting the health and well-being of women of reproductive age, infants, children, and youth, including those with special health care needs and their families. OCFS provides oversite to state-employed nurses, nutrition educators and dietitians for the provision of public health services in the state. The OCFS recently underwent a major change in leadership. The OCFS Administrator, MCH Director, Community Health Administrator, MCH Epidemiologist, and OCFS Business Operations Coordinator positions all changed hands in late 2022/early 2023. The MCH Child Domain position is currently vacant, and the women's domain has an interim lead.

Katelyn Strasser, MPH, RN and former MCH Epidemiologist, became the OCFS Administrator in 2023. Katelyn has been with the DOH for 8 years. Samantha Hynes, MPH, MSW is the OCFS Assistant Administrator and MCH Director and has been with the DOH for 2 years. Whitney Brunner serves as the CYSHCN Director and MCH Assistant Program Director and has been with the DOH for 4 years. Other OCFS team members that work with MCH include the following:

- Rhonda Buntrock, OCFS Assistant Administrator- WIC Program Administrator
- Joel Arriolacolmenares, OCFS Assistant Administrator- Community Health Administrator
- Wade Huntington, OCFS Assistant Director of Operations
- Carrie Churchill, Bright Start Home Visiting Program Manager
- Bernadette Boes, Newborn Screening Coordinator
- Hope Kleine, South Dakota Family Planning (SDFP) Program Nurse Manager
- Nikki Krier, SDFP Nurse Consultant
- Jill Munger, MCH Nurse Consultant/ Child Death Review Coordinator, Infant domain lead
- Vacant, MCH Child Domain lead
- Sarah Barclay, MCH Adolescent Coordinator, RPE, SRAE, PREP
- Vacant, Prevention Services Manager, including Maternal Mortality and Infant/Child Mortality. This is a new/revised position.
- Amy Mattke, Pregnancy Care/Maternal Health Home, Interim MCH Women's domain lead
- Tim Heath, Immunization Program
- Mark Gildemaster, Manager, Data and Statistics
- Fabricia Latterell, MCH Epidemiologist
- Isaac Snaza, OCFS Epidemiologist
- Caleb Van Wagoner, OCFS Health Informatics Analyst
- Tricia McNeely, OCFS Business Operations Coordinator
- EA Martin, SDSU contractor, MCH and home visiting epidemiology

The DOH contracts with an epidemiology team and has a designated MCH epidemiologist to continually analyze our available data and develop fact sheets/articles based on their findings.

Click on the links below to view the previous years' needs assessment narrative content:

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,147,032	$1,730,405	$2,194,925	$1,396,200
State Funds	$1,611,368	$1,637,090	$514,881	$1,557,960
Local Funds	$149,570	$21,313	$40,940	$88,093
Other Funds	$0	$0	$0	$0
Program Funds	$1,224,994	$1,106,777	$1,100,000	$932,445
SubTotal	$5,132,964	$4,495,585	$3,850,746	$3,974,698
Other Federal Funds	$19,703,960	$21,177,769	$21,996,626	$19,771,485
Total	$24,836,924	$25,673,354	$25,847,372	$23,746,183

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,319,160	$1,763,580	$2,458,310	
State Funds	$1,035,794	$1,553,467	$1,735,315	
Local Funds	$13,485	$15,197	$93,379	
Other Funds	$0	$0	$114,005	
Program Funds	$700,263	$867,768	$988,392	
SubTotal	$4,068,702	$4,200,012	$5,389,401	
Other Federal Funds	$20,895,980	$22,083,730	$20,150,177	
Total	$24,964,682	$26,283,742	$25,539,578	

	2024	
	Budgeted	Expended
Federal Allocation	$2,630,392	
State Funds	$1,048,236	
Local Funds	$16,261	
Other Funds	$0	
Program Funds	$919,834	
SubTotal	$4,614,723	
Other Federal Funds	$22,613,738	
Total	$27,228,461	

III.D.1. Expenditures

The mission of the South Dakota (SD) Maternal and Child Health (MCH) Program is to improve the health and well-being of SD families and to assure access to preventive and primary health care services for mothers, infants, children, adolescents and young adults which also includes children and youth with special health care needs. The Office of Child and Family Services (OCFS) utilizes funds to enhance work in communities and tribal areas across the state. The expenditures complement the mission of the SD MCH program.

The OCFS is divided into three sections: Community Health Services, WIC, and MCH. These sections work collaboratively to utilize funding appropriately to support outreach to underserved populations through nurses and dietitians located in community health offices across the state. When at full capacity, SD has an MCH staff comprised of six program coordinators and the MCH Director that work with internal and external partners to implement the state action plans. The MCH program shares an epidemiologist and contracted epidemiology staff with other OCFS programs.

For FY 2022 expenditures, SD met federal Title V requirements that at least 30 percent of federal funds support CYSHCN activities. In addition, at least 30 percent of federal funding was used for preventive and primary care for child and adolescent activities. SD did not exceed the 10% administrative requirement. South Dakota's maintenance of effort was fully met.

While South Dakota was able to meet federal spending requirements, FY22 presented a unique challenge for South Dakota to spend our federal allocation. Two years into the Covid 19 pandemic, a deficit in spending was anticipated due to staff time being deferred to Covid prevention efforts, including contact tracing and assisting with various activities. However, we had underestimated the amount unspent, and with less than half of the fiscal year remaining the program was faced with the challenge of spending a significant amount of federal funds in a few short months. The MCH Program did not have an internal system or process in place at the time for monitoring our spending and was fully reliant on the DOH fiscal department to monitor spending and alert our office to concerns.

The situation spurred much needed change in the MCH Program and created new avenues for spending that we otherwise may not have explored. The additional FY22 funds were a welcomed asset to many program areas. The DOH Office of Disease Prevention (ODP) utilized MCH funds to create mini grants for breastfeeding friendly businesses to create or upgrade lactation spaces and mini grants for early childcare and education entities to update and implement Harvest of the Month Materials. The ODP utilized MCH funds to finish a project, the Move Your Way Playbook, a useful resource utilized across several programs to promote physical activity during pregnancy as well as for children. The DOH partnered with ODP to launch a statewide campaign promoting awareness of the congenital syphilis outbreak. The MCH Program also used extra funds to further development of the OCFS doxy.me telehealth platform to be utilized by WIC staff to increase face to face visits with clients when transportation is a barrier. Telehealth usage was also expanded within the Sanford Complex Medical Care Program with the purchase of additional TitoCare units to be used with participants. Staff trainings on Collaborating Across Differences, and SOAR (Strengths, Opportunities, Aspirations, and Results) for MCH staff were conducted with MCH funds as well as a cannabis training from national experts for DOH staff. South Dakota Learn the Signs Act Early was provided a sponsorship to increase printing of developmental monitoring materials to be distributed statewide. MCH funds were utilized for a variety of other projects, trainings, and supplies including the life.sd.gov website (resources for women during and after pregnancy and adoption), contraceptives for family planning services, purchase of short educational video clips in English and Spanish to be used in community health offices, marketing for Bright Start Home Visiting expansion, various travel to conferences, AMCHP memberships for additional staff, and increased social media budgets for the Women, Infant and Adolescent domains. The spending deficit also led to the development of an

internal monitoring system allowing the MCH Program to have more oversight and control over spending. The new system has proven to be successful into 2023 as we were able to catch another Covid spending deficit (a ripple effect from the previous year) much earlier in the year, allowing time to adequately plan and spend down extra funds in FY23. At this time, it is anticipated spending will return to pre-covid levels in FY24 and the MCH Program will return to spending the federal allocation within one year.

South Dakota Title V is the payer of last resort and MCH Block Grant funds were not used to reimburse a claim for a service that was otherwise covered under Medicaid. All services supported by the MCH Block Grant reflect services that were not covered or reimbursed through the Medicaid program or another provider.

Total Expenditures excluding Administrative Costs (Federal/General/Other) by Populations:

CYSHCN	$938,724
Pregnant Women/Infants	$2,001,468
Child/Adolescents	$1,231,991
All others	$27,830

Total Expenditures excluding Administrative Costs (Federal/General/Other) by Type of Service

Direct Services	$30,762
Enabling Services	$2,440,492
Public Health Services and Systems	$1,728,758

In broad terms, expenditures typically support personnel that facilitate MCH program efforts and provide services to the MCH population through Community Health's nurses and dietitians. Additional outreach is provided through population-based strategies such as public education, data and surveillance, community outreach, epidemiology support, training, social media etc. across all MCH domains. Systems Development Initiative funding is also utilized to build and expand MCH data capacity to support Title V activities and contribute to data-driven decision making in MCH programs, including assessment, planning, implementation and evaluation.

Expenditures that are related to program management, including contract management, are implemented by MCH program staff within the OCFS. All MCH program activities include data analysis, evaluation, and continuous quality improvement activities to drive data driven decisions and program improvement.

Office of Child and Family Services

OCFS expenses shared within contractual agreements include evaluation and epidemiology, consultation for the needs assessment, and media/communication support. Each contractual agreement includes detailed invoices to account for MCH spending.

An overview of the ongoing activities that are partially or fully funded with MCH dollars is below.

Women and Infants:

- Modified case management of high-risk pregnant women not covered by Medicaid
- For Baby's Sake website and Facebook page – promoting healthy moms and healthy babies
- Developing, implementing and evaluating local office maternal mortality prevention plans
- Postpartum home or office visits including assessment, education/counseling, anticipatory guidance, client need coordination, referral and follow-up

- Prenatal education/counseling for pregnant moms who are not high risk
- Ages and Stages Developmental Screening and related education, counseling, and anticipatory guidance for infant caregivers. Referrals as needed
- Ages and Stages Social and Emotional Screening and related education, counseling, anticipatory guidance for infant caregivers. Referrals as needed.
- Developing, implementing, and evaluating local office infant mortality prevention plans
- Quality Assurance activities
- Newborn home or office visits including assessments, education/counseling, anticipatory guidance, client need coordination, referral, and follow-up (mothers/infants not covered by Medicaid)
- Cribs for Kids safe sleep kit distribution/safe sleep education for parents/caregivers
- Child death review (previously infant death review)

Child and Adolescent:

- Community-based and youth-driven activities to reduce suicide and injuries
- Well Visit promotion with Medicaid and 3rd party payers
- School-based health assessments/preventive health education including screening, education/counseling, referral, and follow-up
- Oral health assessments
- Nutrition/physical strategies to reduce overweight and obesity (i.e. healthy concessions, training for school personnel, height and weight data collection)
- Ages and Stages Developmental and Social/Emotional screenings for young children including education, counseling, anticipatory guidance and referrals when needed

Children and Youth with Special Health Care Needs

- Direct service reimbursement through the Health KiCC program
- Newborn screening identification, referral and follow-up
- Support for families of children with chronic conditions, i.e. respite care; special needs car seats; resource and referral
- Support genetic/specialty consultation in areas of the state where services are not available.
- Care coordination and development with an emphasis on evaluation.

Budgeted versus expended:

During FY22, the OCFS responded in a variety of ways to the COVID-19 pandemic, leading to a decrease in typical MCH spending. The OCFS also experienced high turnover in staffing and struggled with long lag times in receiving invoices from some public health alliance sites. The form field notes on budget and expenditure differentials list out these challenges.

Significant variations of more than 10% in the expenditure data reported on Form 2 and are explained below:

The amount expended this year is significantly less than the amount budgeted. This reporting year was budgeted with the expectation that MCH work would resume to full capacity right away following the Covid 19 pandemic, however, staff time was still going to Covid efforts the first several months of this reporting period. Additional factors include staffing shortages and vacancies as well as increased lag time receiving invoices from some field offices.

Significance of federal MCH Block Grant funding support:

Without the MCH Block Grant dollars, the SD DOH would be forced to make significant cuts to the services and education provided to SD families.

Accountability:

MCH block grant activities performed by MCH program and field staff are accounted for by a daily time study. The time study includes funding codes that reflect the population being served (i.e., child/adolescent, pregnant women, mothers and infants, and CYSHCN). Function codes determine if the service was direct, enabling, or public health services and systems (e.g., developmental screening, travel to provide services, training, networking, quality assurance, or modified case management).

The DOH Division of Finance updates electronic grant reports monthly that are housed on a shared drive. More detailed reports are available on the shared drive where end users can utilize a pivot table to bring into focus the expenses by detail to track expenses on a regular basis. When the MCH spending shortage was learned in FY22, OCFS grant leaders were provided training from fiscal staff on how to use and interpret these reports, leading to the creation of the internal MCH spending monitoring system. A recurring call was set up between OCFS grant leaders and fiscal staff to open lines of communication and provide clarification when questions and concerns arise. Contracts are monitored and invoices approved by MCH staff to assure program activities are accounted for. If a contract is determined to be a subrecipient contract the Division of Finance assists with monitoring and compliance. A monitoring guide is available to DOH staff to ensure a monitoring plan and methods for proper oversight of subrecipient entities is in place. The guide also includes tools and suggestions that could be included in the monitoring process.

Securing and monitoring of match is the primary responsibility of the MCH Director but is heavily monitored by the DOH fiscal office. Finance staff refresh expenditure data monthly and publish to program managers as well as an annual report to our federal HRSA partners.

Opportunities:

The infrastructure of an electronic health record platform is now operational and is being utilized by the community health offices. The platform has been expanded to include a comprehensive billing platform for services provided in field offices such as immunizations, fluoride varnish application, developmental screening and maternal depression screening in the last quarter of FY21. The expanded platform also provides data that will inform strategy development and program improvement measures.

In FY21 the OCFS finalized a plan to monitor outcomes and financial measures around service delivery, utilizing data and recommendations gathered during a detailed service assessment looking at expenses, revenue and return of investment of services provided in counties across the state.

Challenges:

South Dakota law prohibits deficit spending of general funds, so the Governor and state legislature control the spending of general funds that in turn affect dollars that are available for MCH block grant match.

III.D.2. Budget

MCH block grant funds have historically been used to address priorities outlined in the needs assessment and strategic action plans for the MCH population. The comprehensive needs assessment process assists the DOH in setting priorities for resource allocation. The amount of funding allocated to MCH services is determined as part of the state budget process that includes development of the budget by DOH; interim approval by the Bureau of Finance and Management (BFM) and Governor's Office; and final approval by the State Legislature.

The budget outlines areas for which Title V funds will be allocated. Development of the budget complies with the "30-30" requirement for primary and preventive care and special health care needs for children and adolescents and is consistent with the requirements to limit administrative costs to no more than ten percent. The DOH maintains the overall level of funds for MCH at the level established in FFY 1989 and monitors funding allocations quarterly to ensure compliance. Pre-Covid 19 pandemic, the DOH regularly spent more than the federal allocation but it was difficult to reflect this due to the overlapping periods of obligation under the previous fiscal year and the spending of funds in the current fiscal year. The Covid pandemic created challenges with setting a budget and anticipating expenditures due to additional funding coming into the state and uncertainty of how much staff time would be deferred to preventing the spread of Covid through contact tracing and other activities. A decrease in MCH spending was expected during this time. The FY22 budget was set with the anticipation that MCH staff could return to full capacity early into the fiscal year, however, Covid prevention efforts continued into early 2022.

Appropriation of general funds for MCH state match is at the discretion of the Legislature, Governor's Office, and DOH. State match funding sources are state funds (including general funds appropriated by the Legislature), local match, program income, and other sources. The level of funds utilized from each match source varies from year to year based on availability of funds and the state's allocation process. Increasing inflationary costs have depleted revenue reserves within the DOH and the state requiring a shift in match fund sources.

Budget development is subject to rules and requirements set by BFM dictating both the process and content of the budget, including availability of funds and limitations on authorization levels. SD continues to refine the budget development and expenditure process to meet both state and federal rules and requirements. The DOH continues to move toward accounting programs that more easily reflect population group and pyramid level reporting requirements.

In addition to state general funds, MCH federal funds are also supported by matching funds from partners and other income from fees collected on birth certificates and services provided in local Community Health Offices. Federal funds from Family Planning, PREP, Sexual Risk Avoidance Education (SRAE), Home Visiting (MIECHV), Pregnancy Risk Assessment Monitoring System (PRAMS), State Systems Development Initiative (SSDI), Universal Newborn Hearing, and WIC complement MCH federal and non-federal funds and enable the state to address its priority needs and provide a greater reach to all populations served by MCH.

Proposed budget for FY2024 reflects:

- A shift to a more sustainable case management-based model in community health offices through review of the operations and implementation of services in local communities. WIC services will move under the WIC program, separate from community health services, creating greater capacity for community health staff to expand MCH services in their local communities.
- Renewed efforts to comfortably spend our federal allocation within the designated spending period. MCH staff have returned to full capacity following the Covid pandemic. Workforce recruitment and retainment efforts, including improved orientation processes and training and educational opportunities will also help

meet our federal year's allocation. The MCH program is committed to enhancing services and programs through new initiatives, as well as supporting our partners that serve the MCH population.

- The budget also reflects the 2025 needs assessment planning, implementation, and analysis beginning in 2023. A public health consultant has been contracted to guide the process and needs assessment efforts will be enhanced with preemptive community and family engagement training sessions for MCH staff.

A large portion of our funding supports workforce infrastructure and capacity to deliver services. Without the Title V Block Grant dollars, services to our MCH population would need to be provided at a reduced capacity, either reaching fewer people or conducting fewer program activities. In addition, our capacity to communicate and work with our existing MCH partners would be greatly affected. Although our state is able to leverage funding from other sources, the loss of MCH funding would result in a change of priorities to meet program requirements.

For the FY24 budgeted amounts, our agency used FY23 budgeted amounts and based it more on the federal allocation. The expenditures for FY20, FY21, and FY22 were not typical due to COVID response and the availability of COVID funding. We felt budgeting based on expenditures from any of those years would not provide the most accurate budgeted amount.

III.E. Five-Year State Action Plan

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

State: South Dakota

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

The South Dakota Department of Health (DOH) is the lead agency for the Title V Maternal and Child Health (MCH) Block Grant. The DOH is an executive-level department with the Secretary of Health appointed by and reporting to the Governor. South Dakota Codified Law (SDCL) 34-1-21 designates the DOH as the sole state agency to receive, administer, and distribute federal Title V monies. The DOH is organized into four divisions – Licensure and Accreditation, Health Care Access, Family and Community Health, and Finance and Operations.

The Division of Family and Community Health is the service delivery arm of the DOH. It administers programs and provides direct health care services such as community health nursing, MCH programs, nutrition programs, infectious disease control, and chronic disease prevention/health promotion activities. Within this division, the Office of Child and Family Services (OCFS) coordinates programs and services that serve infants, young children, adolescents and pregnant and postpartum women. These programs and services are delivered by DOH staff working in a network of 74 sites across the state. Programs and services that directly relate to MCH populations are listed below. The programs with an asterisk are partially or fully funded by MCH. The other programs are programs Title V coordinates within the OCFS to enhance program delivery.

Programs for Infants & Young Children

- Newborn Metabolic Screening*
- Newborn Hearing Screening*
- WIC
- Bright Start/Nurse Family Partnership Home Visiting Program
- State-wide Child Death Review*
- Cribs for Kids Program*-
- For Baby's Sake – information and resources to help women have healthy pregnancies and healthy babies*

Programs for Children & Adolescents

- Rape Prevention Education
- Abstinence Education/Sexual Risk Avoidance Education
- Personal Responsibility Education Program
- Children and Youth with Special Health Care Needs*
- Family Planning*

Programs for Pregnant & Postpartum Women

- WIC
- Breastfeeding Peer Counseling
- Family Planning*
- Maternal Mortality Review
- Pregnancy Care Program (formerly Baby Care)– modified case management for high risk pregnant women*
- Bright Start/Nurse Family Partnership Home Visiting Program

While the OCFS has a huge service delivery and outreach presence, it is just one piece of the efforts to serve the maternal and child populations. It is partnerships with other Divisions within DOH, other state agencies, and local

entities that supplement capacity to meet the needs of our MCH population. This is accomplished through both formal (MOUs and contracts) and informal (committee/council memberships) collaboration efforts and partnerships. MCH domain leaders, funded through Title V, serve as the backbone for collaboration with interagency partners and with external community-based or research organizations. Each domain leader prioritizes strategies that are informed by data and addresses health inequities through collective impact. Each of the domain workgroups were evaluated using the Wilder Collaboration Index in 2021.

To ensure fidelity to the health equity model and life course theory, MCH domain leaders will build multi-sector partnerships and workgroups to address the priority needs of the MCH population. Through this collaboration the State Action Plans have been developed and external partners will continue to be instrumental in implementation. The MCH program has also implemented policy to systemically embed the principles of the Joint Policy Statement on Family Engagement within the objectives of maternal and child health systems and programs.

The Life Course Theory and Health Equity Model shaped the needs assessment process and planning. During that process it became clear that to diagnose health disparities and begin to address health inequities, there is a need for focused data systems building and reporting. Systems building requires sustained efforts, and intentional culturally appropriate outreach. The MCH domain leaders will engage with the MCH epidemiologist, who leads SPM 3, to ensure data needs are communicated. Challenges may arise with interagency data sharing, data privacy concerns and data coordination with Indigenous nations.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

The South Dakota Department of Health (DOH) released its 2020-2025 Strategic Plan in January of 2020. The plan is reviewed and updated regularly and provides a road map for the future to guide staff working together to achieve meaningful outcomes. Goal 5 of the Strategic Plan, *strengthen and support a qualified workforce*, was developed to address the workforce needs of the Department. The goal has four objectives:

1. Develop an internal recruitment plan to attract qualified applicants to Department of Health positions.

2. Develop a retention plan to maintain a qualified and diverse Department of Health workforce.
3. Enhance training opportunities for Department of Health employees.

4. Increase healthcare workforce recruitment and retention in South Dakota.

Each objective has activities and performance indicators listed to monitor progress toward the goal.

In October 2019, the DOH began to explore accreditation through the Public Health Accreditation Board (PHAB). Domain teams were established to review accreditation requirements and identify gaps and weaknesses. The Department is now focusing on operationalizing the quality improvement and performance management program and has recently taken steps to create a new Health Improvement Coalition that will guide the department in establishing the health improvement plan. Becoming PHAB accredited will strengthen the department to better serve South Dakota communities through continuous quality improvement, multi-sector partnerships, accountability to external stakeholders, workforce enhancement, utilization of resources, and focus on community health.

The Division of Family and Community Health is the service delivery arm of the DOH and administers MCH services and programs within the Title V Block Grant. The Office of Child and Family Services (OCFS) provides leadership and technical assistance to assure health, public health, and social systems are promoting the health and well-being of women of reproductive age, infants, children, and youth, including those with special health care needs and their families. MCH domain leads provide training and ongoing technical assistance to DOH field staff as well as private healthcare providers who deliver MCH services and programs. In 2021, OCFS went through a reorganization of regional community health structure and teams toward a public health model through a theory of change. This reorganization offers more opportunities for advancement in the MCH dietitian and nurse professional fields and development of a core of paraprofessionals. Over the next year, the OCFS will undergo another restructure that allows public health nurses to choose whether they want to exclusively provide WIC services or Community Health Services. This change is in response to noted challenges in service delivery and staff workload. The new structure will allow staff to more effectively deliver services to the public by increasing nursing capacity to expand services and opportunities.

Over the next year, MCH domain leaders will utilize the TRAIN platform to systematize training and offer guidance around quality improvement and assurance for new community health staff. The MCH Title V program also began a restructure in 2021 to add additional staff so each domain has a unique domain lead. This change allows domain leads to focus on one domain area, improving their capacity for program development and networking. Title V staffing capacity is currently under review and additional changes may be implemented over the next year.

MCH domain leads have built off the training provided through the National Center for Education in MCH on evidenced-based practice when developing strategies relevant to the delivery of MCH services. The MCH and other OCFS administrative staff have participated in health equity and family engagement skills building sessions over the past few years. In 2022, they attended trainings through Wilder Research and a local public health consultant to support the ongoing community health offices transition. The former MCH Director and the CYSHCN Director completed the Building Expertise in Administration and Management, BEAM, training in summer of 2021.

The MCH team works closely with field staff on data collection for federal and state reports and program evaluation. These efforts were initially enhanced through SPM 2 and will continue to be enhanced through SPM 3 Percent of data equity principles implemented in South Dakota MCH projects, which replaced SPM 2 in late 2021 and exposes a need for data interpretation training and peer learning with MCH domain leads and field staff. In 2021 the MCH and OCFS epis took a Tableau training to gain the skills needed to create data dashboards to enhance data sharing capacity. This training has led to the development of the MCH data dashboard utilized by OCFS staff for guidance and assessment.

MCH workforce development includes internal training/staff development opportunities. Staff orientation modules have been developed to assist new hires in acclimating to the OCFS infrastructure and program delivery. Formal needs assessments are conducted every other year to assist in identifying training needs of all OCFS staff. In addition, as a part of our performance appraisal system there is a section devoted to continuous learning and development. Staff are to identify at least one behavior or performance expectation to develop over the coming year and define how progress will be evaluated. In addition, the state's Bureau of Human Resources provides a wide selection of trainings and team building courses that staff can opt to attend either in person or online throughout the year.

Another operational change within the DOH was the development of a Strategic Orientation workgroup which has representation from each division of the department. This workgroup has developed an onboarding manual to bring new employees into the organization in a well-planned and organized manner. This process also includes assigning a guide to the new employee to facilitate communication, motivation, performance, and serve as a role model. In 2019, the first New Employee Orientation Day in Pierre was held for all employees starting within the last year. New Employee Orientation Day is now held biannually, so employees will attend within six months of their start date.

To develop the MCH workforce through virtual platforms, the MCH domain leaders, OCFS field staff, family leaders, and external partners will utilize the TRAIN SD learning management system (LMS) acquired by the DOH. TRAIN is meant to house, provide, and track training with the capability of building training plans to keep track of the users' progress. The platform will be open to the public; however, courses can be set up to be viewed by anyone or by a select group such as DOH staff only. In 2023, mandatory trainings were implemented for all DOH staff in the train platform. The first mandatory training covered emergency operations.

Programming throughout the DOH is supported through an initiative to improve cultural competency. A Cultural Competency Workgroup and the resulting Action Plan was developed to address needs identified by DOH staff. Various trainings were offered to DOH staff, with topics including Mental Health First Aid and Hispanic cultural awareness. Native American Cultural Awareness training was incorporated into new employee orientation. An assessment of cultural representation on DOH advisory boards and coalitions was presented to MCH programs staff. This assessment also included recommendations for improvement, as well as resources for further education. Over the past year, this workgroup has been working on updating the DOH Cultural Competency Action Plan.

Additional strategies to assist in staff retention and recruitment include:

- Department-wide engagement survey – all employees of the DOH were asked to take part in a confidential survey to assist in strengthening the infrastructure of the Department. The survey looked at engagement level, satisfaction with workplace, and opportunities for improvement. Results were shared to assist in enhancing the work experience.
- The OCFS surveys staff when issues/challenges arise to gain staff input and perceptions.
- The Bureau of Human Resources surveys new employees and those leaving their positions – to identify ways to improve our processes and employee retention.
- Allowing alternate work schedules and alternate work locations (may work in locations other than the state office in Pierre) for central office positions. In 2023, remote work privileges were expanded to allow more staff

an opportunity for remote work and allowed for staff to take advantage of an alternate work schedule in combination with remote work.

- Differential pay is offered for hard to staff tribal or frontier positions.

III.E.2.b.ii. Family Partnership

South Dakota's MCH family engagement strategy is to implement programs that partner with families, engage families as programmatic drivers, employ positive, two-way communication strategies, and make efforts to reflect the culture, values and preferences of families. Family engagement strategies form the basis of partnerships that serve the needs of children, improve quality of care, and support family well-being. This is a process that takes on many different shapes and forms and is always evolving to better include all aspects of true family partnership.

The OCFS and the MCH program are committed to implementing meaningful family engagement at an office-wide level. In 2018 the OCFS enlisted the assistance of a consultant to hold a Family Engagement Strategic Planning meeting with staff to identify strengths, weaknesses and opportunities and threats (SWOT) across OCFS programs. In addition to the SWOT activities and planning, a definition for OCFS Family Engagement was also developed - *Accomplishing Change Together (ACT) through partnerships, relationship building, family voices, with integrity and respect.* In 2022, work began to draft a family engagement policy to guide MCH planning and programming. The new policy is adapted from the Joint Policy Statement on Family Engagement and was implemented in late 2022.

The needs assessment brought to light the need for more engagement with external partners (outside state government), including those impacted by the programs and strategies that each workgroup will develop and implement. To build and continue to develop community-based partners and family leaders, the OCFS has developed a broad strategy for engagement leveraging our 74 community health offices. The OCFS completed an office-wide services assessment in 2021 that resulted in change in regional and leadership structure meant to facilitate this approach to outreach and engagement. In 2023, a decision was made to improve on the recent restructure by separating WIC services from Community Health and moving WIC nurses under WIC leadership, as opposed to Community Health Leadership. This change will expand the capacity of WIC and Community Health nurses to focus in on their communities and expand their outreach potential to community-based and family leaders.

This strategy also relies on training for OCFS personnel to develop and sustain partnerships at the local, region and state level. This strategy includes three objectives: 1) develop regional innovation labs for community and family engagement; 2) OCFS leadership will identify and begin to develop partnerships with statewide/national providers, community and family centered groups; and 3) support MCH domain leaders to create workgroups to guide the priorities identified in the needs assessment.

Family and community engagement is a structural support listed in the new OCFS re-organization and will remain in place with the 2023 restructure. The support will be at the program administrative level and the regional level. Training began with program administrative staff and regional leadership in late 2021. MCH domain leaders have utilized and implemented the health equity and family engagement virtual skills trainings through the MCH Workforce Development Center, to focus efforts to engage diverse sectors and individuals with lived experience as workgroup members. The workgroups were evaluated at the end of 2021 using the Wilder Collaboration Index.

The OCFS strategy for engagement includes several specified activities, outlined below.

Communication and Outreach

- Assess communication preferences of OCFS clients within the 74 community health offices and with community and state partners.
- Support OCFS regional managers' time to build community and family engagement collaboratives.
- Continue to develop online communities through the Cor Health (adolescents), For Baby's Sake (women and infants) web and social media channels and the development of the new MCH website.
- Identify and better understand the needs of English as a second language or non-English speakers in South Dakota.
- Expand the use of telehealth services within Community Health Offices

Develop Community and Family Leaders

- MCH training offered to regional managers and MCH domain leads on Collective Impact as a model for community collaboration.
- Develop a statewide network, relying on family centered, patient or provider organizations to develop family leaders.
- Utilize the TRAIN platform, which allows training to be video recorded and disseminated, to OCFS regional managers and staff, community partners and family leaders.
- Support and learn from the development of the Youth Council, which is a main strategy within the Child/Adolescent domain.
- Support and learn from the Newborn Screening Advisory Council
- Learn from the breastfeeding peer counselors' model – WIC breastfeeding peer counselors provide a valuable service to their communities, addressing the barriers to breastfeeding by offering breastfeeding education, support, and role modeling. The WIC program identifies mothers who were previous breastfeeding WIC participants to fill these paid positions.

Program Development, Improvement and Evaluation

Family input is acknowledged and used to inform program planning and policies through opportunities for regular feedback. This regular feedback will enhance the programmatic continuous quality improvement and program evaluation and evolution to meet community and state needs.

- Development of the infant safe sleep survey
- PRAMS guides much of our work and is an opportunity to hear from SD mothers.
- Expand the WIC annual survey to include not just WIC services but MCH services as well. These surveys are completed for statewide, regional and clinic information and are incorporated in the clinic nutrition and marketing plans as goals and objectives for overall improvement to the program.
- The Sanford Patient Navigation Program for CYSHCN relies on surveys and feedback from participants to develop and tailor the services provided to families
- The Newborn Screening program relies on input from the Newborn Screening Advisory Committee comprised of professionals, families, and advocates to steer the program.
- Public comment and direct solicitation of external reviewers of the MCH Block Grant

Training and Professional Development

- Each year there will be opportunities for gathering ideas and strategies for statewide family engagement implementation within the OCFS. Every other year the OCFS will hold an All-Staff Conference to train field staff on various topics including family engagement. The OCFS is considering holding the first post-Covid all staff conference in 2024.
- Renewed focus on orientation and onboarding new employees, cultural competency, and health equity.
- MCH staff serve on multiple state and national advisory panels, councils, and workgroups that bring together family/consumer partners. This includes but is not limited to the advisory group for the HRSA Hearing Screening grant, early intervention State Interagency Coordinating Council, Developmental Disabilities Council, State Community of Practice team for Intellectual Disabilities, Department of Human Services Developmental Disabilities Stakeholder Collective, South Dakota Youth Suicide Prevention Advisory Committee, Oral Health Coalition, Bright Start Home Visiting Community Advisory Boards, Community Based Child Abuse Prevention Board, and the USD Center for the Prevention of Child Maltreatment Advisory

Committee. These groups while each having their own focus all include families that provide insight and direction to inform decision making at all levels. This assists in ensuring our services are targeted to best meet consumer needs.

- In 2022, MCH domain leads participated in the Wilder Research Collaborating Across Differences training. In 2023, MCH domain leads, Bright Start Home Visiting leadership, and Family Planning leadership participated in community engagement training provided by a local public health consultant and family engagement training provided by the state's Early Childhood Comprehensive Systems project lead.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

Name/credentials	Title/organization	Funding	Roles/responsibilities
Fabricia Latterell, MPH, RN	MCH Epidemiologist SDDOH	SSDI, PRAMS, WIC	Analyst for MCH data including infant birth, infant and maternal mortality, FAD data, and WIC data.
Isaac Snaza, MPH	OCFS Epidemiologist, Black Hills Special Services Cooperative	COVID-19 Enhancing Detection ELC grant	Epidemiologist for MCH data, including child death review data and FAD data
Jennifer Kerkvliet, MA, LPC	Director, SDSU Population Health Evaluation Center	PRAMS, MCH	Project director
Beth Wahlstrom, M. ED	Evaluation Specialist, SDSU Population Health Evaluation Center	MCH, RPE, SRAE, PREP	Evaluation specialist for MCH programs
Caleb VanWagoner	Health Informatics Analyst Black Hills Special Services Cooperative	COVID-19 Enhancing Detection ELC grant	Analyst electronic health record data
Allison E. Waugh (Eaton)	Bright Start Epidemiologist		Analyst for Bright Start Home Visiting Program and the Pregnancy Care Program

South Dakota Department of Health (DOH) supports one FTE for epidemiology, Fabricia Latterell, Maternal Child Health Epidemiologist. Fabricia has a Master of Public Health degree and works on data across the Office of Child and Family Services including infant and maternal mortality data, MCH FAD data, WIC data, and other MCH program related data needs. She also works with SD PRAMS to translate data into action. She co-leads and serves as the analyst for the South Dakota Maternal Mortality Review Committee.

The DOH also contracts with several individuals to increase epidemiology capacity. The names, titles, roles, and responsibilities and associated funding sources are all listed in the table above. The contracted staff work in the areas of infant death and child death review analysis, PRAMS data analysis and project management, evaluation, and other MCH data analysis needs.

In June 2022, the DOH hired a Bright Start Epidemiologist to work with home visiting data and pregnancy care program data from the OCFS electronic health record. The SD Legislature recently funded statewide expansion of Bright Start home visiting, which brought the opportunity to hire full-time staff in this role. This position will be funded with a combination of HRSA MIECHV, Medicaid, and TANF. This additional data support will give the MCH team

another piece of data around maternal and infant outcomes in South Dakota. The Bright Start Epidemiologist will be attending the Beginner/Intermediate CityMatch MCH Epidemiology course in June 2023.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The State Systems Development Initiative (SSDI) Grant Program provides South Dakota with a platform and resources to strengthen the development and expansion of data capacity for performance measure reporting in the state's Title V Program. With the support of SSDI, the state conducts targeted activities to meet the greatest collective needs based on the MCH Needs Assessment to implement evidence-based approaches. The SSDI and Title V Programs conduct ongoing checks throughout the grant cycles to ensure progress is being made and new challenges and gaps are identified and addressed.

The SSDI Grant Program supports a full time MCH Epidemiologist (epi) who establishes and maintains routine communication with the SSDI project team, Office of Child and Family Services (OCFS) managers and program managers, and contractors. This is accomplished by: 1) data sharing at quarterly MCH Team meetings and monthly OCFS manager meetings and; 2) sharing data and epidemiology updates at monthly Division of Family and Community Health Administrator's meetings by the Office of Health Statistics and the epidemiology staff within the division and; 3) data sharing through agreements with the DOH Office of Vital Records to review maternal and child deaths in the state. The epidemiologist also oversees the MCH cross-cutting domain focused on data sharing and collaboration. In 2021 additional epidemiologists were contracted for OCFS. These epis focus on Child Death Review data, data analysis, program evaluation, and additional MCH data projects.

The MCH team has been trained on implementing evidence-based strategies and measures to continuously evaluate the progress being made toward each domain's objectives through activities outlined in the action plans. The MCH epidemiologist checks in regularly with MCH domain leaders to assess progress toward objectives and evidence-based strategy measures. The MCH epi has also contributed to the development of an Electronic Health Record (EHR) system that was implemented office-wide in OCFS in January 2022. The EHR will provide a new opportunity for the MCH team to analyze data from programs and services and evaluate the impact of these services on health outcomes.

Other methods of evaluation include MCH staff utilizing infant mortality data from vital statistics, PRAMS, and infant death review to evaluate programs focused on safe sleep. In 2020 infant death review expanded to include all child deaths up to age 13 and was renamed to Child Death Review (CDR). This data will eventually be used to determine leading causes of natural and accidental deaths and evaluate programs and education focused on injury prevention. The CDR team has also begun looking at life stressors and social determinants of health which may have been a factor in some deaths. Another recent development is the DOH's addition of a maternal mortality case abstractor in 2021 and the establishment of a maternal mortality review committee to review maternal deaths in the state as well. In 2023 this role will transition to a Prevention Services Coordinator and will oversee both maternal and child death reviews.

The SSDI Grant Program has supported several projects, products, and resource materials that support State Title V program efforts in addressing its MCH priority needs. In 2021, the MCH and OCFS epis took a Tableau training on creating data dashboards. As a result of this training, an infant mortality dashboard was created for the SD DOH website https://doh.sd.gov/statistics/infant-mortality. The MCH epi also hosted a summer intern that focused on creating a plan for officewide data reporting and visualization that includes overarching MCH outcomes and program specific data. The intern laid the groundwork for the MCH epi and WIC data specialist to begin building an internal data dashboard for staff to use. In 2022, the MCH Epidemiologist and WIC data specialist finalized the MCH data dashboard and posted it to the internal knowledge base site for Office of Child and Family Services (OCFS) staff use.

SSDI has also supported several data presentations and reports. In 2022, this included 2020 PRAMS data reports,

newsletters and listservs sharing MCH Child Health data, and infant and child health data presented at an MCH Child workgroup meeting, Preventable Death Committee, Safe Sleep Workgroup, East River Child Death Review, and West River Child Death Review. The 2016-2020 Infant Mortality and Prevention Report was released and shared with partners through a variety of methods. Additional projects include the creation of a spreadsheet to track the life course social determinants of health factors identified during CDR and Maternal Mortality Review and development of a socio spatial tool to further gain information about the possible contribution of locations lived to women's deaths. The epidemiologists have also joined Tribal calls between the American Indian Tribes and the Department of Health to discuss rising infant mortality rates in South Dakota. Detailed descriptions of these publications and presentations can be found in the SPM 3 annual report.

The MCH Epidemiologist, along with a contracted consultant with expertise in needs assessment and health equity, lead the MCH Five Year Needs Assessment. They created a steering committee that met regularly to provide guidance and support on data collection related to MCH domains and indicators needed for home visiting. Data collection related to needs assessment planning and implementation included domain specific data briefs, adolescent and community-based surveys, and family centered focus groups.

A cross-cutting domain focused on data sharing and collaboration was created from the Five-Year Needs Assessment. This domain is led by the MCH Epidemiologist and has a dedicated workgroup comprised of epidemiologists from DOH, Great Plains Tribal Leaders Health Board, Missouri Breaks Research, SDSU, USD, and Medicaid. This workgroup is focused on providing access to timely, reliable data, developing reports that highlight health inequities in SD, analyzing data to assess social determinants of health and other underlying factors that play a role in morbidity and mortality, and increasing collaboration around American Indian data between state and tribal partners.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

The Maternal Child health (MCH) Epidemiologist works closely with South Dakota Department of Health (DOH) data staff including the Vital Records State Registrar, injury epidemiologist, the Health Statistics Administrator, chronic disease epidemiologist, and the state epidemiologist. This allows the MCH program timely access to data and opportunities to collaborate on data projects. Infant, child, and maternal death reviews are also housed within the Maternal and Child Health program section of the Office of Child and Family Services (OCFS). Data and recommendations produced from these review committees are shared with MCH partners and implemented into MCH programs and other programs across OCFS.

One of the current MCH/Title V state performance measures is equity in data sharing and collaboration. The MCH epidemiologist leads this workgroup and has other epidemiologists from DOH and other organizations across the state including Great Plains Tribal Leaders Health Board, Missouri Breaks Research, South Dakota State University, the University of South Dakota, and Medicaid. This has resulted in more diverse voices in the creation of MCH data projects and dissemination of this data. The group has centered on six guiding principles of equity in data sharing, created a tool with these principles, and is using the tool to improve data sharing and collaboration across their organizations.

The CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) was implemented in South Dakota in 2017 and has played a significant role in expanding MCH data capacity. PRAMS has become the main source for maternal and infant health indicators. It has been shared widely through various reports, data briefs, presentations, newsletters, and publications. The data from PRAMS helped inform the 2020 MCH Needs Assessment and priority setting process. PRAMS supplemental questions about maternal opioid use have been shared with many MCH partners and organizations. The PRAMS COVID-19 supplement provided valuable data around maternal attitudes and experiences during the COVID-19 pandemic. This grant also has a multi-disciplinary steering committee that guides data dissemination and ideas for data-to-action activities.

The MCH Epidemiologist also collaborates closely with the Women, Infants, and Children (WIC) program staff, including the WIC Data Specialist. The OCFS data team created an office-wide action plan, the strategic community outreach and outcomes plan (SCOOP), that includes the implementation of both WIC and MCH goals through the community health offices. This will help officewide programs work together on shared outcomes such as breastfeeding, obesity, nutrition, outreach, and infant mortality. The plan created regional goals, evidence-based strategies, community-level activities, and outreach. MCH staff served as content experts and helped clinic staff align their work with existing MCH priorities. The WIC Data Specialist and MCH Epidemiologist also look at Pediatric Nutrition Surveillance System (PedNSS) and Pregnancy Nutrition Surveillance System (PNSS) data for child and maternal health indicators that could support program efforts.

The MCH Epidemiologist frequently builds MCH data capacity with Master of Public Health (MPH) students. Over the past year, the MCH Epidemiologist had an MPH student creating a women's health data report card and another student working on quantitative and qualitative analysis of the data from the first year of Maternal Mortality Review. South Dakota also hired a contracted epidemiologist to work with the MCH Epidemiologist on projects across OCFS. The epidemiologist assisted with SCOOP, creating an evidence-based strategy library for the goal areas of breastfeeding, nutrition, outreach, and infant mortality. The epidemiologist has also taken over data for the child death review and is working to move data and recommendations to prevention. The epidemiologist also assists with FAD data and reporting for the block grant.
In September 2021, OCFS hired a health informatics analyst. This person's primary duty is to manage the data reporting and analysis coming for the new electronic health record which launched in January 2022. The electronic

health record captures data on many MCH funded or related services such as immunizations, Ages and Stages Questionnaires, pregnancy care, and home visiting.

A consistent challenge with MCH data capacity is having enough staff to meet all the data needs. Hiring the additional epidemiologist has been helpful, but as MCH grows through new partnerships, programs, and grants, there is always a need to find staff who can analyze and present MCH data, along with supporting and evaluating MCH activities.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

The mission of the South Dakota Department of Health (DOH) Office of Public Health Preparedness and Response (OPHPR) is to develop and maintain the relationships, infrastructure, and expertise necessary to prepare for and respond to public health emergencies. The OPHPR has developed an Emergency Operations Framework to support preparedness, response and recovery operations involving multiple agencies, partners, plans, and procedures. This framework allows OPHPR to follow the mission of developing and maintaining the relationships, infrastructure, and expertise necessary to prepare for and respond to public health emergencies.

The South Dakota Emergency Operations Framework (SDEOF) is an organization of written plans and procedures used to activate, coordinate, manage, sustain, and demobilize public health emergency operations throughout all phases of an emergency. The SDEOF functions as an overarching document that brings together several functioning plans used in preparedness and response activities throughout South Dakota.

The SDEOF will function as a framework amongst emergency plans managed and maintained within and outside of the DOH. The plans are maintained separately, but OPHPR is involved in the process for updating these plans as well as this framework. One of these plans is the DOH Continuity of Operations Plan (COOP). In late 2021, the DOH created a committee to take a fresh look at the agency's COOP. The OCFS business operations coordinator, who has a strong background in military emergency response, represents the OCFS on this committee and was tasked with creating a more detailed plan for the role OCFS staff will play in keeping essential services going in the event of an emergency. This plan has been completed and focus will now shift toward making an OCFS specific COOP that drills down to each element of OFCS including Community Health, WIC, and MCH. This focus will begin in mid to late August 2023.

Another plan is the use of Points of Dispensing (POD)s. PODs can be activated in response to a disaster event and set up to distribute medicine, vaccine, and medical supplies. Disaster events could include bioterrorism, pandemic, disease outbreaks, or natural disasters. The stockpile is designed to protect the public if there is a public health emergency severe enough to cause local supplies to run out. South Dakota has designated 32 Points of Dispensing (POD)s in 28 communities geographically dispersed to provide reasonable access to a POD. Additional locations may be utilized depending on need. Specific location information would be shared in communications about the event. In the event a POD is activated, the OCFS would send appropriate staff to administer supplies and services.

The former OCFS Administrator was involved in emergency operations planning within the Department of Health and was Community Mitigation Lead within the incident command team tasked with community outreach, business support, engagement and school monitoring during the COVID-19 pandemic. The Department of Health emergency operations planning team is working to create and update the DOH Emergency Operations Plan (EOP) that fits within the larger Emergency Operations Framework and is planning an EOP functional exercise for a date in late July or early August 2023. During this exercise, four site Emergency Operations Centers will be created in response to a mock inclement weather situation.

Department of Health Office of Child and Family Services (OCFS) staff provide direct services to MCH populations statewide. All OCFS field staff are trained to do the same programs regardless of home station in the event DOH sends staff from any area of the state if there is a localized emergency/need. All OCFS nursing staff is trained in incident command system. Records are retained in hardcopy in the local offices and on electronic systems. In 2022, the OCFS local offices transitioned to an electronic health record system which streamlines this process even more. MCH populations can be contacted via social media on our virtual communities, For Baby's Sake and Cor Health and Wellbeing, websites, and texting services.

OCFS nurses are supported through funding from the OPHPR to participate in local emergency preparedness planning. OCFS nurses filled key positions in incident command system structure during points of dispensing exercises, serving as medical screeners, vaccinators, and post vaccine observers. OCFS also partners with the Department of Health Immunization Program to market vaccines and focus on vaccines and awareness on routine childhood vaccinations. During the first few months of COVID pandemic, OCFS nurses reached out by phone to all community health clients offering information and checking to see how they were doing. Innovative strategies such as drive-up outdoor vaccination appointments were implemented to facilitate in-person services.

When the 2022 formula shortage began, the WIC program took the lead and created an emergency channel in Microsoft Teams to communicate updates to all OCFS staff including Title V. The Title V team was also added to monthly WIC calls to receive updates to respond to inquiries from the public with the most current information. The emergency channel will remain in place as a communication tool for future public health emergencies that impact the MCH population.

The MCH data team was awarded a PRAMS COVID supplement to build data infrastructure into PRAMS to analyze COVID impacts. The MCH data team also has identified a need for more “real time” data plans during an emergency in order to respond appropriately.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

In the last year the MCH team has focused on strengthening partnerships with multi-sector organizations and entities to identify innovative models of care and to analyze systems of care for effectiveness and efficiency. In this capacity, the MCH team has leveraged the MCH block grant to serve as healthcare delivery pilot projects, worked with Medicaid to build sustainable systems of care, and evaluated and aligned goals and objectives of publicly funded, privately executed programs and services.

Children and Youth with Special Healthcare Needs domain has focused its efforts on the public-private partnership with the Sanford Children's Specialty Clinic. This partnership has positive outcomes for providers, patients and the healthcare delivery system. This project is currently providing data to both the health system and to payors, including Medicaid. Utilizing an evidence informed model, the MCH block grant funding has supported this successful pilot program and we are hopeful that it will become permanent.

In the last year, the MCH program has partnered more intentionally with the University of South Dakota's Center for the Prevention of Child Maltreatment (CPCM). Substantial support from the Title V Director and the MIECHV Director helped to secure funding through the HRSA Early Childhood Comprehensive Systems. This effort also included support from Departments of Education, Social Services and Health. This funding award supports South Dakota's first attempt to align, coordinate and ultimately improve early childhood services and systems. The MCH Director and MIECHV Director have served on the SD Early Childhood Comprehensive Systems (SD-ECCS) Cross-Sector Advisory Council that was created as a result of this effort. The MCH child domain has been working with the ECCS Project Lead to address goal one of the ECCS project: *Leverage the capacity of those working directly with families (such as child care providers, community health workers and home visitors) to increase reach and support to families for early childhood health, development, and well-being* through a collaboration with SD Parent Connection and the DOH Community Health Workers Program. The community health workers are delivering education and materials directly to the families they work with under the guidance of SD Parent Connection and the MCH child domain.

The MCH adolescent domain leader embarked on a broad project with South Dakota State University (SDSU) Population Health to evaluate programs and align goals, resources and services for youth. The Healthy Relationship Evaluation project coordinates evaluation efforts regarding youth Healthy Relationships of 5 programs: Rape Prevention Education, Title V Sexual Risk Avoidance Education (SRAE), State Personal Responsibility Education, General SRAE, and Title X Family Planning Program. Evaluation of these programs included examination of partnerships, assessment of efforts to implement evidence-based individuals and community change strategies, and monitoring of progress on identified activities. Activities include examining logic models, program implementation and program participant information, evaluating the long-term program goals of improving the healthy relationships of youth. The project will assess that the intended outcomes are achieved, including changes in identified risk and protective factors. Recent peer-reviewed literature and state case studies indicate many shared risk and protective factors across youth violence prevention and healthy relationship efforts. The knowledge gained from evaluating South Dakota's healthy relationship grants/initiatives in this partnership with SDSU will inform and direct our other MCH youth priority, suicide prevention.

Over the last year, the MCH Program has partnered with the DOH Office of Disease Prevention programs on several initiatives to address public health needs. In 2022, the DOH Nutrition & Physical Activity Program released the Breastfeeding-Friendly Business Grant opportunity open to all South Dakota worksites. MCH funds support the state and federal breastfeeding law by providing worksites up to $2,000 to create a new lactation space, improve an existing space, and/or implement innovative, space-saving ideas to meet staff breastfeeding needs for employees including those who work outdoors and/or who frequently travel. Awarded grantees received assistance from the SD DOH on policy development, use of the Employer Breastfeeding Accommodation Form, and resource sharing based on need/request. Ten applications were received with eight applicants being awarded. Awardees will submit a final report of successes, challenges, and overall project outcomes in 2023.

In 2022 the Department of Health, Nutrition & Physical Activity Program also released the Harvest of the Month funding opportunity in collaboration with the MCH Program to support youth programs in South Dakota to actively engage children in learning about and exposing them to fruits and vegetables utilizing Harvest of the Month educational lesson plans, recipes and supporting materials. Thirty-two applications were received from various childcare/daycare and other youth programs (i.e. Boys & Girls Club, YMCAs) with 18 applicants being awarded funds up to $1,500 to support implementation of 12 Harvest of the Month lessons including purchase of produce for sampling and preparation of recipes, small equipment/utensils, and print materials. Awardees will submit final reports to the DOH on project outcomes in 2023.

The final reports of both mini grant programs will inform the DOH of successes, challenges, and overall project

outcomes to determine the effectiveness of mini grants to seed systems change to create more breastfeeding friendly businesses and better health and nutrition promotion within programs that serve youth.

In 2022, the MCH Program partnered with the DOH Office of Disease Prevention to launch a statewide media campaign to raise awareness of the congenital syphilis outbreak in South Dakota. The campaign features radio ads, printed materials, and social media. The goal of this project is to raise awareness of the outbreak, provide prevention education, and provide resources to the public. In 2023, the DOH began plans to take the campaign one step further, and purchase STI tests for HIV and congenital syphilis to be utilized in the community health offices. This plan is in collaboration with SD Medicaid, and discussions are taking place for Medicaid to provide reimbursement for STI testing. In addition, the DOH has three mobile units in development with a July 2023 goal of completion to begin providing mobile public health services to remote communities that do not have a community health clinic. One mobile unit will be dedicated to the county with the highest STI, teen pregnancy, and infant mortality rates. The DOH Family Planning Program will provide training to all community health staff on family planning services including STI prevention.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

South Dakota State Medicaid and Children's Health Insurance Programs provide services for pregnant women, postpartum women up to 60 days, and children. The partnership and relationship with the state Title V program is strong and aligns with all federal requirements for both Medicaid and Title V.

The relationship focuses on patient and provider outreach, increased utilization of healthcare services, and coordination of innovative initiatives and programs for MCH populations. Long-standing examples of this relationship include allowable coverage and billing of modified case management for pregnant women (Pregnancy Care), ASQ and ASQ-SE administered and follow up in all state-run community health offices, application of fluoride varnish, and financial support of the Nurse Home Visiting Program. In 2022 the relationship was expanded to include data sharing between the Office of Child and Family Services and Medicaid as needed for the prevention of maternal morbidity and mortality.

The OCFS and Medicaid have also established an interagency collaborative which meets monthly. As a result of this collaboration Medicaid and Title V are working to implement a Pregnancy Health Home. During the 2023 legislative session the SD Medicaid program was appropriated funding for the implementation of the Pregnancy Health Home which would work to:

- Increase timeliness and utilization of prenatal, postpartum, and well-child visits.
- Provide and connect pregnant and postpartum women with supports that help them to be healthy and thrive.
- Improve health outcomes for pregnant women and their babies.
- Curb long-term Medicaid expenditures for newborns and in early childhood.

Providers who are enrolled in the Pregnancy Health Home will conduct a pregnancy risk assessment, assist pregnant patients to address social determinants of health (SDoH), and provide referrals and supports to access other needed services. Providers in the program will be required to make referrals to DOH programs including the Pregnancy Care Program, Home Visiting, and WIC. DOH nurses with the Pregnancy Care and Bright Start programs will be able to collaborate with medical clinics to help address areas of needs identified in the risk assessment, provide education on a variety of health topics and provide referrals and other support to address SDoH. Title V and Medicaid are working on the implementation plans in 2023 and plan for full implementation in 2024.

Beginning in July 2023 the post-partum period for Medicaid clients will be expanded from 60 days to one year. As a result of this expansion of post-partum services Title V is working with Medicaid to be able to offer up to six post-partum visits as part of the Pregnancy Care Program. Implementation of this service is anticipated for late 2023/early 2024.

In late 2021 South Dakota was selected to participate in an infant well-child visit learning collaborative affinity group conducted by the Centers for Medicare and Medicaid Services (CMS). The core state team meets several times per month and includes representation from SD Medicaid, SD WIC, MCH Program, Great Plains Tribal Chairmen's Health Board, Indian Health Services, and the Medicaid Medical consultant. The group's primary objective is to increase the rate of well child visits to 6 visits for 0-15 months for the American Indian/Alaskan Native population by 10% by December 2023.

This initiative has five goals:

- Goal 1: Educate pregnant and post-partum women about the importance of well-child visits by working with providers.

- Goal 2: Target messaging to primary care providers to encourage them to get their patients in for well visits.
- Goal 3: Explore alternative methods to email for communicating with recipients.
- Goal 4: Increase collaboration with IHS, Tribal 638, and WIC providers to encourage AIAN recipients to come in for well-child visits.
- Goal 5: Utilize claims data to track the rates of well-child visits for Medicaid beneficiaries.

This is a two-year initiative with expected completion in December 2023.

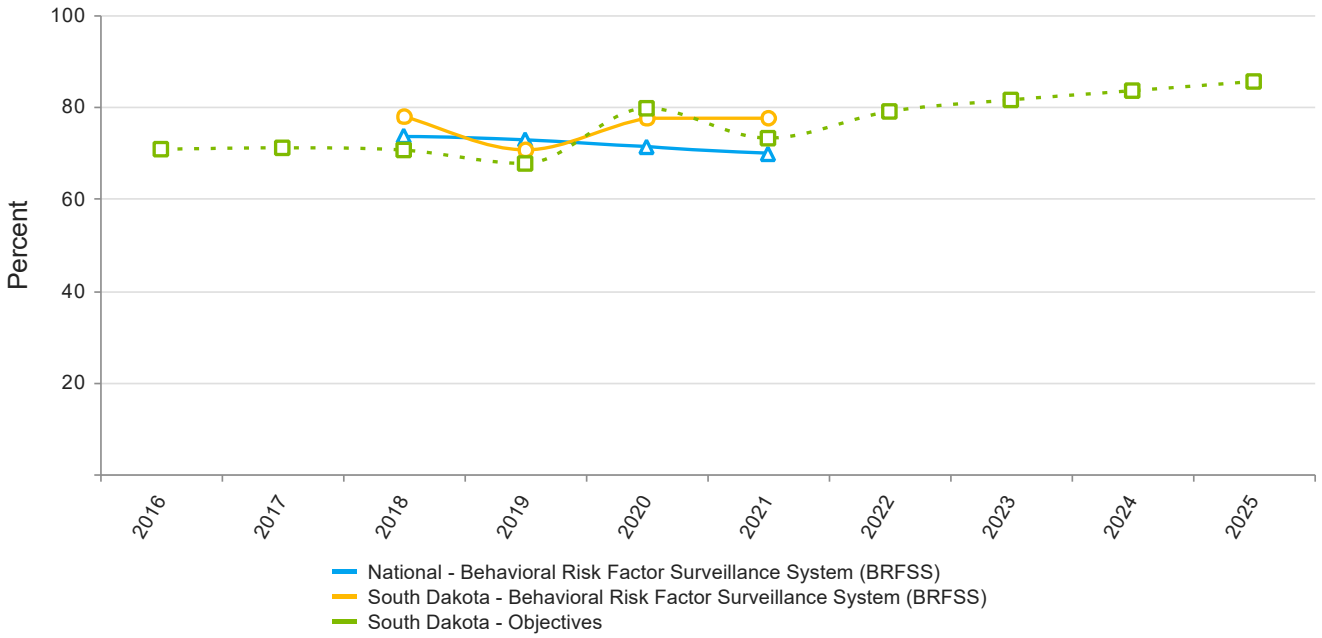
The Title V program collaborates with the SD Department of Human Services (DHS). DHS operates the state's four Medicaid waiver programs including the Family Support 360 (FS360) waiver which provides supports and services to children with intellectual or developmental disabilities. Title V contracts with the FS360 program for the implementation of a respite care program for children with brain injury, chronic illness, disability, or mental health needs. Respite care is temporary relief care designed for families of children or adults with special needs.

III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			79.6	73.1	78.9
Annual Indicator		77.6	70.4	77.3	77.4
Numerator		110,174	101,908	110,595	112,934
Denominator		141,888	144,765	143,127	145,872
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives			
	2023	2024	2025
Annual Objective	81.4	83.4	85.4

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - % of WIC clients with a positive response to Whooley questions that received a PHQ 9 screening

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			100	100
Annual Indicator			0	60.3
Numerator			0	295
Denominator			100	489
Data Source			DOH EMR	DOH EMR
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Final

ESM 1.2 - % of WIC clients whose PHQ 9 score met criteria for a referral and were referred

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			100	100
Annual Indicator			0	78.2
Numerator			0	86
Denominator			100	110
Data Source			2021	2022
Data Source Year			DOH EMR	DOH EMR
Provisional or Final ?			Provisional	Final

ESM 1.3 - # of messages posted promoting well women care

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	12	9
Numerator		
Denominator		
Data Source	SD Media Services	SD Media Services
Data Source Year	2021	2022
Provisional or Final ?	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	13.0	14.0	15.0

ESM 1.4 - % of women with positive depression screen who are referred to their PCP within OCFS field offices

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator		57.4
Numerator		109
Denominator		190
Data Source		DOH EMR
Data Source Year		2022
Provisional or Final ?		Final

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (South Dakota) - Women/Maternal Health - Entry 1	
Priority Need	
Mental Health/Substance Misuse	
NPM	
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
Increase the percent of women, ages 18 through 44, with a preventative medical visit in the past year from 77.4% (2021) to 85.4% in 2025.	
Strategies	
1.1: Develop partnerships with diverse, multisector stakeholders to promote preventative care for women of childbearing age.	
1.2: Create toolkit of resources on Maternal Mental Health/Substance Misuse and Health Equity for OCFS field offices.	
1.3: Increase depression screening and referrals to PCP among low-income women within OCFS Community Health offices.	
1.4: Develop a policy recommendation with Department of Social Services to create Maternal Medical Homes.	
ESMs	Status
ESM 1.1 - % of WIC clients with a positive response to Whooley questions that received a PHQ 9 screening	Inactive
ESM 1.2 - % of WIC clients whose PHQ 9 score met criteria for a referral and were referred	Inactive
ESM 1.3 - # of messages posted promoting well women care	Active
ESM 1.4 - % of women with positive depression screen who are referred to their PCP within OCFS field offices	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Women/Maternal Health - Annual Report

Women/Maternal Domain: Annual Report (October 1, 2021- September 2022)

Objective: Increase the proportion of women receiving a Well Women visit annually from 77.4% in 2021 to 85.4% by 2025. (BRFSS)

In 2021, South Dakota had 77.4% of women receiving a Well Women visit annually. The new 2022 annual target is 79.4%. South Dakota was ranked 2nd in the nation in 2021 and had a significantly higher percentage than the overall U.S. percentage of 69.7%.

Strategy 1.1 Develop partnerships with diverse, multisector stakeholders to promote preventative care for women of childbearing age

MCH Needs Assessment findings (2019-2020) indicated the importance of a yearly well women visit with a Primary Care Provider (PCP) as a care coordination and referral starting point for women of childbearing age. A well woman visit provides a comprehensive assessment of a women's overall health including her mental health and substance use. Preventive care is important to stop diseases or conditions before they start. Mental health screenings are a component of a well women visit and can identify women who may be suffering needlessly. Throughout this grant year Title V continued to collaborate with Title X, the SD WIC program, and Bright Start Nurse Visiting to promote a medical home and annual Well Women check-up with their clients. All three programs are located within the Office of Child and Family Services and have representatives on the National Performance Measure (NPM) #1 workgroup making collaboration easier. The Well Woman Workgroup saw expansion with new members from the South Dakota chapter of Postpartum Support International and Sanford Health, executive director of children services. Other partnerships have included the MCH lead participating on the leadership of the North/South Dakota Perinatal Quality Collaborative and the South Dakota Perinatal Association conference planning committee. Cross participation in the NPM#5 workgroup- Infant domain has fostered collaboration in efforts to promote healthy moms and improved infant outcomes. Other engagement has been in person visitation to tribal leaders in women's health throughout the state.

ESM: Number of messages posted promoting well women care

Media strategies the MCH team utilized to promote annual well women visits and well woman care included continuation of a social media campaign on *For Baby's Sake* website and *For Baby's Sake Facebook* /*Instagram* page. Social media was also expanded into other outlets including, *Snapchat,* and *Google* to improve reach. Posts related to well women and the mental health/substance misuse priorities are included on the social media metric table below. During the year we also transitioned from Hot Pink media services to an internal state-run communications team. We focused on our American Indian population in all our media content to represent our population with the most disparities. Information about well women visits (It Starts with You) and Perinatal Depression (You and Baby) can be found on the For Baby's Sake website at For Baby's Sake | Healthier moms + Healthier babies (forbabysakesd.com). Print advertising in South Dakota Medicine Journal focused on the new 988 helpline and ads related to Syphilis screening and treatment as we saw our syphilis rates markedly increase across the state. As of spring 2023, syphilis cases have increased over 1713% above the five-year median. Congenital syphilis cases are also on the rise in South Dakota, increasing 2200% over the five-year median

POST IMAGE	TITLE	TYPE	CUMULATIVE IMPRESSIONS	SWIPE UPS
	Well-Woman Checkups	Paid	252,142	2,890
	Vaccinations & Vitamins	Paid	17,677	256
	Well-Woman Checkups	Paid	11,466	188
	Preconception Health & Planning	Paid	19,910	451

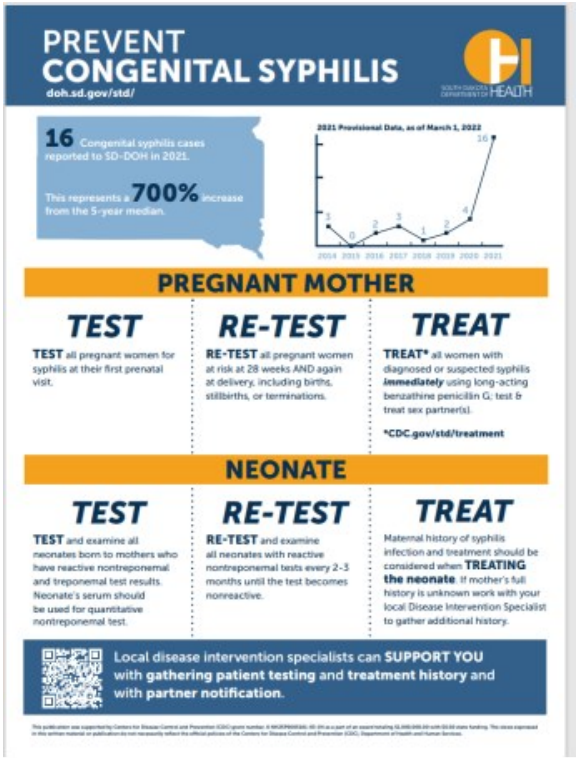
Snapchat posts

POST IMAGE	TITLE	TYPE	CUMULATIVE REACH	AVERAGE FREQUENCY
	Checkups/Well Visits	Paid	76,962	3.33
	Well-Woman Checkup	Paid	164,382	3.96
	Post-Partum Depression	Paid	89,311	2.23
	Well Woman Checkup	Paid	5,529	3.36
	Checkups/Well Visits	Paid	10,604	5.07

Facebook posts

988 Hotline

988 is more than a suicide hotline. It is for anyone in need of crisis support and can be used for those in emotional distress, including substance use crisis. If you or someone you know needs support now, call or text 988 or chat https://www.helplinecenter.org/9-8-8/



South Dakota Medicine Journal advertisement- target audience: providers

Radio advertisements

Following is an overview of the two media flights scheduled October 4 thru 29, 2021, and December 6 thru 31, 2021. The primary audience was American Indian women of childbearing age (18-34) and while the buy was essentially a statewide schedule, the emphasis was in and around reservations and counties with high American Indian populations and high need. There were over 105 spots per month running consistently throughout the month. Our placement strategy also allowed us to buy 10 stations deep (7 of the 10 stations are Native). Two 60-second American Indian voiced spots ran in rotation. The first focused on safe sleep with emphasis on putting babies to sleep on their backs, on a firm surface alone, room sharing, not bed sharing, and safe cribs. This ad pointed listeners to the website. The second ad discussed postpartum depression and encouraged listeners to reach out and to build a circle of support if they have symptoms. This spot included a call to action directing people to the Depression after Delivery Hotline and the For Baby's Sake website.

For Baby's Sake Postpartum Depression Awareness: 30 radio spots

> A new baby brings joy and happiness – right? But sometimes new moms get the baby blues. With all these changes, it's normal to feel sad or anxious. If you are having trouble getting through the day, feel overwhelmed, exhausted, or hopeless – reach out. Postpartum depression can be very serious but with support, you will get better. Call one eight hundred nine, four, four, four, seven, seven, three or visit For Baby's Sake SD today.

Strategy 1.2 Create toolkit of resources on maternal mental health/substance misuse and health equity for OCFS field offices

Training on Motivational Interviewing (MI) was done to empower field staff to adequately screen and refer women. Field staff in 74 WIC/Community Health Offices were asked to complete 4 online interactive modules provided by JBS consultants.

- MI Modules- 84.5% completion rate across SD Office of Child and Family staff (nurses, dieticians, community health workers, and ancillary staff)

WIC staff and nurse team leads from each of the 4 public health regions were brought together to complete an in- person comprehensive Train-the-Trainer program on MI. Following training, a Teams channel was set up with resources to assist trainers in ongoing education of staff.

Continuing education on substance misuse was provided to all field staff. The first topic was on Cannabis from a MI focus. National experts provided the live virtual trainings. These trainings were recorded and added to the SD-TRAIN platform for future viewing by new staff and as refreshers. Ongoing training on other substances of misuse and lived experience are planned.

The women's domain coordinator participated in the Quality Improvement Community of Learning (QICOL) sponsored by

AIM and NICHQ. This was a 9-month course that reviewed the Model for Improvement in implementing the SUD AIM bundle. The work focused on structural measures or readiness within our OCFS field offices in anticipation of our Strategic Community Outreach and Outcomes plans (SCOOP) that addressed mental health/substance use.

Throughout this grant year, needs assessment plans and metrics were made. Development of a CQI tool to measure compliance with depression screening protocol and referral process was refined.

Strategy 1.3 Increase depression screening and referrals to primary care provider (PCP) among low-income women on the SD WIC program

According to the 2021 SD PRAMS data, 19.7% of postpartum women on the WIC program reported experiencing Postpartum Depression versus 8.6% of non-WIC mothers.

Beginning in October 2021, the DOH Community Health Offices WIC team was able to move data to action with depression screening using a validated tool, the PHQ9. The SD WIC team consists of RNs, LPNs, Licensed Dieticians, Nutrition Educators and Public Health Assistants (PHA) located in 74 Community Health Offices across the state. There are over 100 staff providing WIC services. Registered nurses are responsible for administering the PHQ9 and making referrals to PCP as needed.

To support understanding of depression in pregnancy, the South Dakota Perinatal Association (SDPA) annual conference hosted a talk on *Depression in Pregnancy*. Objectives of the talk provided by an obstetrician with an interest in pregnancy mental health focused on post-partum blues and depression, medication management, and services in the state.

ESM: Percentage of women with positive depression screen who are referred to their PCP within the OCFS offices

At the end of January 2022 an electronic health record (MyInsight) went live in the OCFS field offices. This allowed for the electronic documentation of the PHQ9 results as well as referrals made. The results are shown for the timeframe 1/31/22-10/31/22. Whooley Questions (PHQ2) are first asked as part of the Pregnancy or Postpartum WIC certification and any positive screens are referred to a nurse for a follow-up PHQ9 assessment.

Whooley Questions (PHQ2) timeframe = 1/31/2022-10/31/2022
3714 unique Whooley assessments done in WIC and MyInsight

- 70.2 % of ALL clients in WIC and Pregnancy Care were asked Whooley Questions
- 593 Positive screens (includes duplicate clients)
- 528 Unique positive screens (no duplication)

PHQ9 assessments timeframe = 01/31/2022 thru 10/31/2022
Overall:
700 PHQ9s completed

- 190 positive PHQ9
  - 27.1% positivity
- 109 People Referred
  - 57.4% of positive PHQ9s referred to their PCP or Community Mental Health Center

Strategy 1.4 Develop a policy recommendation with DSS to create a maternal medical home

Activities done to this point

- National Academy for State Health Policy MCH Policy Innovations Program Policy Academy (NASHP) is a two-year policy academy comprised of representatives from state Medicaid agencies, public health agencies, and other state stakeholders. The objectives for the academy include:
  - Identify, develop, and implement policy changes or develop specific plans for policy changes and/or strategies necessary to build state capacity to address maternal mortality for Medicaid-eligible pregnant and parenting women, with the goal of improving access to quality care.
  - Technical assistance to improve health care delivery systems and related supports for Medicaid-eligible pregnant and parenting women, with a particular focus on implementing policies or health system transformation that address racial disparities in maternal mortality
- Data from PRAMS and March of Dimes (MOD) to inform risk factors.
- The Association of State and Territorial Health Officials (ASTHO) links PRAMS data to Medicaid claims to understand the cost for risk factors identified in the payment model
- Stakeholder interviews with providers across the state were conducted to ascertain themes of needs, barriers, and views on the current state of maternal health care in their practices.
- Expansion of Bright Start
  - Bright Start is the nurse visiting program implemented by the South Dakota Department of Health. In 2022,

the program expanded statewide due to legislative approval of additional Medicaid and state general funds to support service delivery. The program uses the Nurse Family Partnership (NFP) model, and additionally offers support to families who do not fit NFP model criteria. The program enrolls pregnant women and families with children up to 6 weeks postpartum who are Medicaid enrolled or eligible. Families work with an assigned personal nurse until their child is two or three years old. Visits are held in the client's home, another location of the family's choosing, or by telehealth. Program goals are to improve pregnancy outcomes, improve child health and development and to improve the family's economic self-sufficiency. Program components include education, referral linkages, and assessments of maternal depression, anxiety, intimate partner violence, child development and parent-child interaction. Nurse visitors support families in both meeting health and parenting goals, but also in addressing the social determinants of health that impact their lives.

- To identify pregnant women earlier who would benefit from the expanded services of Bright Start across the state an advertisement was placed in South Dakota Medicine. Information was also distributed through South Dakota Association of Healthcare Organizations (SDAHO), SD ACOG chapter, tribal healthcare, and hospital medical staff emails. To promote the expanded services, team leads from WIC and Bright Start presented at the SD Perinatal Association annual conference in a talk titled, *Partnering with WIC and Bright Start.*

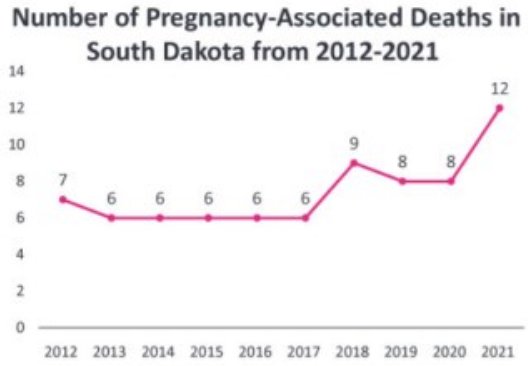
Other MCH activities related to Women's Domain

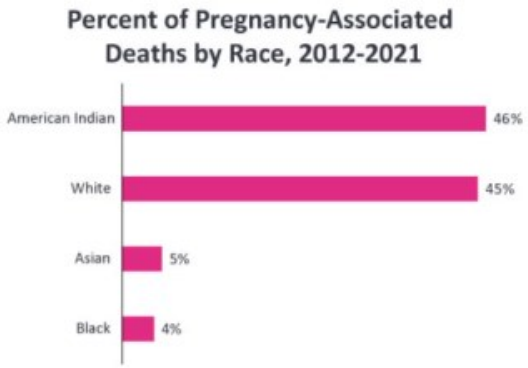
Maternal Mortality Review:

The SD Department of Health's Maternal Mortality Review Committee (MMRC) is a multidisciplinary expert panel with representation from public health, nursing, maternal and fetal medicine, mental health, substance use, pathology, obstetrics/gynecology, tribal health, and social work.

The MMRC reviews all deaths of SD residents that occur while pregnant or within one year of the end of pregnancy. The MMRC determines pregnancy-relatedness, preventability, and contributing factors to the death. The MMRC develops recommendations based on these factors to improve policies and practices and reduce preventable maternal deaths in SD.

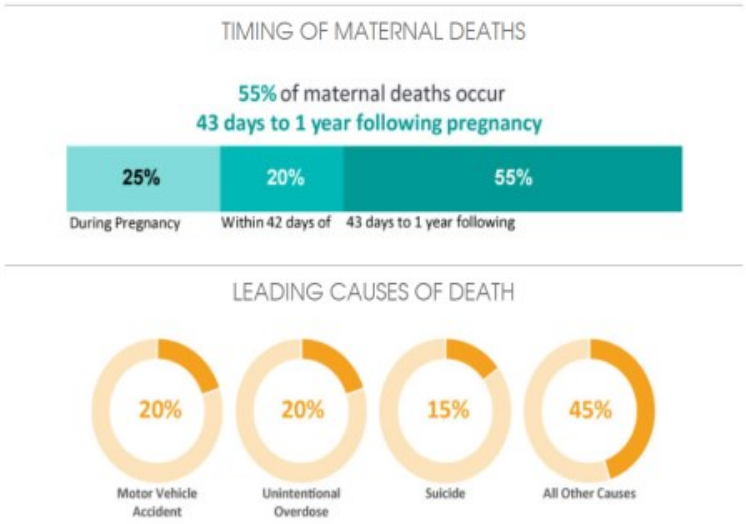
The SD MMRC began reviewing cases in October 2021 and reviewed 20 cases in its first full year. These deaths occurred from 2018-2021. Preliminary findings from this review are represented below. An in-depth analysis including social determinants of health and themes of recommendations is underway. Recommendations from the MMRC will inform prevention to action to improve women's health.


Number of Pregnancy-Associated Deaths in South Dakota from 2012-2021
14
12
10
8
6
4
2
0
7
6
6
6
6
6
9
8
8
12
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021


Percent of Pregnancy-Associated Deaths by Race, 2012-2021
American Indian
46%
White
45%
Asian
5%
Black
4%


PREGNANCY-RELATED VS. PREGNANCY-ASSOCIATED
Nearly 1/2 of deaths reviewed were determined to be pregnancy-related
Pregnancy-related
9
Pregnancy-associated but not related
7
Pregnancy-associated but unable to determine pregnancy-relatedness
4


PREVENTABILITY
4 in 5
maternal deaths were determined to be preventable



Pregnancy Care Program: The Office of Child and Family Services' Pregnancy Care Perinatal Services Program provides a risk assessment and subsequent modified case management for those found eligible for services. The risk assessment is comprised of chronic, and pregnancy induced risk factors as well as social determinants of health. Modified case management involves registered nurses providing ongoing assessment, education, and support throughout the pregnancy and up to 3 months postpartum. Other services include screening for depression, safe sleep education, breastfeeding education and referrals to community-based resources based on the mother's identified risks and factors as they arise.

North Dakota-South Dakota Perinatal Quality Collaborative (NSD PQC): The NSDPQC has been awarded a five-year grant through the CDC for state based PQC capacity building. With these funds, the NSDPQC staff will be growing to include a Tribal Liaison and a Data and QI Specialist to better support participating hospitals in the QI work. Moving forward, the NSDPQC will continue to grow in name recognition and as a known source for science-based quality improvement and dissemination of best practices. We hope to enroll a larger portion of SD hospitals and affect change to a wider population. Currently, the NDSPQC participants cover less than 40% of SD births. Our goal is to cover over 70% of SD births in the coming initiatives.

Referrals for medical insurance coverage: Community Health Offices across the state promoted Medicaid and Marketplace enrollment for clients that initiated services and were uninsured. Staff utilized available translating services (Language Link or Lutheran Social Services translators) if a client 's primary language was other than English. Clients were referred to DSS Economic Assistance or Navigators if more assistance was needed to promote equity in accessing insurance.

Breastfeeding-Friendly Business Mini Grants: Over the last year, the MCH Program has partnered with the DOH Office of Disease Prevention programs on several initiatives to address public health needs. In 2022, the DOH Nutrition & Physical Activity Program released the Breastfeeding-Friendly Business Grant opportunity open to all South Dakota worksites. MCH funds support the state and federal breastfeeding law by providing worksites up to $2,000 to create a new lactation space, improve an existing space, and/or implement innovative, space-saving ideas to meet staff breastfeeding needs for employees including those who work outdoors and/or who frequently travel. Awarded grantees received assistance from the SD DOH on policy development, use of the Employer Breastfeeding Accommodation Form, and resource sharing based on need/request. Ten applications were received with eight applicants being awarded. Awardees will submit a final report of successes, challenges, and overall project outcomes in 2023.

Congenital Syphilis Awareness Media Campaign: In addition to SD Medicine Journal provider ads, the MCH Women's Domain has partnered with the DOH Office of Disease Prevention to launch a media campaign to raise awareness of the congenital syphilis outbreak and direct the public to available resources. The campaign is geared toward both males and females aged 25-39, with an emphasis on women of child-bearing age. The campaign is statewide; however, increased focus has been placed on the counties with the highest numbers of cases and include a mix of social media, radio, and signage.

Women/Maternal Health - Application Year

Women/Maternal Domain Plan for Application Year Oct 1, 2023 - Sept 30, 2024

The workgroup continues to focus on *Mental Health* and *Substance Misuse* as identified priorities in the 2019-2020 needs assessment which are critical to overall wellbeing and a part of the recommended screenings for a well women yearly check-up.

NPM 1: Percent of women, ages 18-44 with a preventive medical visit in the past year

Objective: Increase the proportion of women receiving a Well Women visit annually from 77.3% (2020) to 81.3% by 2025. (BRFSS)

Evidence-based Strategy Measures:

- Number of Facebook messages posted promoting well women care
- Percentage of women with positive depression screen who are referred to their PCP (within the OCFS Community Health Offices)

Strategy 1.1: Develop partnerships with diverse, multisector stakeholders to promote preventive care for women of childbearing age

Significance:

The MCH team decided if we were going to reach all women of childbearing age with the well women message, we needed to develop multisector partnerships. No single organization or sector has full control over the determinants of population health, effective solutions require interorganizational coordination and collaboration. Multisector partnerships across local, regional, and state agencies improve delivery of health and social services to vulnerable populations.

Continued partnerships

The MCH team/Well Women workgroup will continue to partner with the North/South Dakota Perinatal Quality Collaborative, the South Dakota Perinatal Association and the MCH infant domain workgroup.

New Efforts

- The MMRC will partner with Child Death Review (CDR) committees to begin the work of moving recommendations to action. A Prevention Services Manager will be hired to coordinate maternal/infant/child mortality prevention efforts and will be part of the MCH team.
- Collaborate with tribal liaisons on the Well Women workgroup.
- Add families with lived experience to the Well Women workgroup.
- Other partnerships that are emerging are in relation to work with other state and local agencies around the rising syphilis rates in regions of South Dakota. The MCH team will work to bring awareness, testing and treatment to mitigate rates of congenital syphilis as a priority.
- Potential partnerships with state universities to support work on perinatal depression.

Strategy 1.2: Create toolkit of resources on Maternal Mental Health/Substance Misuse and Health Equity for OCFS field offices.

Significance:

A toolkit helps field staff to promote well woman health by providing information to navigate care related to mental health and substance use.

Activities to date

Education talk February 2022, lived experience with stimulants and peer counseling

Partnership with Mountain Plains ATTC and MHTTC to provide education assistance on topics of substance use disorder and mental health

New Efforts

- Focus on finding a validated screening tool for substance use disorder for clients seen within the OCFS Community Health Offices. This work will align with The AIM bundle and the work of the NSDPQC.

Strategy 1.3: Increase depression screening and referrals to PCP among low-income women within OCFS Community Health Offices.

Significance:

The MCH team and Well Women workgroup will continue to address the mental health priority by referring all clients (within the OCFS Community Health Offices) with a positive response to the PHQ-9 to their PCP. If the client does not have a PCP, field staff will assist the client to find a provider. This will promote the use of a PCP as a medical home to direct all care including preventive care.

Activities to date

PHQ9 screenings done in the community health offices and metrics.

Mental health metric on Strategic Community Outreach and Outcomes Plan (SCOOP) in 2 of 4 regions within community health offices.

New Efforts

- Activities to support SCOOP plans and metrics around screening for depression and substance use disorder
- Education on harm reduction strategies to support staff in assisting clients
- Establish partnerships and support for PQC work across the state with hospitals and clinics for the AIM SUD bundle

Strategy 1.4: Develop a policy recommendation with DSS to create Maternal Medical Homes

Significance:

Rates of maternal mortality and morbidity from pregnancy related complications in the US have increased with an average of over 1200 deaths per year in 2021. Complex medical, social, and behavioral risks increase the likelihood of major morbidities and death. Low birthweight, short interpregnancy spacing, gestational diabetes, and social determinants of health and disparities increase the likelihood of adverse outcomes. Some of these risk factors could be minimized through pregnancy case management in a medical home model.

Activities to date

Development of the Pregnancy Health Home program which was part of the Governors proposed budget for FY 24.

Expansion of the Bright Start Nurse Visiting Program. The program provides prenatal and parenting support during pregnancy and postpartum up to child turning 2. The program was limited to specific counties in the state and is now statewide.

New Efforts

- Finalization of policies and actual implementation of the Pregnancy Health Home including:
  - How to get recipients enrolled.
  - How to get providers to participate.
  - How the Pregnancy Health Home interacts with other maternal services outside of SD Medicaid.

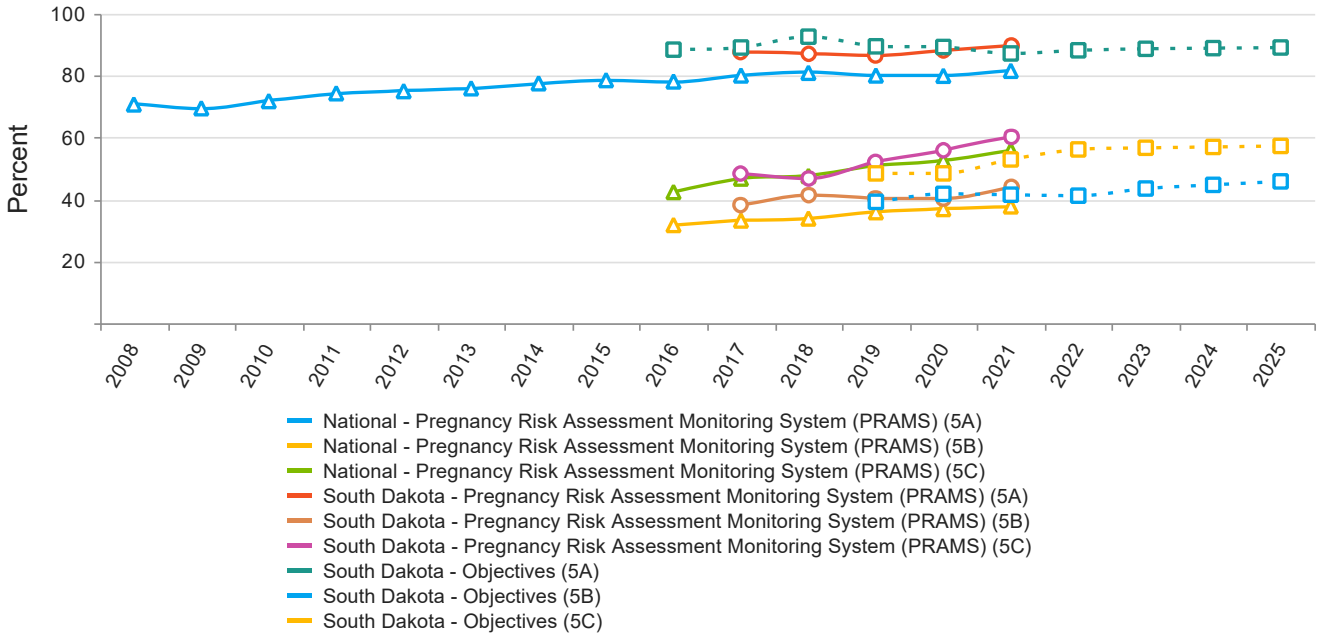
Ongoing Efforts Supported by MCH for the Women/Maternal Domain:

- Continue to educate all women on the importance of yearly preventive visits which address mental health as well as physical health in Community Health Offices across the state.
- Continue to support the OCFS Pregnancy Care program to provide prenatal and postpartum education, assist low-income pregnant women to obtain early and on-going prenatal care, provide smoking cessation counseling and referrals and link women to resources that can help support healthy pregnancies and healthy newborns.
- Continue to partner with Title X, Bright Start Nurse Visiting, the SD WIC program, and other community partners to promote yearly check-ups for women of childbearing age and their families.
- Continue to support the CDC's PRAMS and utilize the findings for planning, assessing, and evaluating our programs with the goal of improving health outcomes for women and infants.

Perinatal/Infant Health

National Performance Measures

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding Indicators and Annual Objectives



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	92.4	89.3	89.1	87	88
Annual Indicator	87.6	87.0	86.6	87.8	89.4
Numerator	9,793	9,485	9,150	8,964	9,349
Denominator	11,174	10,900	10,566	10,213	10,456
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	88.5	88.7	88.9

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		39.2	41.8	41.5	41.2
Annual Indicator	38.4	41.6	40.5	40.1	43.9
Numerator	4,014	4,380	4,136	3,932	4,422
Denominator	10,466	10,533	10,223	9,810	10,070
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	43.5	44.7	45.8

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		48.4	48.4	52.9	56.1
Annual Indicator	48.2	46.9	52.0	55.8	60.3
Numerator	5,069	4,923	5,339	5,404	6,039
Denominator	10,516	10,495	10,267	9,676	10,020
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	56.6	56.9	57.2

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - % of Child Death Review (CDR) team members who scored above 80% on a post-test

Measure Status:	Inactive - Completed			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			100	100
Annual Indicator			100	100
Numerator			10	15
Denominator			10	15
Data Source			Post test results	Post test results
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Final

ESM 5.3 - % of birthing hospitals that receive information on certification process that become safe sleep certified

Measure Status:	Active		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			100
Annual Indicator		0	25
Numerator		0	2
Denominator		7	8
Data Source		Manual count	Manual count
Data Source Year		2021	2022
Provisional or Final ?		Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (South Dakota) - Perinatal/Infant Health - Entry 1	
Priority Need	
Safe Sleep	
NPM	
NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	
Objectives	
Reduce the number of SUID deaths related to unsafe sleep environment from 139.8/100,000 in 2019 to 103.9/100,000 by 2025 (NVSS)	
Increase the percent of infants placed to sleep without soft objects or loose bedding from 60.3% in 2021 to 66.3% in 2025 (PRAMS)	
Strategies	
5.1: Disseminate culturally appropriate safe sleep educational materials, resources, and messages via social media and print.	
5.2: Collaborate with Community Health offices across the state to educate birthing families/infant caregivers on evidence based safe sleep practices.	
5.3: Collaborate with diverse, multi-sector organizations/agencies to promote safe sleep.	
ESMs	**Status**
ESM 5.1 - % of Child Death Review (CDR) team members who scored above 80% on a post-test	Inactive
ESM 5.2 - % of daycares who respond to survey and indicate that they follow safe sleep guidelines	Inactive
ESM 5.3 - % of birthing hospitals that receive information on certification process that become safe sleep certified	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

Perinatal/Infant Health - Annual Report

Perinatal/Infant Domain: Annual Report (October 1, 2021 – September 30, 2022)

Priority: Safe Sleep

National Performance Measure 5:

1. *Percent of infants placed to sleep on their backs*

South Dakota exceeded the 2021 annual target of 88% with 89.4% of infants placed to sleep on their backs in 2021. The new annual target for 2022 is 91.6%. South Dakota ranked 4th in the nation in 2021 with a significantly higher percentage than the U.S. percentage of 81.4%.

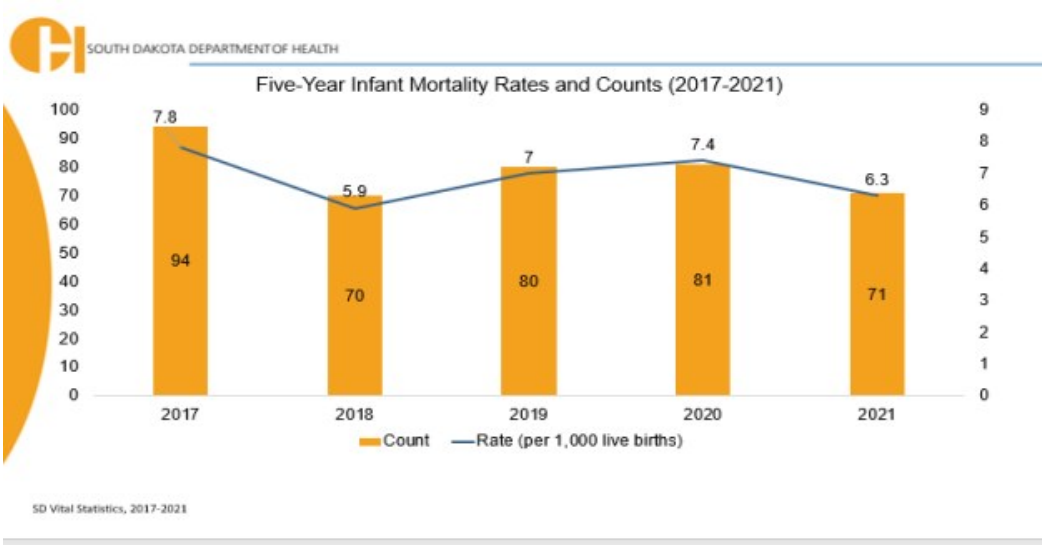
2. Percent of infants placed to sleep on a separate approved sleep surface

South Dakota exceeded the 2021 annual target of 41.2% with 43.9% of infants placed to sleep on a separate approved sleep surface in 2021. The new annual target for 2022 is 44.4%. South Dakota ranked 4th in the nation in 2021 with a significantly higher percentage than the U.S. percentage of 37.8%.

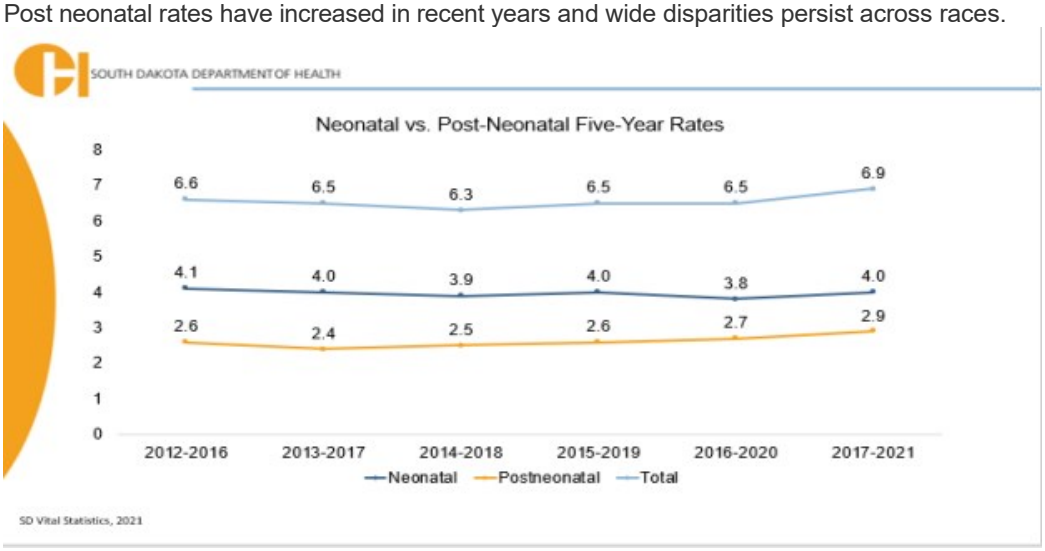
3. Percent of infants placed to sleep without soft objects or loose bedding

South Dakota exceeded the 2021 annual target of 56.1% with 60.3% of infants placed to sleep without soft objects or loose bedding in 2021. The new annual target for 2022 is 61.8%. South Dakota also met the 2025 objective of 57.2% and therefore the new 2025 objective was increased by 10%. The new 2025 objective is 66.33%. South Dakota ranked 11th in the nation in 2021 with a significantly higher percentage than the U.S. percentage of 55.8%.

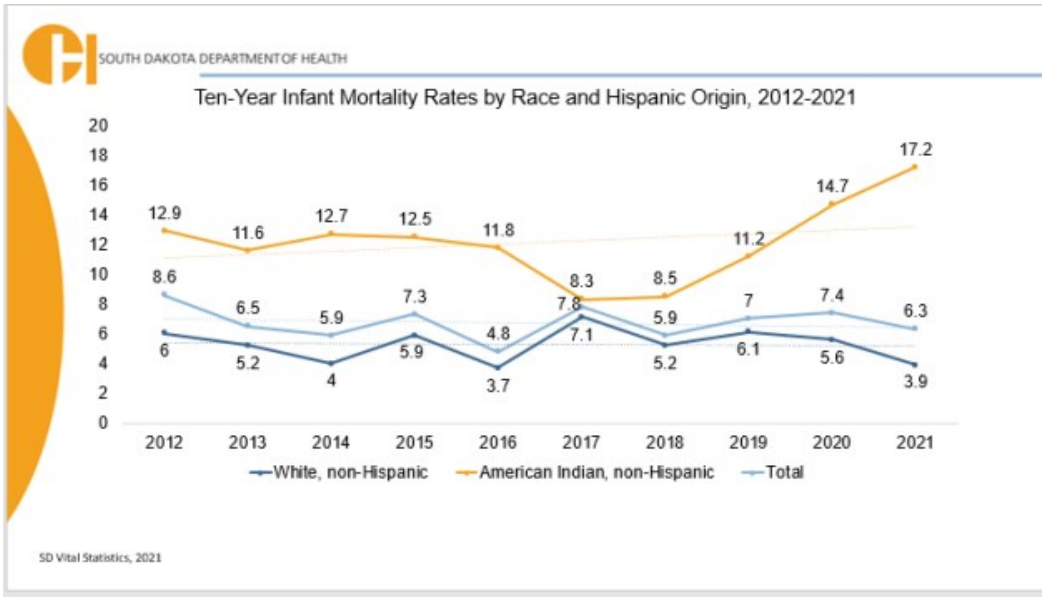
Reducing infant mortality is a public health priority in SD. The graph below shows the fluctuating yearly mortality rate.



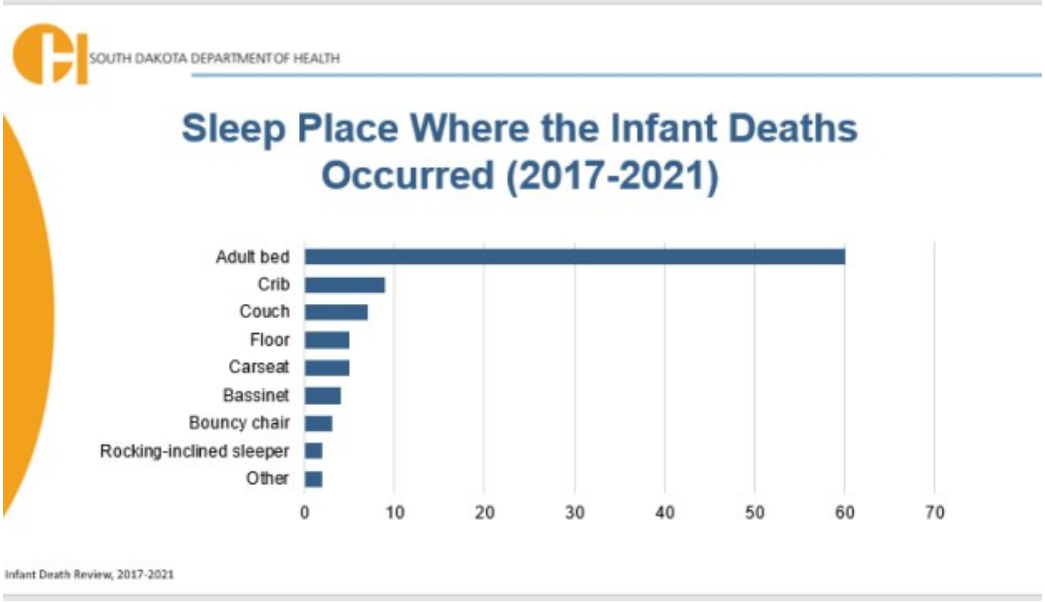
Post neonatal rates have increased in recent years and wide disparities persist across races.



Infant mortality rates of American Indian, non-Hispanic infants have historically been 2-3 times higher than that of white, non-Hispanic infants in SD as the graph below shows.



Most infant deaths in the post-neonatal period are related to infant sleep or an unsafe sleep environment. Of the 97 sleep related deaths that occurred post birth hospitalization, nearly 80% occurred in an unsafe sleep environment such as an adult bed, couch, chair, car seat, swing, Rock ‘n Play, or unsafe crib (SD Child Death Review 2017-2021).



SUID rates remain higher in SD than the national average.

2019 **SD:** 139.8 per 100,000 live births (16 SUID deaths) **National:** 89.8

2020 **SD:** 209.9 per 100,000 live births (23 SUID deaths) **National:** 92.5

To address this problem, the SD Department of Health's Strategic Plan, Goal 2: *Provide Services to Improve Public Health* includes the following strategy that the MCH Infant Domain/NPM #5 workgroup is currently working on: Increase the number of birthing hospitals in SD that are Cribs for Kids Safe Sleep Certified (Bronze Level).

The MCH NPM #5 Safe Sleep workgroup has a diverse membership including:

1. Nurse Manager, Postpartum and Newborn Nursery, Avera McKennan Hospital
2. Clinical Nurse Specialist, Sanford Children's Hospital NICU
3. Licensing Program Manager, Department of Social Services (DSS) Childcare Services
4. Early Childhood Field Specialist, SDSU Extension Services
5. Death Review Abstractor, Child Death Review (CDR)/National Violent Death Review (NVDR)
6. Family Advocate – Lach's Legacy founder
7. Research Assistant, Avera Research Institute, Pine Ridge Reservation
8. MCH Coordinator, Women's Domain/MMR Coordinator
9. Community Health Nurse, Pine Ridge Reservation
10. MCH Coordinator, Infant Domain/CDR Coordinator

A summary of our progress on NPM #5 follows.

Objective: Reduce the number of SUID deaths related to unsafe sleep environment from 139.8/100,000 in 2019 to 103.9/100,000 by 2025. (NVVS)

Data Statement: In 2020, South Dakota's (SD) SUID death rate related to unsafe sleep environment was 209.9/100,000. SD did not meet the 2020 annual target of 136.5/100,000. The new annual target for 2021 is 188.7/100,000. SD ranked 43rd in the nation in 2020 and had a higher rate than the U.S. rate of 92.5/100,000, which shows SD's SUID death rate is significantly worse than the US overall. The change from the base year (2015) to the current year is not significant.

Objective: Increase the percent of infants placed to sleep without soft objects or loose bedding from 60.3% in 2021 to 66.33% by 2025. (PRAMS)

Data Statement: South Dakota exceeded the 2021 annual target of 56.1% with 60.3% of infants placed to sleep without soft objects or loose bedding in 2021. The new annual target for 2022 is 61.8%. South Dakota also met the 2025 objective of 57.2% and therefore the new 2025 objective was increased by 10%. The new 2025 objective is 66.33%. South Dakota ranked 11th in the nation in 2021 with a significantly higher percentage than the U.S. percentage of 55.8%.

Strategy 5.1: Disseminate culturally appropriate safe sleep educational materials, resources, and messages via social media, print, and radio.

The MCH team worked with Hot Pink Media group to run safe sleep messaging via radio flights for 4-weeks in October and December of 2021. The radio flights were focused on/around reservation stations first and built out using vulnerable counties as the second geographic layer. Sample messaging is noted below:

(Lakota Phrase) "BEBELA WA IYUNKA" or "ABU… ABU... ABU" or combine phrases
(Repeat in English): SHHHHH! BABY IS ASLEEP.

IT SEEMS SIMPLE, BUT WE KNOW THERE'S MORE TO KEEPING BABY SAFE.
BEFORE YOU LAY YOUR BABY DOWN TO SLEEP, BE SURE TO FOLLOW THESE SAFE SLEEP GUIDELINES –

FIRST, BABIES SLEEP SAFEST ON THEIR BACKS, ON A FIRM SURFACE, WITHOUT PILLOWS, BLANKETS, BUMPER PADS, OR TOYS.

NEXT, BABIES SHOULD ALWAYS SLEEP ALONE, NEVER SHARING ANY SLEEP SURFACE WITH AN ADULT, ANOTHER CHILD, OR PET. ***ROOM*** *SHARING IS OKAY,* ***BED*** *SHARING IS* ***NOT****.*

COUCHES, CHAIRS, INFANT SEATS OR SWINGS ARE NOT SAFE PLACES FOR BABY TO SLEEP. EVERY SLEEP TIME COUNTS.

AND, FINALLY, BABIES NEED A SAFE CRIB. IF YOU HAVE QUESTIONS ABOUT WHERE YOUR BABY SHOULD SLEEP, OR CAN'T AFFORD A SAFE CRIB - WE CAN HELP.

(Lakota Phrase) "ENAH EEWAH CHEE CHEE YE" (Mommy I need your help)
HELP YOUR BABY SLEEP SOUNDLY AND SAFELY.
FIND OUT MORE AT FOR BABY'S SAKE S-D DOT COM.

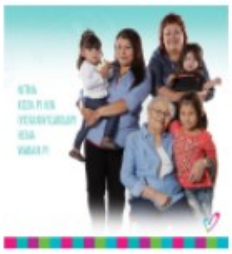
Radio ads were discontinued at the end of calendar year 2021 as the contract with our media company was discontinued and the MCH team wanted to evaluate whether radio was still the most effective tool to communicate with our American Indian population.

MCH began working with our own DOH Communications team in January 2022 to disseminate culturally appropriate safe sleep messages via social media (Facebook/Instagram and Snapchat). Safe sleep posts were promoted to a SD specific audience consisting of:

- females with pregnancy interests
- females between the ages of 16-25
- 16+ expectant parents, new parents, and low income
- expectant parents, grandparents, and babysitters

Facebook metrics

POST IMAGE	TITLE	TYPE	CUMULATIVE REACH	AVERAGE FREQUENCY
	SIDS	Paid	12,616	3.08
	Safe Sleep	Paid	9,182	3.61
	Safe Sleep – 11 Guidelines	Paid	3,556	5.33

POST IMAGE	TITLE	TYPE	CUMULATIVE REACH	AVERAGE FREQUENCY
	Safe Sleep – Tribal	Paid	63,544	2.39
	Safe Sleep	Paid	56,535	3.97
	Dads – Safe Sleep	Paid	88,255	3.92
	Safe Sleep	Paid	9,636	3.05
	Grandparents: Safe Sleep	Paid	95,213	14.93

Snapchat metrics

POST IMAGE	TITLE	TYPE	CUMULATIVE IMPRESSIONS	SWIPE UPS
	Dads – Safe Sleep Snapchat	Paid	49,526	324
	Grandparents: Safe Sleep	Paid	153,629	4,024
	Bed Sharing Safety	Paid	505,165	9,050

The MCH team continued to disperse an 8 1/2" x 11" glossy *Safe Sleep Practices Can Save Lives* infographic statewide in English and Spanish. The infographic is included in newborn discharge packets at the 3 largest birthing hospitals; Sanford Sioux Falls, Avera McKennan Sioux Falls, and Monument Health Rapid City. It is also given to new parents/caregivers at the IHS hospital in Pine Ridge. Three hundred copies were distributed to participants (added to registration packets) at Lach's Legacy's *Run for Their Lives* walk/run fundraiser on Mother's Day 2022. Lach's Legacy hosts this event yearly in Spearfish to promote SIDS awareness. The infographic is also utilized as a teaching tool by field staff within the Office of Child and Family Services (OCFS) who serve low-income families in 73 Community Health Offices across the state. A copy of the infographic is included below:

We continued to place ads in SD Medicine Journal targeting providers that work with pregnant families and parents/caregivers of infants. SD Medicine has approximately 2000 subscribers. The following is a sample ad:

Infant Mortality data and safe sleep information is also disseminated on For Baby's Sake website and the DOH's Infant Mortality page.

Infant Mortality Data Dashboard
Infant Mortality - Infant Death Review (sd.gov)

For Baby's Sake | Healthier moms + Healthier babies (forbabysakesd.com)

Strategy 5.2: Collaborate with diverse community partners to provide Child Death Review (CDR) and disseminate findings to all South Dakotans.

MCH continues to support the work of 2 Regional CDR teams (East River and West River) and a Statewide Preventable Death Committee. Child Death Review is exclusively funded by the MCH Block Grant in SD. In this fiscal year, we partnered with the National Center for Fatality Review and Prevention (NCFRP) to train all team members on *Shifting from Recommendations to Findings: Using Brain Science*.
What are Findings?

- objective facts that are tied to key risk and protective factors
- focus on how systems interacted and are identified for every death
- should be used to write formal prevention recommendations

Broad categories of findings include characteristics of the child, characteristics of the parents and/or caregivers, physical environment, social environment, agency practices, collaboration across systems, social determinants of health/equity and unique characteristics of each system. All team members scored above 80% on a posttest of the subject matter. (**ESM 5.1**)

In addition to this training, the State CDR coordinator participated in the Health Equity Learning Collaborative through NCFRP. Topics this grant year included:

- How can we as CDR programs motivate action on our recommendations?
- Unconscious and implicit bias: what do they have to do with surveillance bias?
- Mechanisms through which surveillance bias could impact fatality reviews-zeroing in on specific fatality processes

In FY 2022, CDR found new ways to disseminate death review data to all South Dakotans. The following are examples of a Facebook post and several billboards in addition to the safe sleep practices infographic that was previously discussed.

2022 BILLBOARDS

2022 BILLBOARDS

MCH collaborated with Lach's Legacy, a non-profit fighting SIDS in SD on the design and cost of the billboards. Brianne Edwards, founder of Lach's Legacy is a member of the NPM #5 Safe Sleep workgroup as well as the West River CDR team. Brianne published a book in 2022 about her lived experience losing an infant to SIDS.

At the end of this fiscal year, the statewide CDR coordinator, DOH Infant/Child Epidemiologist, and the DOH Pediatric Medical Consultant began preparing for their part of law enforcement/medical examiner training on CDR process and the importance of the SUIDI form in death scene investigations which was scheduled October of 2022 in Sioux Falls.

Strategy 5.3 Collaborate with diverse, multi-sector organizations/agencies to promote safe sleep

The NPM #5 workgroup continued to encourage birthing hospitals across the state to receive Cribs for Kids bronze level safe sleep certification. By the end of this grant year, 2 hospitals or **25%** (of the 8 that had been approached last fiscal year) became bronze level certified (**ESM 5.3**); Sanford Health Aberdeen and Sanford Health Chamberlain. Two hospitals were in the process of certification; Monument Health Rapid City and Monument Health Spearfish. An additional hospital system, Avera, was provided information about the certification process. A champion for the Avera system was chosen and became part of the NPM #5 workgroup. Avera has 7 birthing hospitals in SD.

Bronze Silver Gold

Another activity we were planning, to explore a new opportunity partnering with *Today's Baby* and the SD WIC program, did not come to fruition as WIC was involved with other research/survey projects and felt the WIC population was being over surveyed at the time.

Perinatal/Infant Health - Application Year

As elsewhere, the burden of SUID in SD disproportionately impacts racial and ethnic minority groups, including tribal populations. Furthermore, families of lower socioeconomic status typically comprise a considerable proportion of cases. In SD, American Indians, or Alaska Natives (AI/AN) are the group of people most affected by health disparities, not only related to infant deaths, but also with congenital syphilis, violent death, substance use disorders, and other health indicators. The SD DOH seeks a relationship with the nine sovereign nations present in the state to better understand the underlying factors behind those disparities. For instance, steps to improve record access are ongoing through American Indian members of CDR and the public health officer of The Great Plains Tribal Leaders Health Board.

Given the magnitude of disparities faced by AI/AN in the state, the MCH program recognizes the need to do more.

In this section, MCH Title V reports on planned activities in the Perinatal/Infant Health Domain for the period October 1, 2023, through September 30, 2024. A notable need identified during SD's five-year comprehensive Needs Assessment was education and programming around infant safe sleep. The 3 multisector teams focused on this goal are the MCH NPM #5 Safe Sleep workgroup, and the East and West River Child Death Review teams. These teams have been focusing on upstream factors that contribute to infant deaths and objective findings that can address root causes of infant mortality.

State Priority: Safe Sleep

NPM 5: A) Percent of infants placed to sleep on their backs
B) Percent of infants placed to sleep on a separate approved sleep surface
C) Percent of infants placed to sleep without soft objects or loose bedding

ESM 5.1: Percentage of birthing hospitals that receive information on certification process that become safe sleep certified.

This ESM will remain active as we continue to promote Cribs for Kids Hospital Safe Sleep bronze level certification for all birthing hospitals in the state. According to the MCH Evidence Center, this ESM is moderate evidence level.

Moderate. *Aligns with the hospital policy component Multicomponent Strategy: Caregiver Education + Health Care Provider Education + Hospital Safe Sleep Policy. Note the moderate evidence level is for the multicomponent strategy as a collection of efforts beyond just the hospital safe sleep policy.*

2023-2024 Objectives

Reduce the number of SUID deaths related to unsafe sleep environment from 139.8/100,000 in 2019 to 103.9/100,000 by 2025 (NVSS).

Increase the percent of infants placed to sleep without soft objects or loose bedding from 60.3% in 2021 to 66.3% by 2025 (PRAMS).

Strategies and new Activities

- **5.1** Disseminate culturally appropriate safe sleep educational materials, resources, and messages via social media and print.

Title V will continue working with our own DOH Communications team to post culturally appropriate safe sleep messages on For Baby's Sake and DOH Facebook pages. The MCH team will be putting out an RFP to have the

For Baby's Sake website www.forbabysakesd.com revamped. The goal is to have the update done by the end of this fiscal year (September 2024). The site will include a separate section on safe sleep with references to vetted sites for information like NIH and AAP.

We will continue to distribute our updated safe sleep infographic to partners across the state and increase its circulation targeting FQHC's and tribal health clinics. We will explore other venues for safe sleep messaging such as radio. We will continue to support Lach's Legacy's safe sleep messaging on billboards across the state and hope to expand our efforts by bringing in other partners for monetary support.

Old Strategy:

- 5.2 Collaborate with diverse community partners to provide Child Death Review (CDR) and disseminate findings to all South Dakotans.

CDR has applied for the CDC SUID Case Registry grant and if received, will no longer use the MCH block grant as its primary funding source. In anticipation of alternate funding, we have revised this strategy.

New Strategy:

- **5.2** Collaborate with Community Health Offices (CHO) across the state to educate birthing families/infant caregivers on evidence based safe sleep practices.

The Office of Child and Family Services has a total of 73 CHOs across the state. Each CHO has developed an individualized Infant Mortality Plan with a standardized strategy to provide safe sleep education to every pregnant

and postpartum client receiving services in their office. The activity that is common to all plans is using client-centered counseling skills to assess current infant sleep practices. Community Health Nurses (CHNs) will provide safe sleep education within the curriculum of their Pregnancy Care case management program. Established performance measures for the infant mortality plan will be:

- % of Pregnancy Care clients that received safe sleep assessment and education by 36 weeks' gestation
- % of Pregnancy Care clients that have sleep assessed at the first postpartum office visit (optimally within the first 2 weeks after birth)
- % of Pregnancy Care clients that received safe sleep follow-up visit (between 2-3 months after birth)

Other activities that will coincide with strategy 5.2 will be:

1. to develop a safe sleep policy for CHNs working with pregnant and postpartum families within the OCFS and
2. to provide guidance to CHNs in evaluating and updating their offices' infant mortality plan.

- **5.3** Collaborate with diverse, multisector organizations/agencies to promote safe sleep.

Title V will continue to partner with SD birthing hospitals to promote Cribs for Kids BRONZE Level safe sleep certification. The goal is to identify 3 new birthing hospitals willing to become safe sleep certified and to have 2 additional hospitals complete the certification process this grant year. (We currently have 1 gold certified hospital and 2 that are bronze certified). We will continue our work with the Avera healthcare system to promote system-wide certification. (Avera has a total of 7 birthing hospitals in the state.)

Bronze Silver Gold

A new activity will be to develop partnerships within tribal communities where SUID disparities exist to address barriers to safe sleep. The MCH infant coordinator and Bright Start free personal nurse program coordinator plan to travel to reservation counties with the highest disparities to offer services and find new ways to collaborate. Several NPM #5 workgroup members are from these communities and can facilitate this effort.

Ongoing Efforts Supported by MCH for the Infant/Perinatal Domain:

- Continue to support newborn metabolic and hearing screenings in all birthing hospitals and for home births to identify abnormalities and provide early intervention.

- Continue to partner with Cribs for Kids, SD WIC, Bright Start Nurse Visiting Program, and community partners to provide safe sleep education and distribute Pack 'n Plays to low-income families with no safe sleep environment for their infant.

- Continue to promote infant immunization (as a strategy to decrease infant mortality) through For Baby's Sake website and Facebook page.

- Continue to promote infant growth and development screening in OCFS Community Health Offices and partner organizations for early recognition of delays and appropriate referrals to early intervention services.

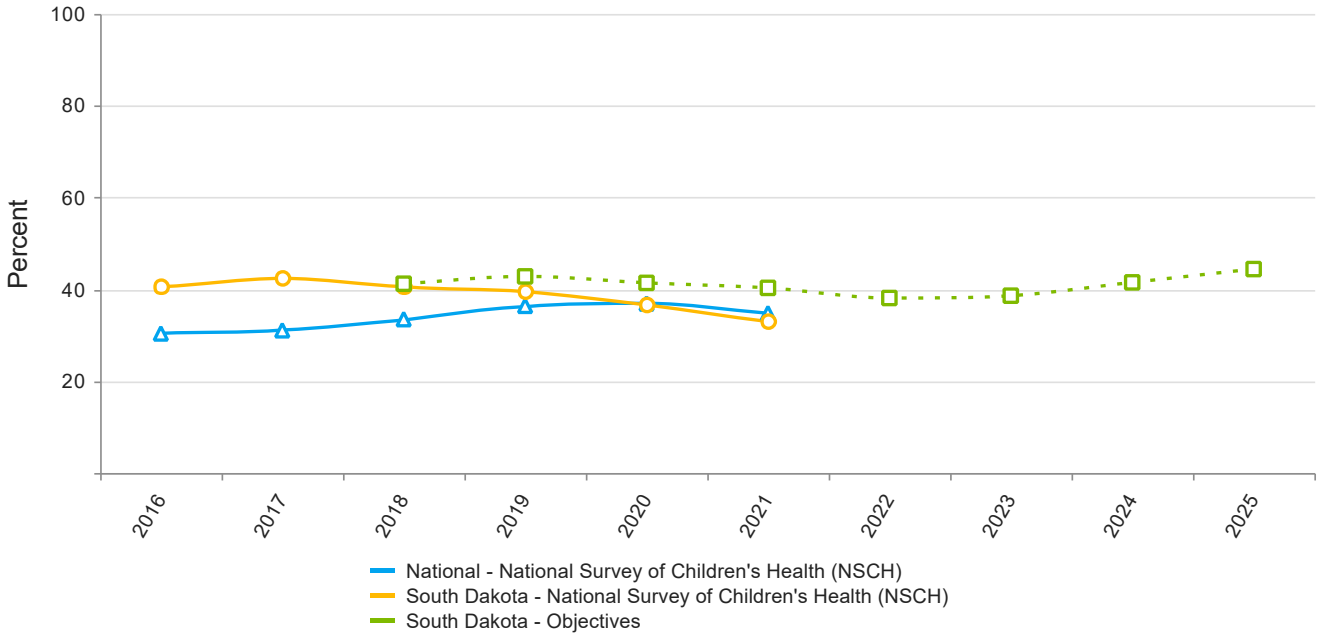
- Continue to promote breastfeeding through social media and provide support for breastfeeding moms through partner agencies, OCFS Certified Lactation Counselors (CLCs) and WIC's breastfeeding peer counselors statewide.

- Continue to support the DOH's efforts to reduce the rates of congenital syphilis and syphilitic stillbirths in SD. In 2022, SD reported 38 congenital cases (up from 16 in 2021) and 3 syphilitic stillbirths. Disease Intervention Specialists across the state (employed by the DOH) provide case management to all physician-diagnosed and/or suspect cases. The MCH program has placed posts on For Baby's Sake and DOH Facebook pages and will continue to provide information to our childbearing families via social media in the coming year.

Child Health

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	41.2	42.8	41.4	40.3	38.1
Annual Indicator	42.4	40.4	39.4	36.5	32.9
Numerator	10,542	8,655	9,910	9,949	9,000
Denominator	24,884	21,429	25,131	27,272	27,376
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	38.6	41.5	44.4

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - % of Community Health Offices that distribute tracking cards

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			100	100
Annual Indicator	100	100	100	100
Numerator	76	76	76	74
Denominator	76	76	76	74
Data Source	OCFS Community Health Offices	OCFS Community Health Offices	OCFS Community Health Offices	OCFS Community Health Offices
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

ESM 6.2 - Percentage of children enrolled in Bright Start Home Visiting that receive a developmental screen by 18 months of age.

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	92	64.9
Numerator	23	24
Denominator	25	37
Data Source	Bright Start Home Visiting program data records	Bright Start Home Visiting program data records
Data Source Year	2021	2022
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (South Dakota) - Child Health - Entry 1	
Priority Need	
Parenting Education and Support	
NPM	
NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	
Objectives	
Increase the percent of children from non-metropolitan areas 9 through 35 months who received a developmental screening using a parent-completed screening tool in the past year from 22.3% (2019-2020) to 29.4% by 2025 (NSCH)	
Strategies	
6.1: Utilize Community Health offices and Bright Start Home Visiting Program to provide Ages and Stages developmental screen tool to clients.	
6.2: Create new and promote existing parenting resources to support healthy children and families	
6.3: Collaborate with partners to identify gaps in parenting education and support and reduce duplication of efforts	
ESMs	**Status**
ESM 6.1 - % of Community Health Offices that distribute tracking cards	Inactive
ESM 6.2 - Percentage of children enrolled in Bright Start Home Visiting that receive a developmental screen by 18 months of age.	Active
NOMs	
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

Children are always learning, growing, and developing. Every child should reach certain milestones in learning, language, motor skills, even in playing. A child's environment, genetics, and daily interactions with adults and other children can have a great impact on a child's development. Developmental screens are a critical component to determining if a child is experiencing a delay in any of these areas. Early identification of developmental delays and subsequent early intervention is critical to giving the child the best possible outcome and potentially reducing costly treatment over time.

Parenting education and support was the chosen priority to focus on in the child domain from the 2020 Needs Assessment. Parents and caregivers should be aware of the developmental milestones every child should reach and the importance of screening. In addition, there are many things parents and caregivers can do to ensure optimal development and help their child grow. Families with a child with a developmental delay should also be given adequate support to help address the delay and improve the outcomes for the child.

The MCH Program carries out Ages and Stages Questionnaires (ASQ) and ASQ Social Emotional (SE) developmental screens through 72 of the 74 Community Health Offices. Families who visit a community health office are offered a developmental screen when they come to the clinic for WIC services as well as other services. Families are given education from the ASQ screening kits and laminated posters are displayed in the offices promoting developmental screening. In the event of an abnormal screen, additional education is provided, and a family may be referred to Birth to 3 or their local school district for follow up. During this reporting period, the community health staff facilitated the completion of 1981 ASQs and ASQ SEs.

The MCH Program also carries out developmental screens through the Bright Start Home Visiting Program. This program utilizes the evidence-based Nurse Family Partnership (NFP) model and offers services to at-risk pregnant women and parents with young children by partnering families with a registered nurse. The program also offers an adapted curriculum for clients who don't meet the NFP requirements but are still in need. The majority of program services are offered during home visits, but families and nurses also meet in other locations if the family prefers. Bright Start is funded in part through the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) federal grant, as well as through a contract with the South Dakota Department of Social Services using Medicaid and TANF Block Grant funding. In 2022, the state legislature approved allocating additional Medicaid funds toward expanding Bright Start Home Visiting statewide. The program has since added a dedicated epidemiologist, regional team leads, and has been actively recruiting nursing and support staff. In 2022, the MCH Program contributed funding for new Bright Start promotional materials including brochures, posters, and media. The Bright Start Home Visiting Manager sits on MCH workgroups, leads a child health interagency meeting, and is supervised by the MCH Director.

During this reporting period, 65% of children enrolled in the Bright Start program had a completed ASQ-3 at 18 months. This number is significantly lower than previous years, however, with the addition of a program epidemiologist and improved data collection and reporting methods, this percentage is likely more accurate than previous years as we are able to better tease out the specific data we are measuring.

National Performance Measure 6: *Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool*

Data Statement:

South Dakota did not reach the 2021 annual target of 37.3%, with 32.9% of children ages 9-35 months receiving a developmental screening using a parent-completed screening tool in 2020-2021. This is a decrease from 36.5% in 2019-2020. The new annual target for 2022 is 35.8%. In 2020-2021, South Dakota was ranked 36th in the nation in percent of children receiving a developmental screening tool with a national percentage of 36.9%. The change from the base year (2016) to the current year is not significant.

State Objective:

Increase the percent of children from non-metropolitan areas 9 through 35 months who received a developmental screening using a parent completed screening tool in the past year from 22.3% (2019-20) to 29.4% by 2025 (NSCH).

State Objective Data Statement:

The 2020-2021 South Dakota percentage of 25.6% exceeded the 2021 annual target of 23.7%. However, this percent among children from non-metropolitan areas was lower than the overall South Dakota percentage of 32.9%. The new annual target for 2022 is 26.6%. There is a data note for this indicator that the percentage should be interpreted with caution because the confidence interval width is greater than 20% points.

Strategies:

6.1. Develop and equitably disseminate a clear and consistent message to communicate the importance of developmental screening to families and community health providers

- Communicating a clear and consistent message starts from within. All staff administering ASQ and ASQ SE screenings in Department of Health (DOH) Community Health offices and the Bright Start Home Visiting Program are provided with ASQ training on administering the screens as well as education from the ASQ kits to provide to families. In addition, the MCH program consistently promotes CDC Learn the Signs Act Early materials to Community Health, WIC, and Bright Start staff as a resource to provide to families and maintains a strong partnership with the state's LTSAE ambassador to stay current on information and materials.
- For continuing education, staff are encouraged to use the Brookes Publishing ASQ/ASQ-SE newsletters.
- The MCH program works closely with other state agencies including the Department of Social Services and the Department of Education to increase awareness of what we are working on and the messages we are communicating to families and the public.

6.2. Create new and support existing parenting resources to support healthy children and families

- The MCH program provided funding for increased printing of Learn the Signs Act Early developmental materials including books and developmental checklists. Community Health, WIC, and Bright Start Home Visiting staff were given ordering information and encouraged to utilize these items when working with families.

- Community health staff utilize posters promoting the CDC Milestone Tracker App and assist families with downloading the app and going through the app's instructions. Staff also assist families with signing up for Bright by Text and Text4Baby.
- Trifold developmental screening tracking cards are available to be ordered through the DOH central ordering system. Cards are similar to immunization tracking cards and are given to parents for their records.
- Continued to offer online confidential ASQ screening tool at https://doh.sd.gov/family/childhood/child-development.aspx. This tool can be accessed by anyone with an internet connection. This tool may not be available at the time of writing as the DOH website is being rebuilt, however, the tool will become available again when the site is up and running.
- In 2022, the MCH program partnered with the Department of Health Office of Disease Prevention and Health Promotion to create the Move Your Way Playbook, a useful resource across many of our Department of Health programs when promoting physical activity. The Playbook is completed and includes content for physical activity during pregnancy and the postpartum period, preschool-aged audiences, youth 6-17 years and families. The Playbook can be found at the following link: https://healthysd.gov/move-your-way-south-dakota-

playbook/. Next steps are to identify 1-3 communities who will implement the Playbook.

- The MCH Program also partnered with the Department of Health, Nutrition & Physical Activity Program to release the Harvest of the Month funding opportunity to support youth programs in South Dakota to actively engage children in learning about and exposing them to fruits and vegetables utilizing Harvest of the Month educational lesson plans, recipes and supporting materials. Thirty-two applications were received from various childcare/daycare and other youth programs (i.e. Boys & Girls Club, YMCAs) with 18 applicants being awarded funds up to $1,500 to support implementation of twelve Harvest of the Month lessons including purchase of produce for sampling and preparation of recipes, small equipment/utensils, and print materials. The project period for these funds is September 15, 2022- September 15, 2023. Additional information will be gathered (successes, challenges, overall project outcomes) upon grantee submission of a final report due no later than September 15, 2023.

- The MCH Program contributed funding for statewide promotion of life.sd.gov and also promotes the resource on the DOH website. The site was created by the South Dakota governor's office and provides education and resources to parents and expecting parents, including information on well child checks, safety, and parent trainings. Many resources for parents are available on this page.

- SD WIC began an initiative to prioritize and increase the number of face to face visits, regardless of whether they are in-person or virtual and limit phone calls to be only used when other options are not possible. In order to accomplish this, the program began to develop and implement a new telehealth system on the doxy.me platform. MCH contributed funding to the purchase and development of this new system to be used by WIC and Community Health nurses to reach families and provide face to face interaction.

- During this reporting year, MCH funding supported the purchase of Injoy video clips for the Community Health Offices on a variety of pregnancy, postpartum and newborn care topics. The nurses watch a short educational clip with the client and then they discuss it. The most viewed clips are on labor and delivery, newborn care, and postpartum care. Clips are also available on parenting, hunger cues, breastfeeding (to supplement WIC information), developmental milestones, and health and safety. Many times, families come in with multiple children and it can be challenging to sit through a 30 minute educational video with little ones. The video clips are meant to be short discussions on pertinent information they want and need and are available in English and Spanish.

6.3. Collaborate with partners to identify gaps in parenting education and support and reduce duplication of efforts

- The MCH Child domain maintains a strong partnership with SD Parent Connection and the state's Learn the Signs Act Early (LTSAE) ambassador (employed within SD Parent Connection). The MCH child domain lead sits on the LTSAE advisory committee and promotes LTSAE materials to community health, Bright Start, and WIC staff. The LTSAE advisory committee has membership with organizations all over the state including both state government and non-state government organizations.
- The SD DOH facilitates a child interagency workgroup, led by the Bright Start Home Visiting manager. The workgroup meets quarterly and is attended by leadership from the MCH Program, WIC, Community Health, Bright Start Home Visiting, Department of Social Services including Medicaid, Behavioral Health, and Child Protective Services, and the Department of Education including Birth to 3. The agencies and programs report on current projects, goals, and activities, and opportunities for collaboration are discussed.
- The child domain coordinator participates on a Medicaid well-child affinity group focused on improving well-child visit rates amongst the American Indian/Alaskan Native populations in our state.
- The CYSHCN Director, who works closely with the child domain coordinator and oversees the child domain when the coordinator position is vacant, is a member of the South Dakota Developmental Disabilities Council, the state Community of Practice team for Intellectual Disabilities, and attends the Department of Human Services Division of Developmental Disabilities stakeholder collective. These groups are well attended by partners both in and out of state government as well as family and self-advocates. Identifying and

addressing the gaps in support, resources, and education for caregivers and families is a frequent topic of these meetings as well as discussion of current efforts to address these gaps.

Child Death Review

In addition to developmental screening efforts, South Dakota has reviewed post hospitalization infant deaths statewide since 2012. In October of 2020 the SD Department of Health expanded death review to include all child deaths up to age 13. The process includes two review teams, East River and West River. The East River team reviews infant/child deaths *(post hospitalization through age 12)* that occur in the 44 counties east of the Missouri River. The West River team reviews deaths that occur in the 22 counties west of the Missouri River. The teams are multidisciplinary and are comprised of volunteers from law enforcement, Child Protection Services, hospital staff, fire departments, emergency medical services, public health, behavioral health, forensic pathology, the Bureau of Indian Affairs, Indian Health Services, the Great Plains Tribal Leader's Health Board, and the States Attorney's and U.S. Attorney's offices.

Data from death review is shared with the public via published infographics, presentations, and an Infant Mortality Report, developed every 5 years. A data dashboard also displays information from death review and vital statistics on the Department of Health's website under Infant Mortality.

With the expansion of death review to include all child deaths up to age 13, discussions began within the MCH child domain around how we can use the data collected to provide parenting education around injury and death prevention. South Dakota has the 5th highest crude death rate in the nation for child mortality (2010-2019, CDC WONDER). Creating educational materials around injury and death prevention was discussed by the Child workgroup as well as the broader MCH team. Following these discussions, the decision was made during the previous reporting year to bring the DOH Injury Prevention Coordinator in to co-lead the child domain and eventually take over leadership duties.

The decision to bring the DOH Injury Prevention Coordinator in to eventually lead the child domain was met with some challenges in 2022. The position was designed to be shared with the Office of Disease Prevention and Health Promotion, which created some complications for the injury prevention coordinator when reporting to two different lines of leadership, working with multiple grants, and only being able to allocate half their time to MCH. In addition, the Child Death Review data had not been collected long enough to really look at trends and determine leading causes of child injury and death over time. The position turned over and a new Injury Prevention Coordinator came on board at the end of this reporting period. In the absence of a child domain lead, the CYSHCN director stepped in to lead the domain.

Child Health - Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Child Health Domain for the period October 1, 2023, through September 30, 2024. In the upcoming year, the Child Domain will continue to focus on parenting education and support and improving developmental screening rates in South Dakota.

Priority Need: Parenting education and support

NPM 6: Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool

ESM 6.2: Percentage of children enrolled in Bright Start Home Visiting that receive a developmental screen by 18 months of age.

2023-2024 Objective and Strategies

Objective: Increase the percent of children from non-metropolitan areas 9 through 35 months who received a developmental screening using a parent-completed screening tool in the past year from 22.3% (2019-2020) to 29.4% by 2025 (NSCH)

The MCH Child Domain will continue to see changes in the upcoming grant year. The child domain lead position has turned over twice in the last year, leading to a change in direction and focus. Previously, the plan was to have the DOH Injury Prevention Coordinator lead the child domain on parenting education focused on injury prevention, however, this is not feasible with our staffing capacity. The position is vacant at the time of writing, so emphasis will be placed on staff restructuring and keeping current projects running until a new lead can be found. The MCH Child domain is always evolving to meet the priority needs of families and adapt to changing circumstances in program structure and data collection.

Proposed Strategies:

6.1: Utilize Community Health offices and Bright Start Home Visiting Program to provide Ages and Stages Developmental Screening tool to clients.

The Bright Start Program continues to expand statewide under the supervision and leadership of the MCH Director and has added an epidemiologist to assess the program's impact in many different areas, including developmental screening. A new ESM was created last year to measure the percentage of children enrolled in Bright Start Home Visiting that receive a developmental screen by 18 months of age. This measure will track the progress of the Bright Start Home Visiting Program in providing developmental screens throughout the expansion process and beyond. The measure will replace the previous ESM, "Percentage of community health offices who distribute trifold developmental screening tracking cards."

The community health offices in the state will also continue to provide developmental screening, referrals, and education. In January 2022, an electronic health record (EHR) was implemented in all community health offices to streamline data collection and documentation. The EHR will host data from family planning, nurse home visiting, and community health services. Over the next year, data collected through the EHR will give the MCH team a new opportunity to analyze data from programs and services and link risk factors to outcomes. It will also assist in identifying areas where quality improvement is needed.

The community health offices and Bright Start Home Visiting program will continue to provide training to staff on developmental screening and early identification as part of their orientation. Staff are specifically trained in providing and scoring ASQ developmental questionnaires. Ongoing training will also be provided, and staff will be encouraged to sign up for Brookes' Newsletters. Staff are also trained in using the CDC Milestone Tracker app, Bright by Text

app, and Text4Baby and encouraged to assist families with signing up for these services. In addition to technology resources, community health and Bright Start will also offer hard copy resources, including trifold developmental screening tracking cards, milestone checklists, books, and pamphlets to assist families in planning and tracking their child's development and screening.

6.2: Create new and promote existing parenting resources to support healthy children and families

The NPM 6 workgroup will continue to identify parenting resources across the state and collaborate on promotion and dissemination to families. As stated above, community health and Bright Start staff will continue to educate parents on developmental screening through both hard copy and technological resources. In additional to growth and development, education will also be provided in the community health and home visiting setting on a variety of topics that impact children, including immunizations, health and safety including safe sleep, well child checks, oral health, dietary needs, breastfeeding, and community resources. Education is also provided for parent health including depression screening and referral, pregnancy care, disease prevention, injury prevention, and adult immunizations.

In 2023, the SD Toy Lending Library established a location within the Sioux Falls DOH Community Health Office with the support and leadership of the previous child domain lead. The Toy Lending Library provides boxes of age-appropriate toys that encourage exploration and development. The Southeast regional nurse team lead is supervising the program activity while the child domain lead position is vacant.

In 2023, the child domain lead developed laminated posters with QR codes for apple and android that link to Learn the Signs Act Early (LTSAE) materials. The posters were disseminated to Community Health offices to be used with families who do not wish to take home books and hard copy materials. Staff will promote the QR codes and posters in FY24.

The child domain established a contract with SD Parent Connection in 2023 to greatly increase their printing capacity of Learn the Signs Act Early materials. Following the printing, the child domain worked with Parent Connection and the DOH Community Health Worker Program to disseminate these materials to families statewide. In addition, the materials are available for order online and open to any person or organization that wants to order. Statewide dissemination of LTSAE materials will continue through the Community Health Worker Program and the effort is currently lead by SD Parent Connection while the child domain position is vacant.

6.3: Collaborate with partners to identify gaps in parenting education and support and reduce duplication of efforts

The Bright Start Home Visiting manager will continue to report to the MCH Director and collaborate with the MCH child domain leader and workgroup to reduce duplication of and/or gaps in developmental screenings and referrals for evaluation between home visiting and other OCFS programs.

The CYSHCN Director will continue to serve on a Medicaid well-child affinity group focused on improving well-child visits in the American Indian/Alaskan Native population 0-15 months of age. The group coordinated the dissemination of well-child rack cards to nine WIC sites that primarily serve the target population in 2022. Three Horizon Healthcare sites also received the rack cards. The rack cards have been handed out to families by nurses and dieticians along with verbal education on scheduling well-child visits. The affinity group will continue to utilize Medicaid IDs and claims data to track each families' well-child activities through 2023 to determine if the rack cards were effective in prompting the families to attend recommended well-child visits.

The MCH program looks to increase partnership and collaboration with the state's ECCS Project Lead in FY24. The previous child domain lead formed a task force focused on reaching more families with resources in 2023 that included the ECCS Project Lead. The task force focused on goal one of the ECCS Project: *Leverage the capacity of those working directly with families (such as childcare providers, community health workers and home visitors)*

to increase reach and support to families for early childhood health, development, and well-being. A combination of ECCS and MCH funding was used to print materials and train DOH Community Health workers on the importance of providing LTSAE resources to families. The ECCS Project lead will be presenting at an MCH all-staff meeting in June 2023 on progress to date, followed by a group discussion on our goals and areas we can expand our collaboration.

Ongoing Efforts Supported by MCH for the Child Domain

In addition to the above planned activities, the MCH Program will continue to provide support to the following programs for children:

- While children participating in the WIC program are a primary target group, vaccines are routinely marketed and provided for infants, toddlers, preschoolers, and school-aged children. The DOH formed an immunization task force in 2020 due to declines in immunizations in the state and nation.

- School Health services, which include basic student health screening, vision screening, scoliosis screening, hearing screening, and health education, are provided at the request of contracting schools. Oral health screening is incorporated with WIC services. Funding supports interpreter services for non-English speaking families and children served. A DOH school health coordinator position was recently posted in 2023 with support from MCH to supervise and coordinate our school health services.

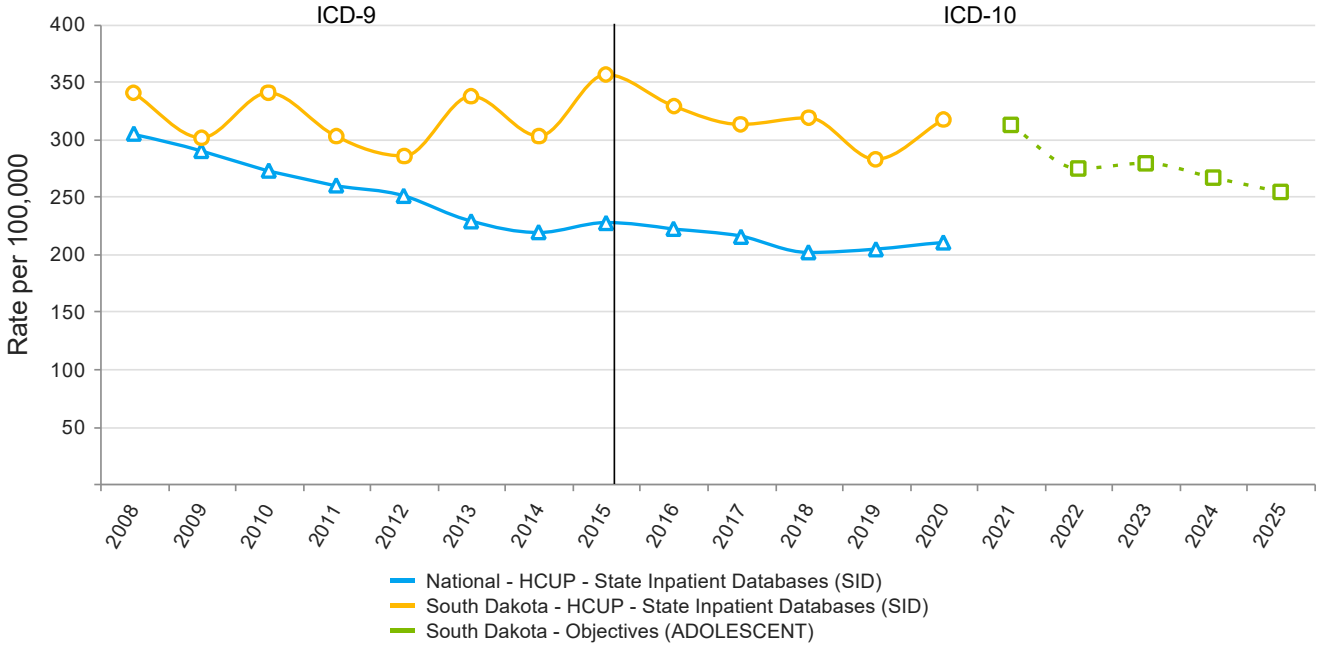
- Park RX Program: WIC programs in South Dakota will be able to prescribe exercise to participants. Participants can take their Park Rx to any South Dakota State Park and turn it in for a free pass for the day. Participants can also turn in the pass that same day and receive a discounted annual pass to encourage yearlong activity.

- Healthy SD: The www.healthysd.gov website has nutrition and physical activity resources that include all age groups. Particularly “Harvest of the Month” is a free curriculum for introducing fruits and vegetables to children http://www.sdharvestofthemonth.org/

Adolescent Health

National Performance Measures

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19
Indicators and Annual Objectives



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data				
Data Source: HCUP - State Inpatient Databases (SID)				
	2019	**2020**	**2021**	**2022**
Annual Objective			312.1	274.2
Annual Indicator	313.0	318.8	281.9	316.4
Numerator	363	378	334	380
Denominator	115,978	118,556	118,466	120,111
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2017	2018	2019	2020

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	278.8	266.3	253.8

Evidence-Based or –Informed Strategy Measures

ESM 7.2.1 - # of students trained in teen Mental Health First Aid

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			60	120
Annual Indicator			38	425
Numerator				
Denominator				
Data Source			class training facilitator	class training facilitator
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

ESM 7.2.2 - Number trained in Youth Mental Health First Aid

Measure Status:	Active
State Provided Data	
	2022
Annual Objective	
Annual Indicator	6
Numerator	
Denominator	
Data Source	Report from training facilitator
Data Source Year	2022
Provisional or Final ?	Final

Annual Objectives		
	2024	**2025**
Annual Objective	12.0	24.0

State Performance Measures

SPM 1 - Increase the percentage of 10-19 year olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 58% in 2022 to 60.74% in 2025.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			46.1	52
Annual Indicator			50.9	58
Numerator			199	307
Denominator			391	529
Data Source			SRAE and PREP survey	SRAE and PREP survey
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	58.9	59.8	60.7

State Action Plan Table

State Action Plan Table (South Dakota) - Adolescent Health - Entry 1	
Priority Need	
Mental Health/Suicide Prevention	
NPM	
NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19	
Objectives	
Decrease the adolescent suicide rate among 15 through 19-year olds from 34.4 per 100,000 (2018-2020) to 26.3 in 2025 (NVSS).	
Decrease the percentage of 9th-12th graders who attempted suicide in the past 12 months from 12.3% in 2019 to 9.0% in 2025 (YRBS).	
Strategies	
7.2.1: Promote evidence-based programs and practices that increase protection from suicide risk.	
7.2.2: Create opportunities for Positive Youth Development (PYD) among diverse youth with a health equity lens.	
7.2.3: Develop and disseminate equitable and accessible Suicide Prevention education material, resources and messaging.	
7.2.4: Develop partnerships with diverse, multi-sector local and state agencies to address youth mental health and suicide prevention among all South Dakota youth.	
ESMs	**Status**
ESM 7.2.1 - # of students trained in teen Mental Health First Aid	Inactive
ESM 7.2.2 - Number trained in Youth Mental Health First Aid	Active
NOMs	
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	

State Action Plan Table (South Dakota) - Adolescent Health - Entry 2

Priority Need

Healthy Relationships

SPM

SPM 1 - Increase the percentage of 10-19 year olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 58% in 2022 to 60.74% in 2025.

Objectives

Decrease the proportion of females aged 15 to 24 years with Chlamydia trachomatis infections attending family planning clinics from 12.1% in 2022 to 11.5% by 2025 (EHR NetSmart).

Decrease the South Dakota teen birth rate, ages 15 through 19, from 17/1000 in 2021 to 16.56/1000 in 2025 (NVSS)

Strategies

1.1: Promote evidence-based programs and practices that increase healthy relationship skills, STI prevention and pregnancy prevention.

1.2: Create opportunities for Positive Youth Development (PYD) among diverse youth with a health equity lens.

1.3: Develop and disseminate equitable and accessible healthy relationship, STI prevention, and pregnancy prevention materials, resources and messaging.

1.4: Develop partnerships with diverse, multi-sector local and state agencies to address youth healthy relationships, STI prevention and pregnancy prevention among all SD youth.

Adolescent Health - Annual Report

Adolescent Health – Annual Report

Adolescent Domain: Annual Report for (October 1, 2021 through September 30th, 2022)

Priorities:

- Suicide Prevention/Mental Health
- Healthy Relationships

NPM 7.2: Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

ESM 7.2.1: Number of students trained in teen Mental Health First Aid

Data Statement:

South Dakota did not meet the 2020 target rate of 279.3 per 100,000 adolescents with a non-fatal injury hospitalization rate of 316.4 per 100,000 adolescents, ages 10 through 19, in 2020. The new 2021 annual target is 303.9 per 100,000 adolescents, ages 10 through 19. South Dakota ranked 48th in the nation in 2020 with a significantly higher rate than the overall U.S. rate of 210.1 per 100,000 adolescents.

State Objective 1:

Decrease the adolescent suicide rate among 15 through 19-year-olds from 34.4 per 100,000 (2018-2020) to 26.3 per 100,000 in 2025 (NVSS).

State Objective 1 Data Statement:

South Dakota did not meet the 2019-2021 target rate of 33.6 with an adolescent suicide rate of 37.2 among 15 through 19-year-olds. This is an increase from 34.4 in 2018-2020. The new 2020-2022 annual target rate is 34.5. South Dakota ranked 48th in the nation in 2019-2021 with a significantly higher rate than the overall U.S. rate of 10.6. The change from the base year (2014-2016) is not significant.

State Objective 2:

Decrease the percentage of 9th-12th graders who attempted suicide in the past 12 months from 12.3% in 2019 to 9.0% in 2025 (YRBS).

State Objective 2 Data Statement:

The objective was aligned to the South Dakota suicide workgroup's target of 9.0% in 2025. The percentage was based on an average rate of 9.4 from 2011-2019. In 2021, 11.9% of 9th-12th graders attempted suicide in the past 12 months.

***Strategy* 7.2.1. Promote evidence-based programs and practices that increase protection from suicide risk**

- Activity: Provide Youth Mental Health First Aid Training
- Activity: Provide Question Persuade Refer trainings for high school staff
- Activity: Provide Teen Mental Health First Aid Training

Title V continued to partner with Helpline Center to provide suicide prevention trainings across the state.

- Youth Mental Health First Aid training – 1 training (6 attendees)
- Question Persuade Refer training – 14 trainings (349 attendees)
- ESM for NPM 7.2.1 - Teen Mental Health First Aid Training – 2 schools (65 attendees)

- Activity: Provide and promote Text4Hope - Teen Crisis Texting Support

Text4Hope: Title V partially funds the Text4Hope program. The program provides crisis texting support for all high school students in the state of South Dakota. Students will typically text in to talk about a variety of issues such as suicidal thoughts, anxiety, depression, stress, concerns about a friend, relationship issues, and family issues.

- Number of texts received: 97

Text4Hope promotions during this reporting period:

- Cōr Health & Wellbeing Social Media posts to promote Text4Hope

September 2022

National Suicide Prevention Month - National Suicide Prevention Week (Sept. 5–11) - World Suicide Prevention Day (Sept
National Yoga Awareness Month
Sexual Health Awareness Month

Text4Hope
Text "icare" to 898211 to talk about a variety of issues such as anxiety, depression, stress, concerns about a friend, and relationship or family issues. With a simple text, you can be connected with Helpline Center professionally trained staff to receive support resources.

Text icare to 898211 to reach Helpline Center staff. Help is available 24/7.

More Information:
https://www.helplinecenter.org/suicide-and-crisis-support/im-having-suicidal-thoughts/

Text4Hope Video:
https://vimeo.com/453441947

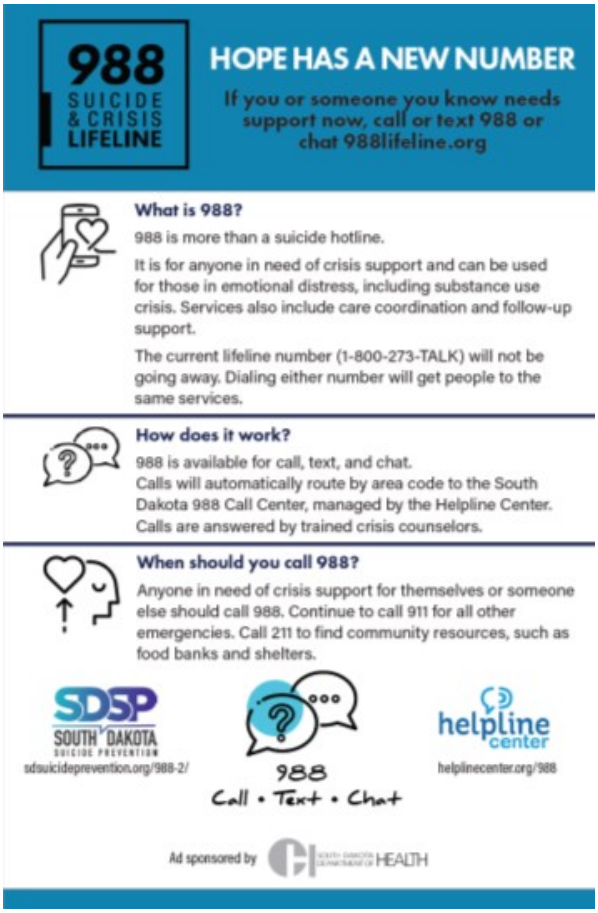
- Partnered with Healthy Relationship grants to promote Text4Hope through a resource card that is shared during class.
- Wrist Key Strap for every High School Student

Title V worked with the Helpline Center to order and distribute a wrist key strap to all 45,667 high school students in South Dakota.

The Helpline Center announced the launch of 988 in July 2022, 988 replaced the National Suicide Prevention Lifeline. Along with the 3-digit number, two other ways to communicate with 988 were the options to chat or text.

At the end of this reporting period, Title V and Helpline Center began looking at how to transition from promoting Text4Hope number to promoting 988 number to youth. This will help illuminate any confusion on what number youth should text and promote a number that is easy to remember but still giving youth the option to text.

South Dakota Medical Journal Ad promotion of 988



Title V worked with the Helpline Center and Department of Social Services to develop and promote this ad in the South Dakota Medical Journal for Suicide Prevention Month (September 2022).

7.2.2. Create opportunities for Positive Youth Development (PYD) among diverse youth with a health equity lens

- Activity: Develop and promote PYD training for organizations working with diverse youth on suicide prevention/mental health.

  Positive Youth Development Conference: Title V partnered with Lutheran Social Services REACH program(www.REACH.LssSD.org) to provide the 5th Annual Positive Youth Development Conference. The conference was started to provide an opportunity for those that work with youth to come together and discuss the latest issues affecting them today. The PYD conference was held online and in person (April 2022) due to the transition back to in person meetings due to COVID-19.
  Topics discussed were:

  - STDs in SD

- Human Trafficking
- Social Media Safety
- Mental Health

- Activity: Collaborate with Youth Advisory Council that focuses on adolescent priorities and provide activities that emphasize health equity and integrating youth voice

  Youth Advisory Council: Title V partnered with LSS of South Dakota to coordinate a youth advisory council. The council will look at both MCH adolescent priorities - Healthy Relationships and Suicide Prevention/Mental Health. In 2021, due to staff turnover and COVID-19, in-person meetings were limited. During 2022, Lutheran Social Services partnered with a youth afterschool program, Youth & Family Services. They meet monthly and participated in activities on Mental Health and Healthy Relationships, incentives for youth participation were provided.

7.2.3. Develop and disseminate equitable and accessible suicide prevention education materials, resources, and messaging.

- Activity: Promote suicide prevention and mental health messaging for Cōr Health & Wellbeing social media

Title V continued to develop suicide prevention, mental health posts for Facebook and Instagram.

www.facebook.com/corhealthsd

www.instagram.com/corhealthsd

Since Cōr Health & Wellbeing's launch in December 2019, the primary goal has been to provide resources to South Dakota parents and youth (10 to 24 years old). To accomplish this, we've been utilizing Facebook and Instagram carousels to distribute Cōr Health & Wellbeing messages on a variety of different subjects such as mental health, suicide prevention, stress management and injury prevention.

During this reporting period the impact of COVID on youth mental health continued to be a high concern. Title V worked with the communication team to develop posts on Mental Health for both youth and parents.

Mental Health Matters
Mental health challenges are the leading cause of disability and poor life outcomes in young people. Unfortunately, in recent years, we've seen significant increases in certain mental health disorders in youth, including depression, anxiety, and suicidal ideation.

Learn more:
https://www.hhs.gov/surgeongeneral/priorities/youth-mental-health/index.html

https://doh.sd.gov/family/Youth/MentalHealth.aspx

- Activity: Develop and promote Suicide Prevention training for parents of young people 10 to 19 years old, including vulnerable/underserved youth.

  At the end of the FY21 reporting period, Title V partnered with USD Center for Disabilities to develop a 4-part Suicide Prevention Video Series. Series focuses on Suicide Prevention, ACEs, Protective Factors, and Mental Health Resources. The video series was developed for parents or those that are working with youth between the ages of 10 to 24 years old. Each part is 5 to 6 minutes long.
  During this reporting period, Title V worked on promoting training through partners such as school newsletters, Cōr Health & Wellbeing, MCH newsletter, and SD DOH Youtube which can be found on the SD DOH website under the youth and young adult section: https://doh.sd.gov/family/Youth/Suicide.aspx.

  - Part 1: Suicide Prevention
  - Part 2: ACES Awareness
  - Part 3: Protective Factors
  - Part 4: Resources

- Activity: Utilize communication platforms to disseminate trainings and materials accessible to diverse parents and organizations working with young people 10 to 19 including vulnerable/underserved youth.

Title V worked on updating both the South Dakota Mental Health & Suicide Prevention Resources and the Adolescent Depression Rack Card. The SD Mental Health & Suicide Prevention Rack Card was updated to include 988 resource and the Adolescent Depression Rack Card was updated to include recent data and resources.

7.2.4. Develop partnerships with diverse, multi-sector local and state agencies to address youth mental health and suicide prevention among all South Dakota youth

Title V continued to partner with organizations that were involved with the Title V Needs Assessment and build rapport with new organizations working with diverse youth in mental health and suicide prevention.

The MCH NPM #7.2 workgroup includes the following diverse partners:

- Suicide Prevention Director, Helpline Center
- Suicide Prevention Director, Department of Social Services
- Crisis Services Program Specialist, Department of Social Services
- Injury Prevention Coordinator, Department of Health
- Director of REACH, Lutheran Social Services
- Pediatric Clinical Nurse Specialist, Sanford Children's Hospital

- Pediatrician/DOH Medical Consultant, Dr. Poppinga
- USD Center for Disabilities, Training Specialist/Adjunct Graduate Faculty
- School Counseling & Student Support Specialist, Department of Education

SPM 1: Improve young peoples' (10-24 years) relationships by increasing the percentage of 10–19-year-olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 50.9% in 2021 to 55.2% by 2025.

Data Statement:

In 2022, South Dakota exceeded the 2025 target of 55.2% with 58.03% of 10-19-year-olds reporting they would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do. A new 2025 target has been set at a 10% increase from the previous target. The new 2025 target is 60.74%. The 2023 annual target is 58.9%.

State Objective 1:

Decrease the proportion of females aged 15 to 24 years with Chlamydia trachomatis infections attending family planning clinics from 12.5% in 2021 to 11.52% by 2025 (EHR NetSmart).

State Objective 1 Data Statement:

South Dakota met the 2022 target of 12.3% with 12.12% of females aged 15 to 24 years with Chlamydia trachomatis infections attending family planning clinics in 2022. The new 2023 annual target is 11.9%.

State Objective 2:

Decrease the South Dakota teen birth rate, ages 15 through 19, from 18.7/1000 in 2020 to 18.4/1000 in 2025 (NVSS).

State Objective 2 Data Statement:

South Dakota met the 2025 target rate of 18.4/1000 with a teen birth rate of 17/1000 in 2021. The new 2025 target was set at a 10% decrease from the previous 2025 target. The new 2025 target teen birth rate, ages 15 through 19, is 16.56/1000. The new 2022 annual target is 16.9/1000. South Dakota ranked 37th in the nation in 2021 and has a rate that is significantly higher than the overall U.S. rate of 13.9/1000. The change from the base year (2015) to the current year is significant.

Strategies:

1.1. Promote evidence-based programs and practices that increase healthy relationship skills, STI prevention and pregnancy prevention

- Activity: Provide and promote STI guidelines training to providers serving young people 10 to 24-years-old, including vulnerable/underserved youth.
    - Promoted 3-session course on syphilis the Department of Health provided from University of Washington Prevention Training Center.
        - Epidemiologic profile of syphilis in South Dakota
        - Recommendations for screening, treatment and management of syphilis infection

- Activity: Collaborate with South Dakota Family Planning Program, Rape Prevention Education (RPE), Title V Sexual Risk Avoidance Education, General Department Sexual Risk Avoidance (SRAE) and Personal Responsibility Program (PREP) Grants serving diverse populations.

At the end of this reporting period Family Planning and PREP grant began looking at partnering to provide a teen pregnancy prevention curriculum within Family Planning Clinics.

- Activity: Develop a youth evaluation plan for MCH programs and partners working on healthy relationship

grants and activities.

Title V will work with the evaluation center, South Dakota State University (SDSU) Population Health to review the MCH healthy relationship priority and five other healthy relationship grants. The five healthy relationship grants are:

- Personal Responsibility Education Program (PREP)
- Title V Sexual Risk Avoidance Education (SRAE)
- General Departmental Sexual Rick Avoidance Education (GDSRAE)
- Rape Prevention Education (RPE)
- Title X Family Planning Program

The evaluation team and SD DOH Healthy Relationships team developed a survey meant to be given to anyone participating in a Healthy Relationships program (which includes SRAE/PREP programs). This survey, the Common Measures Tool, is a pre and post survey to inform on any changes in perspectives or attitudes regarding common subject areas across all Healthy Relationships curriculums:

1. Acceptance of using prevention/protection methods
2. Positive attitudes favoring abstinence
3. Perceived consequences of risky behaviors
4. Perceived self-efficacy (skills & knowledge on healthy relationships)
5. Permissive peer risky behaviors
6. Negative attitudes towards dating or peer violence

1.2. Create opportunities for Positive Youth Development (PYD) among diverse youth with a health equity lens

- Activity: Develop and promote PYD trainings for those working with diverse youth on healthy relationships
- Activity: Collaborate with Youth Advisory Council that focuses on adolescent priorities and provide activities that emphasize health equity and integrating youth voice throughout.

See Positive Youth Development Conference and Youth Advisory Council sections above.

- Activity: Develop an assessment tool for Positive Youth Development activities.

With the development of youth advisory council and the positive youth development conference – a new activity was developed to evaluate youth-focused programming and will measure youth engagement in healthy relationship programming. Development of this tool will help guide Title V and LSS on their youth programming activities and to see the impact of PYD activities in South Dakota.

1.3. Develop and disseminate equitable and accessible healthy relationship, STI prevention and pregnancy prevention materials, resources and messaging.

Title V continued to promote STI and pregnancy prevention posts on Cōr Health & Wellbeing Instagram and Facebook. In addition, Title V partnered with the Rape Prevention Grant to develop specialized messaging on Sexual Violence in South Dakota. With South Dakota being the 3rd highest rape rate in United State.

April Organic Post List

Sexual Assault Awareness Month
April is Sexual Assault Awareness Month (SAAM). SAAM is a campaign to raise public awareness of sexual assault and educate individuals and communities on how to prevent sexual violence. In honor of SAAM, we're sharing what sexual violence looks like in South Dakota.

If you or anyone you know is experience sexual violence, please don't hesitate to reach out to the following resources:

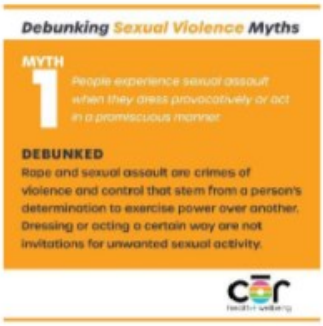
National Sexual Assault Hotline: 1-800-656-4673

https://www.crisistextline.org/

www.rainn.org/get-help

www.endsexualviolence.org/resources/for-survivors

Theses stats came from Whitney Brunner – see below:



- Activity: Develop youth-friendly services materials for agencies and clinics servicing young people 10 to 24 years old.

During this reporting period Title V and Family Planning began working this activity. Looking at what could be developed for both OCFS Community Health Clinics and Family Planning Clinics. Due to Title V Adolescent Health Coordinator staff time being utilized for other projects and grants this project was put on hold.

1.4. Develop partnerships with diverse, multi-sector local and state agencies to address youth healthy relationships, STI prevention and pregnancy prevention among all SD youth

Title V continues to partner with organizations that were involved with the Title V Needs Assessment and build rapport with new organizations working with diverse youth in mental health and suicide prevention.

The MCH SPM #1 workgroup includes the following partners:

- Director of REACH, Lutheran Social Services
- REACH Coordinators, Lutheran Social Services
- Pediatrician/Department of Health Medical Consultant, Dr. Poppinga
- Department of Health, Family Planning Manager
- Department of Health, Sexual Violence Prevention Coordinator
- Department of Health, STI Program Coordinator

Other Adolescent Health activities during this reporting period:

South Dakota Suicide Prevention State Interagency Workgroup: Adolescent Health Coordinator continued to participate in South Dakota Suicide Prevention State Interagency Workgroup that developed the 2020 to 2025 State Suicide Prevention Plan. Workgroup meets monthly to look at understanding local data, develop strategies to address suicide prevention and coordinate efforts and resources in suicide prevention.

OCFS Community Health Office: Adolescent Health Coordinator continued to collaborate with 73 OCFS Community Health clinics located in 61 of SD's 66 counties that provide public health services to the adolescent population such as contracting with local schools for Community Health Nurses to provide preventive health screening and student health education. Education includes growth and development, injury prevention and suicide prevention for middle and high school students.

Adolescent Health – Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Adolescent Health Domain for the period October 1, 2023, through September 30th, 2024. Priority needs identified through the 2020 Needs Assessment process in this domain were: mental health, suicide prevention, and healthy relationships.

PRIORITY: Mental Health/Suicide Prevention

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 to 19.

ESM 7.2.1: Number trained in youth Mental Health First Aid

ESM changed due to no longer providing teen Mental Health First Aid training see *paragraph 7.2.1*

Objectives

Decrease the adolescent suicide rate among 15 through 19-year-olds from 29.2 per 100,000 in 2018-2020 to 26.3 in 2025 (NVSS).

Decrease the percentage of 9th-12th graders who attempted suicide in the past 12 months from 12.3% in 2019 to 9% in 2025 (YRBS).

Proposed Strategies

7.2.1**:** Promote evidence-based programs and practices that increase protection from suicide risk.

- Provide Youth Mental Health First Aid Training

Suicide Prevention Trainings

In the previous reporting period, Title V shifted how they were structuring suicide prevention work. Title V is working with School Health Coordinator who oversees the PHER Workforce Crisis Cooperative Agreement funding. Funding will increase the number of facilitators trained and increase the number of youth Mental Health First Aid trainings provided. With multiple state agencies receiving funding for Mental Health and Suicide Prevention, this changed how Title V supported suicide prevention. Combine efforts regarding Suicide Prevention Gatekeeper trainings – currently an RFP for agencies to apply for funding and Title V will not have a separate contract with the Helpline Center to provide these trainings.

In the upcoming grant year, Title V will focus on supporting other state agencies that are taking the lead in suicide prevention activities. In addition, Title V will begin to focus on the following two new activities.

- *NEW* Provide informational training on the 211 and 988 suicide prevention and mental health resource in South Dakota
- *NEW* Partner with the OCFS Southeast Region to enhance their suicide prevention and mental health support and resources.

7.2.2**:** Create opportunities for Positive Youth Development (PYD) among diverse youth with a health equity lens

- Develop and promote PYD training for organizations working with diverse youth on suicide prevention/mental health.
- Collaborate with Youth Advisory Council to provide activities that emphasize health equity and integrating youth voice

In the previous grant year, Title V partnered with the Lutheran Social Services (LSS) to develop a youth advisory council. The first council meeting was December 2020, council, the council will look at both adolescent MCH priorities - Healthy Relationships and Suicide Prevention/Mental Health. In the current grant year, Title V will continue to partner with LSS to provide Youth Advisory council. With COVID-19 it was difficult start with inconsistency youth attendance and LSS staff turnover. At the end of 2021, Lutheran Social Services partnered with a youth afterschool program, Youth & Family Services. The afterschool program is now the location for the youth action council, they meet monthly and provide activities and incentives for youth participation. In the upcoming grant year, Title V and LSS will continue to grow youth advisory council, plans to coordinate PYD activities and continue striving for the youth voice throughout adolescent programming.

7.2.3**:** Develop and disseminate equitable and accessible Suicide Prevention education material, resources, and messaging.

- Promote suicide prevention and mental health messaging for Cor Health social media
- Utilize communication platforms to disseminate trainings and materials accessible to diverse parents and organizations working with young people 10 to 19 including vulnerable/underserved youth.

Cor Health + Wellbeing: In the current reporting period, Title V worked with their marketing department to develop suicide prevention, mental health posts for Cor Health Platforms – Facebook, Instagram and Snapchat.

www.facebook.com/corhealthsd

www.instagram.com/corhealthsd

In the upcoming grant year, Title V will continue promoting these prevention messages on the Cor Health platforms.

7.2.4**:** Develop partnerships with diverse, multi-sector local and state agencies to address youth mental health and suicide prevention among all South Dakota youth

- Continue to partner with organizations that were involved with the Title V Needs Assessment and build rapport with new organizations working with diverse youth in mental health and suicide prevention.

PRIORITY: Healthy Relationships

SPM 1 – Improve young peoples' (10 to 24 years) relationships by increasing the percentage of 10–19-year-olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 58.03% in 2022 to 60.74% by 2025.

Objectives

Decrease the proportion of females aged 15 to 24 years with Chlamydia trachomatis infections attending family planning clinics from 12.1% in 2022 to 11.5% by 2025 (EHR NetSmart).

Decrease the South Dakota teen birth rate, ages 15 through 19, from 17/1000 in 2021 to 16.56/1000 in 2025 (NVSS).

Proposed Strategies

1.1**:** Promote evidence-based programs and practices that increase healthy relationship skills, STI prevention and pregnancy prevention.

- Provide and promote STI guidelines training to providers serving young people 10 to 24, including vulnerable/underserved youth.
- Collaborate with South Dakota Family Planning Program, Rape Prevention Education, Title V Sexual Risk Avoidance Education, General Department Sexual Risk Avoidance and Personal Responsibility Program Grants serving diverse populations
- Develop a youth evaluation plan for MCH programs and partners working on healthy relationship grants and activities.

Healthy Relationships Youth Evaluation: In the current reporting period, Title V worked with SDSU Population Health Evaluation to review healthy relationship priorities and also five other healthy relationship grants: Personal Responsibility Education Program (PREP), Title V Sexual Risk Avoidance Education (SRAE), General Departmental Sexual Risk Avoidance Education, Rape Prevention Education, Title X Family Planning Program. In Year 2 of the Healthy Relationship evaluation, SDSU completed a Healthy Relationship Curriculum review and wrote a success story.

In the upcoming grant year, the Healthy Relationship Evaluation will continue with the Common Measure Tool. The common measure tool is a pre and post-survey to inform on any changes in perspectives or attitudes regarding common subject areas across all Healthy Relationship curriculums:

1. Acceptance of using prevention/protection methods
2. Positive attitudes favoring abstinence
3. Perceived consequences of risky behaviors
4. Perceived self-efficacy (skills & knowledge on healthy relationships)
5. Permissive peer risky behaviors
6. Negative attitudes toward dating or peer violence

Plans to start utilizing the common measure tool are for the Fall of 2023.

1.2**:** Create opportunities for Positive Youth Development (PYD) among diverse youth with a health equity lens.

- Promote and expand PYD conferences and trainings for organizations working with diverse youth on healthy relationships
- Collaborate with Youth Advisory Council to provide activities that emphasize health equity and integrate youth voice throughout Adolescent activities.
- Promote and expand Positive Youth Development assessment tool for PYD activities.

  In the current reporting period, Title V and LSS REACH program developed a PYD tool and the tool was presented at the April 2023 Positive Youth Development Conference. In the upcoming grant year, Title V and LSS will continue to develop and utilize the assessment tool for PYD activities. LSS REACH plans to provide one on one assistance to agencies that have filled out the PYD assessment tool survey and will have regular meetings with agencies interested in how they can expand their PYD.

Positive Youth Development: See 7.2.2 paragraph above for more details on PYD efforts.

1.3**:** Develop and disseminate equitable and accessible healthy relationship, STI prevention and pregnancy prevention materials, resources and messaging.

- Develop and promote Healthy Relationship, STI prevention and pregnancy prevention messaging for Cor Health social media.
- Utilize communication platforms to disseminate trainings and materials accessible to diverse parents and organizations working with young people 10 to 24 including vulnerable/underserved youth.

In the current reporting period, Title V has worked with their communication team to develop posts on Healthy Relationships subjects to target parents and youth. New COR Health + Wellbeing messaging consists of posts on Healthy Relationships, Sexual Violence Prevention, Dating Violence, STD Prevention, and Immunizations. In upcoming grant year, Title V will continue to develop and promote posts on important and emerging Healthy Relationship topics. Messaging will be promoted on Instagram, Facebook and Snapchat.

1.4**:** Develop partnerships with diverse, multi-sector local and state agencies to address youth healthy relationships, STI prevention and pregnancy prevention among all South Dakota youth.

- Continue to partner with organizations that were involved with the Title V Needs Assessment and build rapport with new organizations working with diverse youth on healthy relationship, STI prevention and pregnancy prevention.

Ongoing Efforts Supported by MCH for the Adolescent Domain:

- Adolescent Health Coordinator and Adolescent Domain leader will continue to participate in South Dakota Suicide Prevention State Interagency Workgroup that recently developed the 2020 to 2025 State Suicide Prevention Plan. Workgroup will meet monthly to look at understanding local data, develop strategies to address suicide prevention and coordinate efforts and resources in suicide prevention.

- Continue to work with Family Planning Program, Rape Prevention Education Program, Department of Social

Services and Department of Education to promote adolescent messaging to parents, youth, and young adults.

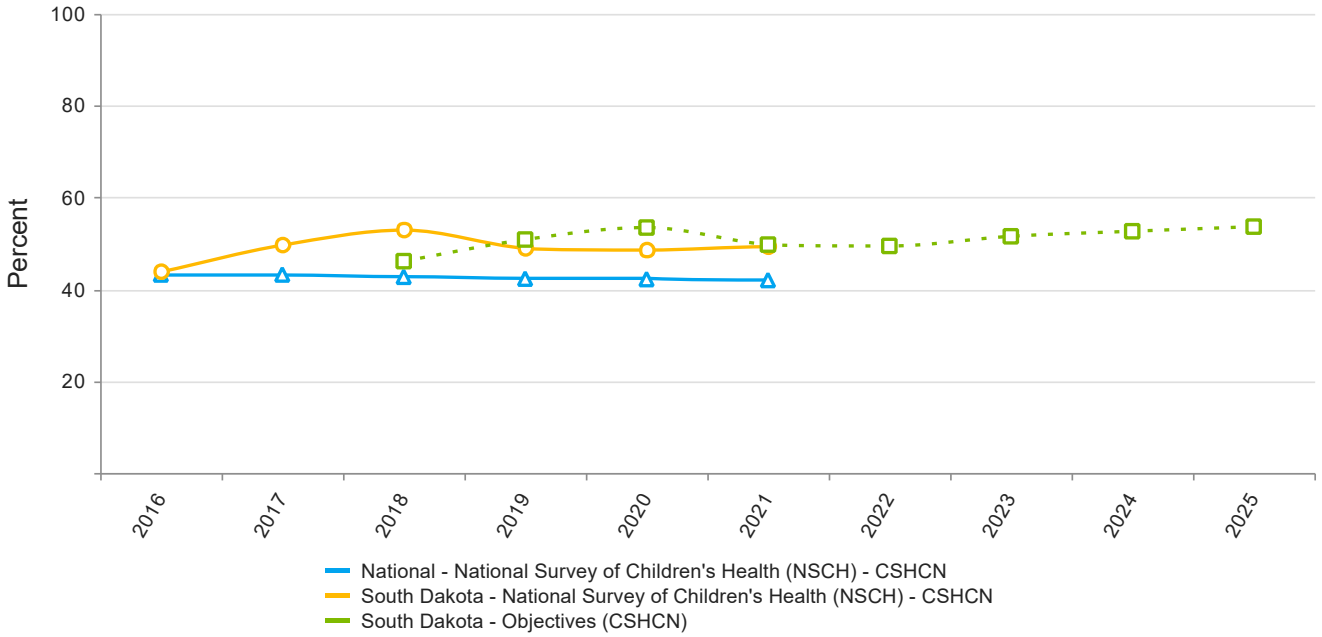
- Continue to collaborate with 73 OCFS Community Health Offices that provide public health services to this Adolescent population such as contracting with local schools to provide preventive health screenings and student health education. Education includes growth and development, injury prevention and suicide prevention for middle and high-schools aged students.
- Adolescent Health Coordinator who oversees Sexual Risk Avoidance Education grant, General Departmental Sexual Risk Avoidance Education grant, Personal Responsibility Education grant, the Rape Prevention Education grant work collaboratively with the Title V Adolescent Domain to ensure there is ongoing collaboration on all adolescent activities.

Children with Special Health Care Needs

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	46.1	50.8	53.4	49.7	49.4
Annual Indicator	49.6	53.0	48.8	48.4	49.4
Numerator	16,789	18,568	17,763	18,368	19,423
Denominator	33,876	35,046	36,404	37,957	39,317
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	51.5	52.6	53.6

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - % of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			100	100
Annual Indicator			18.2	53.7
Numerator			4	22
Denominator			22	41
Data Source			SDSU Population Health	SDSU Population Health
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (South Dakota) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Access to Care and Services	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
Increase the percentage of CYSHCN who report receiving care in a well-functioning system from 20.9% (2019-20) to 21.45% by 2025 (NSCH)	
Strategies	
11.1: Enhance equitable family access to needed supports and services.	
11.2: Identify and implement strategies to equitably advance medical home components for families of CYSHCN through access to family centered care coordination.	
11.3: Coordinate the state newborn screening infrastructure focused on equitable testing and access to follow up services.	
ESMs	**Status**
ESM 11.1 - % of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	

Children with Special Health Care Needs - Annual Report

Caring for a child with special health care needs can be a rewarding and life-changing experience, especially when families and caregivers have appropriate support and access to needed resources. Children and youth with special health care needs (CYSHCN) and their families often face unique challenges as they navigate the health care system. These children may require treatment with multiple specialties, various medications, and use of special medical equipment. Families and caregivers may frequently travel long distances to attend appointments and can suffer significant financial hardship due to treatment costs and time missed from work. Left unsupported, a family may experience emotional distress from trying to manage their child's healthcare on their own.

The South Dakota (SD) Title V 2020 Needs Assessment identified improving access to care and services as the ongoing top priority for our CYSHCN population. The SD CYSHCN Program aims to create and support programs that provide families with the assistance they need to manage their child's healthcare, as well as leverage partnerships to carry out planned activities and deliver services to families. The priority was paired with National Performance Measure 11: Percent of children with and without special health care needs having a medical home.

Data Statement:

Percent of children with special health care needs having a medical home: South Dakota exceeded the 2021 target of 48.9% with 49.4% of children with special health care needs having a medical home in 2020-2021. The new 2022 annual target is 50.5%. South Dakota was ranked 8th in the nation in 2020-2021 and had a significantly higher percentage than the overall U.S. percentage of 42%. The change from the base year (2016) to this year is not significant.

Percent of children without special health care needs having a medical home: South Dakota did not exceed the 2021 target of 54.7% with 51.7% of children without special health care needs having a medical home in 2020-2021. The new 2022 annual target is 54%. South Dakota was ranked 18th in the nation in 2020-2021 and had a significantly higher percentage than the overall U.S. percentage of 47.7%. The change from the base year (2016) to this year is not significant.

State Objective 1:

Increase the percentage of CYSHCN who report receiving care in a well-functioning system from 20.9% (2019-20) to 21.2% by 2025 (NSCH).

State Objective 1 Data Statement:

In 2020-2021, South Dakota did not exceed the 2021 target of 21% with 19.5% of children with special health care needs receiving care in a well-functioning system. The new 2022 annual target is 20%. South Dakota was ranked 4th in the nation in 2020-2021 and had a significantly higher percentage than the overall U.S. percentage of 13.7%. The change from the base year (2016) to this year is significant.

Strategies:

11.1. Enhance equitable family access to needed supports and services

The Western half of the state is underserved in the area of pediatric genetics testing and counseling. Through a contracted partnership with Sanford Health, the CYSHCN Program assists with operational costs for the Sanford Children's Specialty Clinic in Sioux Falls, SD to send a geneticist and genetics counselor to Rapid City, SD eight times per year to conduct genetics outreach clinics. In 2022, a total of 22 individuals were served through this partnership.

Families and caregivers often face higher costs when purchasing car seats with the necessary adaptations to safely transport their child/young adult in a vehicle. To assist families with the higher costs, the SD CYSHCN Program, in partnership with the Department of Social Services Child Safety Seat Distribution Program, funded 29 special needs car seats and accessories in 2022. The funds were used to cover the car seat costs for individual families as

well as for car seats and accessories that are used as short-term loans by our major health care systems.

Caring for a child with special health care needs can be physically and emotionally demanding for a parent or caregiver. They may need a break to recharge, take care of other family members or tasks, or attend to self-care. In order to provide families and caregivers with much needed rest, the CYSHCN Program, through an interagency agreement, provides financial support to the SD Department of Human Services Respite Care Program. The Respite Care Program authorizes families to receive funding for temporary respite care from a provider of the family's choosing. The program is available to any family regardless of income with a live-in child or adult who has a developmental delay, disability, emotional disturbance, severe and persistent mental illness, chronic medical condition, or a traumatic brain injury. The program served 661 individuals statewide in 2022.

The CYSHCN Program's direct service reimbursement program, Health KiCC, continues to be phased out while still running for the participants enrolled. In 2022, a total of 9 participants remained in the program. The program operates as a secondary payer and covers remaining expenses after insurance payment for clinic and hospital services, laboratory, medications, and medical supplies. The program also reimburses participants for travel expenses incurred. If a participant is uninsured, the program reimburses services at the Medicaid rate.

The DOH website continues to be remodeled and the CYSHCN Program page continues to be revised to include an accurate listing of the programs and services supported by the CYSHCN Program. The page is located at https://doh.sd.gov/family/childhood/CYSHCN.aspx.

The CYSHCN Director has established and maintained a partnership with SD Parent Connection to help better connect families to resources in our state. The CYSHCN Director ensures all families who contact the office for resources are aware of SD Parent Connection and provides direct contact information.

The CYSHCN Director serves on many workgroups and councils across the state, including the SD Developmental Disabilities Council, the State Community of Practice team, a child interagency workgroup, a SD Transition Partnership workgroup, the DHS Division of Developmental Disabilities Stakeholder Collective and various other groups by invitation. These groups are often, but not always, attended by family organizations as well as family and self-advocates and provide a line of communication to hear family perspectives as well as share the work we are doing and obtain feedback.

11.2. Identify and implement strategies to equitably advance medical home components for families of CYSHCN through access to family centered care coordination.

In 2022, the Sanford Patient Navigation Program, in partnership with the CYSHCN Program and South Dakota State University (SDSU) Population Health, completed its second year of implementation and was renamed the Pediatric Complex Medical Care (CMC) Program. The program consists of a Registered Nurse Patient Navigator and a pediatric Certified Nurse Practitioner housed in the Sanford Children's Hospital in Sioux Falls, SD. The Patient Navigator and Nurse Practitioner provided extensive care coordination services to the first and second cohorts totaling around 56 participants. This number is fluid as patients enter and discharge from the program. The participants were chosen by Sanford based on criteria provided by the CYSHCN Program. The first cohort criteria included the following:

- The participant must be under 18 years old
- Participant must have a very complex medical condition (3 or more systems involved)
- Participant must have Medicaid or be uninsured
- Preference should be given to participants who live further than 100 miles from Sioux Falls

Participants were given the option to voluntarily participate in the evaluation portion of the program, provided by SDSU. A financial incentive was provided to the families for participation in the evaluation. The evaluation portion

consisted of a pre and one year post family survey, an affiliated professional survey, and an ongoing evaluation based on a care coordination management tool used by the Patient Navigator and Nurse Practitioner.

Based on feedback received from these surveys, the second cohort criteria was modified to include the following:

- The patient must be under 18 years old
- Participant must have a complex medical condition (does not need to involve 3 or more systems)
- Participant must have Medicaid

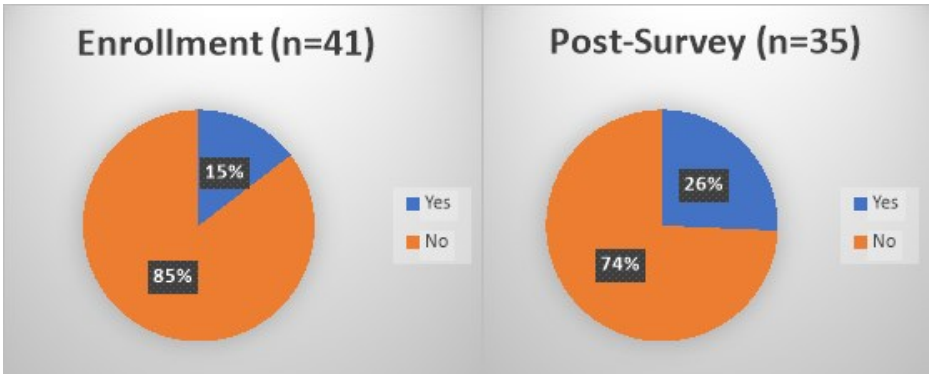
In addition to the above criteria, the preference for families living further than 100 miles from Sioux Falls was dropped as it was noted most families of children with complex medical conditions receiving extensive care at the Children's Hospital have relocated to the Sioux Falls area. By dropping this preference, the Sanford team was able to focus recruitment where they saw the most need, as opposed to giving geographical preference. Additional income verification measures were put in place in 2022 and subsequently dropped as they created too many barriers to get families the services they need. Lastly, the second cohort had a higher percentage of children under 5, as families expressed a greater need for navigation services early on in their journey with their child through the healthcare system.

Recruitment, retention, and surveying of the second cohort was met with some challenges. The RN Patient Navigator position turned over in 2021 prior to the start of the Nurse Practitioner. The position remained vacant for several months and the program was carried on by a combination of nurses and social workers on staff. Recruitment was paused at this time. When a new RN Navigator was brought on, recruitment slowly resumed, but took time as the navigator became acquainted with the existing participants and the level of care they needed. When the Nurse Practitioner came on board in December 2021, recruitment really picked up and the program began to thrive again. Due to the months of program staff vacancy, the participants included in the second family survey report had been in the program for various lengths of time, ranging from 1 to 2 years. However, the same process was followed, and families were surveyed at enrollment and again after 1-2 years in the program, as we wanted to give those families that joined after the vacancy a full year of services received from the RN Navigator prior to filling out a post survey.

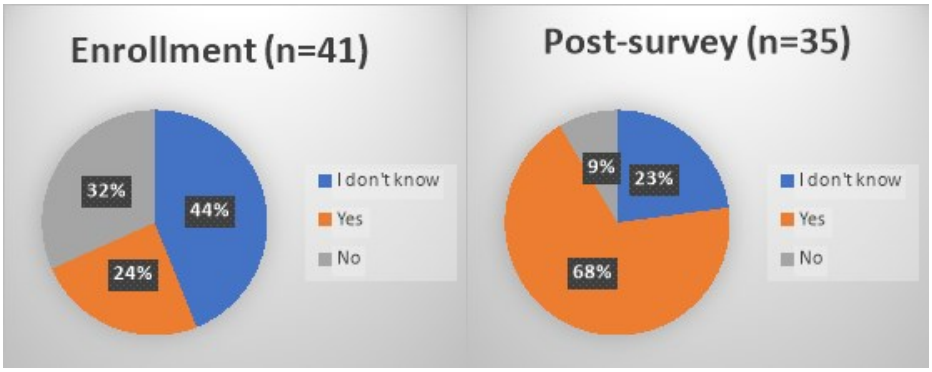
The second cohort post survey was completed in the early spring 2023 and had an 85.4% response rate from the participants. Most notable results included:

- Families meeting criteria for receipt of care in a medical home went from 14.6% at enrollment to 25.7% at the time of post survey.
- Parental awareness of a shared plan of care went from 24% aware of their child's shared plan of care at enrollment to 68% aware at one year.
- Nearly 65.9% of families reported they have not received the extra help with care coordination they need at enrollment. At post survey, no families reported a need for extra help that was not received.

Families Meeting Criteria for Receipt of Care in a Medical Home:



Parental awareness of shared plan of care:



Comments from families about the program:

"I am very happy that this hospital has a care team for patients with multiple doctors. It eases the stress on me and helps me organize appointments with people that care. I am grateful for their help!"

"Right now, I am happy with (child)'s care team and have no complaints. I am extremely upfront and direct and have no issues communicating. We have a great team currently, and we address any issues as they arise!"

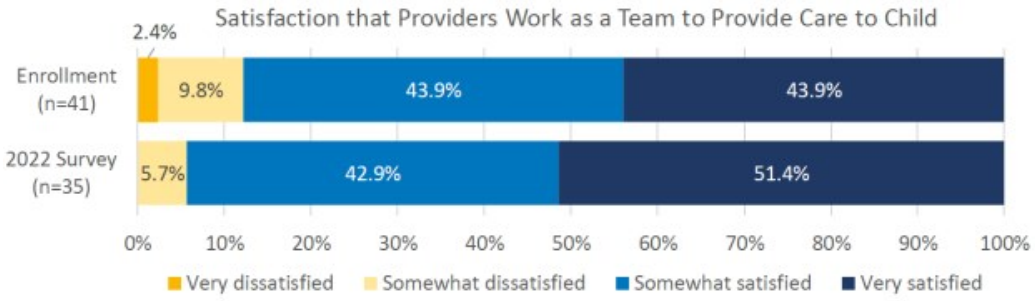
"This program has been a huge blessing to our family. We appreciate everything done for us."

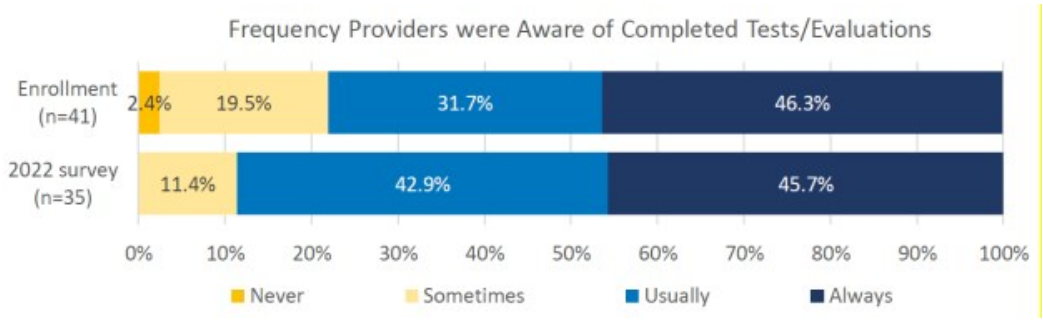
"I am more than happy with the efforts of the care team members. They're very supportive and attentive."

"No (suggestions), I love the team and the care (child) gets."

The program also received suggestions for improvement in the second cohort survey. Several suggestions included better scheduling of appointments to reduce travel and more frequent reminders of upcoming appointments. Other suggestions included more awareness of available community resources and support groups they can connect with. A few families expressed concern over their Medicaid coverage status.

Year one results also showed improvements in parent/caregiver satisfaction with their child's healthcare team.





Extent to which the Healthcare Team Encouraged Family to Share in Decision-Making

In addition to measuring family perceptions and satisfaction, the program also looked at healthcare utilization metrics.

	Medical Visit Days	Medical Providers	All Providers	Cancel/ No-Show Visits	Hospital Stays	ED Visits
Year Prior to Enrollment (n=41)	59.3 days (range: 10 to 170 days)	7.9 providers (range: 3 to 19)	15.3 providers (range: 4 to 40)	9.7 visits (range: 0 to 64)	73.2% had 1+ hospital stay	51.2% had 1+ ED visit
Year 1 (n=41)	42.3 days (range: 3 to 134 days)	14.9 providers (range: 5 to 38)	21.3 providers (range: 5 to 51)	28.3 visits (range: 0 to 156)	65.9% had 1+ hospital stay	48.8% had 1+ ED visit
Year 2 (n=19)	26.1 days (range: 1 to 85 days)	15.5 providers (range: 4 to 38)	19.8 providers (range: 5 to 45)	21.9 visits (range: 1 to 88)	42.1% had 1+ hospital stay	36.8% had 1+ ED visit

The full report on post-program outcomes and perceptions of the cohort two families is available in the supporting

documents of this application.

In 2022, the decision was made to finish the cohort two family post surveys, conduct final patient in-person interviews on 12 selected families, then focus primarily on healthcare utilization metrics moving forward. As the program continues to grow and thrive and participation is becoming more fluid based on need, it is less feasible to group patients into cohorts and accurately capture their perceptions as a group. This is a positive change, as the program is growing out of its pilot phase and into a permanent fixture of the Sanford Children's Hospital. With that, the CYSHCN Program has begun to address the challenge of making the program financially sustainable in the long run. There is high demand for the program, but current funding cannot sustain it in the long run without support from Medicaid. The CYSHCN Director and SDSU evaluation lead met with Medicaid regularly in 2022 to share data from the program and show its potential as a Medicaid Health Home. These conversations are ongoing at this time of writing.

11.3. Coordinate the newborn screening infrastructure focused on equitable testing and access to follow up services.

- The SD newborn screening program continued to utilize a contracted newborn screening laboratory, the State Hygienic Laboratory at the University of Iowa (SHL). SHL provides regional newborn screening testing services and initial notifications to 4 state newborn screening programs. To ensure every infant born in SD has a newborn screening completed (SDCL 34:24:16-25), the contract laboratory sends newborn screening reports electronically through a match process which are linked to the infant's birth certificate via a secure web-based software application known as the Electronic Vital Records and Screening System (EVRSS). This system has the ability to identify infants who may have missed, or the parents have refused the newborn screening. Infant hearing screening results are reported directly into EVRSS as hospitals file birth certificates, the system also can identify missed hearing screens and failed screenings.
- In 2021, the Newborn Screening Program established the South Dakota Newborn Screening Advisory Committee, consisting of pediatric specialists, laboratory personnel, nurses, pediatricians, families, and community members interested in learning more and providing input on the program. The committee was formed to bring professionals and families together and will convene on an annual basis to receive updates from the newborn screening program, provide program input, and discuss additions of new disorders to the South Dakota panel of disorders. SMA and Pompe Disease have been added to the screening panel since the inception of the Newborn Screening Advisory Committee.
- In 2022 and 2023 the NBS program developed new, updated, and improved educational materials as well as HIPPA compliant forms. A physician lab request form will be added in the summer 2023. The program has also been developing a long-term follow up program in conjunction with the CYSHN CMC program at Sanford Children's Hospital to provide assistance, long term follow up and avoid potential loss to follow up.
- The NBS coordinator has partnered with the midwife community to ensure quality specimens, compliance, and reporting. Educational supplies and materials have been created to the specific populations that they serve. The program has also provided high volume midwives and developed a midwife sharing program with hearing screeners to ensure screening. A newborn hearing screening short follow up program was developed and started in September 2022 in conjunction with the SD EHDI program. Expansion of newborn hearing EHDI follow up is planned for later 2023. Looking at missed or not passed hearing screening in the first 6 months of follow up, the program has successfully improved by 78%.
- During this grant period, the MCH team continued to partner with the IOWA SHL for newborn screening testing and destruction of specimen collection cards. The Newborn Screening Program Coordinator participated in Iowa SHL's monthly partnership calls among the four state newborn screening programs; Alaska, Iowa, North Dakota, and South Dakota. In addition, the NBS Program Coordinator attended the 2022 APHL Newborn Screening Symposium.

Children with Special Health Care Needs - Application Year

In this section, South Dakota MCH Title V reports on planned activities in the Children and Youth with Special Health Care Needs (CYSHCN) Domain for the period October 1, 2023 through September 30, 2024. The CYSHCN Domain will continue to focus on improving access to care and services in the upcoming year.

Priority: Access to care and services

NPM 11: Percent of children with and without special health care needs having a medical home

ESM 11.1: Percentage of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services

2022-2023 Objective and Strategies

Objective: Increase the percentage of CYSHCN who report receiving care in a well-functioning system from 20.9% (2019-20) to 21.45% by 2025 (NSCH)

Proposed Strategies:

11.1: Enhance equitable family access to needed supports and services

In the application year, the CYSHCN program will continue to provide funding and support to the following programs:

- Provide financial support to the DHS respite care program for families of CYSHCN and continue to refer families to the program to enhance equitable access to respite services across the state. This program continues to translate all of their materials to Mandarin, Spanish, Amharic, and the Karen language. This is a long-awaited change and will increase family access to these services.
- Provide financial support for operational costs of genetics outreach clinics in Rapid City, SD. This support allows the Sanford Children's Specialty Clinic to send geneticists and genetics counselors to Rapid City, SD for 8 one-day clinics set up throughout the year.
- Partner with DSS to support equitable provision of special needs car seats through the Child Safety Seat Distribution Program. The CYSHCN Program plans to focus on raising public awareness of these services in the upcoming year.
- The CYSHCN Program plans to work toward the final phase out of the Health KiCC Program in FY24. This will involve addressing administrative rule, providing lists of contacts and resources to current participants, and setting a timeline that provides remaining participants enough time to prepare.

11.2: Identify and implement strategies to equitably advance medical home components for families of CYSHCN through access to family centered care coordination

- Partner with Sanford Health to provide care coordination services for families of children with complex medical conditions at Sanford Children's Hospital. In FY24, the CYSHCN program will focus efforts on making this program financially sustainable long-term. The program will continue to collect healthcare utilization metrics and present findings to Medicaid in an effort to turn the program into a Health Home and reduce or eliminate block grant funding.
- The Complex Medical Care program will conduct final interviews of 12 selected families in spring and summer of 2023 to gain final perceptions of the program and recommendations moving forward.
- The Complex Medical Care program received feedback from the second cohort of participants that the program should provide more assistance with connecting families to resources. In addition, the Newborn Screening Program has expressed a need to bring long-term follow up services back to the state. In response to these needs, the Complex Medical Care Program will be adding a full time social worker to provide long-

term follow up services for metabolic newborn screening as well as assisting families in the CMC Program with connecting to resources.

11.3 Coordinate the state newborn screening infrastructure focused on equitable testing and access to follow up services

- Contract with the Iowa State Hygienic Laboratory for the newborn screening and initial follow up of all South Dakota births.
- Partner with Sanford Children's Specialty Clinic to contract medical consultants, genetics counselors, and a follow up nurse to address equitable and appropriate testing, treatment, and follow up for out-of-range results and presumptive positive cases.
- The Newborn Screening Advisory Committee will continue to convene on an annual basis to give families and providers an opportunity to come together, share updates, and obtain feedback. In 2023, the committee adopted mission and purpose statements, and voted to implement a formal nomination process for nominating conditions to be added to the panel.
- A Newborn Screening Subcommittee is in development and plans to hold their first meeting in fall 2023. As part of the new formal nomination process, the subcommittee will review proposals of new conditions to be added to the NBS panel based on specific criteria. If a condition is approved by the subcommittee, it will move to the full committee for consideration and vote.
- The Newborn Screening Program will continue to provide support to SD midwives by providing resources including heel test kits to provide consistent, high quality services.
- The Newborn Screening Program is also preparing for a possible hearing screening mandate in future years. The program has been purchasing hearing screeners to be used in Community Health Offices and is looking into spaces to provide tele audiology services.
- In May 2023 the South Dakota Newborn Screening Program has entered into a MOU with APHL Newsteps for quality improvement programing.
- The NBS Program will continue to develop culturally appropriate materials for diverse populations across the state as well as forms and processes that are HIPPA compliant.

Additional Efforts Supported by MCH for the CYSHCN Domain

- The South Dakota Early Hearing Detection and Intervention (EDHI) Collaborative, a partnership between the University of South Dakota and the South Dakota Department of Health State EHDI program, along with other partners including the South Dakota School for the Deaf was established in 2015. The SD EDHI Collaborative works to improve early identification of hearing loss in children and promote early intervention services for children and their families across the state of South Dakota. The efforts of the SD EDHI Collaborative are funded through a Health Resources Administration and Services grant through the University of South Dakota with Department of Health state EHDI program support. The EDHI Collaborative will continue to develop and expand the newborn hearing follow up program with various state departments to ensure a care coordination and continuum past infancy into childhood.

- The Newborn Screening Program Manager participates in monthly quad-state meetings with the Iowa State Hygienic Laboratory, the Iowa Newborn Screening Program, the Alaska Newborn Screening Program, and the

North Dakota Newborn Screening Program. These meetings bring together the four state programs that utilize the Iowa State Hygienic Laboratory for newborn screening processing to network, work through emerging issues, and collaborate.

- The CYSHCN program supports the cost of early identification and referral of children with possible developmental delays via the purchase of Ages & Stages Developmental Screening instruments and staff time to refer families for further evaluation if a concern is identified on the screening.

- The CYSHCN Director participates in The National Community of Practice State Team meetings, which bring together state agency representatives, public and private partners, and family members focused on the mission of supporting families of individuals with intellectual and developmental disabilities. In 2021, the State Community of Practice Team, led by the Assistant Director of the Department of Human Services Division of Developmental Disabilities (DHS DDD), joined with other workgroups within the DHS DDD and created a Stakeholder Collective, which meets quarterly and brings professionals, families, and individuals with intellectual and developmental disabilities together.

- The CYSHCN Director, MCH Program Director, and Office of Child and Family Services Administrator participate in quarterly DOH-Medicaid Collaborative meetings as well as quarterly Child and Family Services Interagency Workgroup meetings. These meetings bring state agencies together that serve families to discuss current projects, identify and work through challenges, and align our priorities and objectives to promote collaboration.

- The DOH CYSHCN program is part of a multi-program contract to maintain our vital records data system. This allows us access to data specific to births and deaths within our state. Data is collected specific to maternal health issues during pregnancy that could affect the birth outcome.

- The CYSHCN Director will continue to serve on a Medicaid well-child affinity group focused on improving well-child visits in the American Indian/Alaskan Native population 0-15 months of age. In 2022, well-child rack cards were distributed to nine WIC sites that primarily serve the target population. Three Horizon Healthcare sites also received the rack cards. The rack cards will be handed out to families by nurses and dieticians along with verbal education on scheduling well-child visits. The affinity group has been utilizing Medicaid IDs and claims data to track each families' well-child activities through 2023 to determine if the rack cards were effective in prompting the families to attend recommended well-child visits.

Cross-Cutting/Systems Building

State Performance Measures

SPM 3 - Percent of data equity principles implemented in South Dakota MCH projects

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator		50.7
Numerator		73
Denominator		144
Data Source		South Dakota Data Equity Tool
Data Source Year		2022
Provisional or Final ?		Final

Annual Objectives			
	2023	2024	2025
Annual Objective	56.0	57.8	59.6

State Action Plan Table

State Action Plan Table (South Dakota) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Data Sharing and Collaboration
SPM
SPM 3 - Percent of data equity principles implemented in South Dakota MCH projects
Objectives
Increase the extent to which data equity principles have been implemented in SD MCH data projects from 54.2% in 2021 to 59.6% in 2025.
Strategies
3.1 Provide access to timely data to internal partners and policymakers to support evidence-based decision making.
3.2 Provide access to relevant data to external partners and communities to support community-level initiatives for prevention.
3.3 Make the application of data equity principles a required element for sharing data and of epidemiologic reports produced by OCFS so that communities, internal and external partners can use it in their own efforts to advance equity.
3.4 Increase collaboration around American Indian data between state and tribal partners
3.5 Improve internal capacity to share data via referrals between different OCFS programs.
3.6 Increase internal capacity for big data linkage.

Cross-Cutting/Systems Builiding - Annual Report

Priority: Data sharing and collaboration

SPM 2: The extent to which data equity principles have been implemented in SD MCH data projects

2021-2025 Objectives and Strategies:

Objective:

1. Increase the number of new data sharing projects accomplished from zero to seven by September 30th, 2025.

2. Increase the number of new partners that we collaborate with on data projects from zero to five by September 30th, 2025.

Data Statement

During the reporting period, five new MCH data sharing projects were accomplished. This included the 2016-2020 infant mortality report, Women's Report Card, 2020 SD PRAMS report, the Strategic Community Outreach and Outcomes Plan (SCOOP) dashboard, and the mortality data crosswalk. These projects are discussed in greater detail throughout this report. The MCH team also formed four new partnerships for data collaboration, which included the Association of State and Territorial Health Officials (ASTHO), Dakota State University (DSU), Great Plains Tribal, and Johns Hopkins Center for Injury Research and Policy.

Proposed strategies:

2.1: Provide access to timely, reliable data so that partners and communities can use it in their own efforts to advance equity.

- Data dashboard with MCH data
  The MCH Epidemiologist and WIC data specialist finalized the MCH data dashboard and posted it to the internal knowledge base site for Office of Child and Family Services (OCFS) staff use. The dashboard was designed to follow the main health outcomes from a theory of change document that guides the office's work. The dashboard also served as a critical piece of the needs assessment for staff working on the new Strategic Community Outreach and Outcomes Plan (SCOOP).
- South Dakota PRAMS released 2020 data reports. The full surveillance data report can be found on the South Dakota Department of Health website.
  https://doh.sd.gov/documents/statistics/PRAMS_SurveillanceDataReport_2020.pdf
- Maternal Child Health data was shared with partners through a variety of newsletters and list servs, including the April 2022 South Dakota Department of Health Bulletin. The bulleting provided information about and a link to the South Dakota 2020 PRAMS Surveillance Data Report.
- The Infant and Child Health Epidemiologist presented infant mortality and safe sleep data to the following groups:
  - Child Workgroup (February)
  - Preventable Death Committee (April)
  - Safe Sleep Workgroup (August)
  - East River CDR (September)
  - West River CDR (September)

2.2: Develop reports that highlight health inequities across programs and issue areas.

- Infant Mortality and Prevention Report The MCH Epidemiologist finalized the 2016-2020 Infant Mortality and Prevention Report which utilized data from vital records, infant death review, and PRAMS to share infant and maternal health outcomes. This report was shared with partners through a variety of methods including the April 2021 Maternal and Child Health Newsletter that reaches over 150 MCH partners statewide.
  https://doh.sd.gov/documents/statistics/InfantMortalityReport_2021.pdf
- South Dakota Women's Report Card The MCH Epidemiologist worked with a MPH Student from the University of South Dakota to create a women's health report card. This report card brought together health indicators from a variety of areas, including prenatal and postpartum care, birth outcomes, infectious diseases, substance use and mental health, and more. The report card is still in draft version but may be finalized to share with partners during the next reporting period.

2.3**:** Analyze de-identified data to assess social determinants of health and other underlying factors that play a role in morbidity and mortality.

- SD Maternal Mortality Review Committee The South Dakota Maternal Mortality Review Committee began reviewing cases in October 2021. The MCH Epidemiologist serves as the data analyst and co-coordinator for this committee. The committee is using the MMRIA system to abstract deaths. The group also participated in the pilot group to use the Discrimination and Social Determinants of Health (DASH) tool when reviewing cases. This gives the group a consistent set of data points to collect and generate conversation about how discrimination and social determinants of health may have been contributing factors in these deaths. The MCH Epidemiologist also implemented the socio spatial tool to further gain information about the places where these women lived and how that may have contributed to the deaths.
- Social Determinants of Health in Death Review The Infant and Child Health Epidemiologist created a spreadsheet to track the life course social determinants of health factors identified during child death review and maternal mortality review. This spreadsheet helps to track these factors, find common themes between deaths, and perform analysis quickly.

- 2.4 Increase collaboration around American Indian data between state and tribal partners
  - Infant Mortality Meetings with Tribes: Upon seeing the high American Indian infant mortality rates, the Maternal Child Health Epidemiologist and Infant and Child Health Epidemiologist joined the monthly Tribal calls between the Tribes and Department of Health to show new data and discuss current and future collaboration efforts for prevention.
  - The Infant and Child Health Epidemiologist provided the Sisseton-Wahpeton Tribal Health Director with the American Indian pre-term birth, infant mortality, and stillbirth percentages and counts for Tribal counties from the last 10 years.

New Efforts:

- Strategic Community Outreach and Outcomes Plan (SCOOP) SCOOP is a new strategic plan for OCFS that includes WIC, community health services, and MCH priorities and staff. Each of the 75 clinics across the state is required to have a plan. The MCH epidemiologist led public health managers and staff through an evidence-based, public health strategic planning process in 2022. All the staff were led through a community health needs assessment, prioritization, and action planning. Each clinic has 5 action plans, one for nutrition, outreach, and breastfeeding to meet WIC requirements. Each clinic also has an infant mortality plan that aligns with the MCH block grant infant domain, and a fifth plan on a topic of their choice which varies by region of the state. The topics include vaccination for pregnant women, mental health for women, and mental health for youth. These plans also align with current maternal and adolescent domains in MCH. The clinics will start plan implementation in January 2023. The data team is working on outcome and evaluation indicators to measure this work.
- The MCH Epidemiologist attended the 2022 CityMatch Intermediate to Advanced training where she was able to further sharpen her analysis and evaluation skills. There was also a focus on equity and social determinants of health data. She attended a roundtable discussion on small numbers and reporting.
- The MCH Epidemiologist applied for and was awarded the Association of State and Territorial Health Officials (ASTHO) Linking PRAMS and Clinical Outcomes Data grant. The project team consists of the SDDOH vital records manager, Health Informatics Analyst, the MCH Epidemiologist, contracted data staff from South Dakota State University and Dakota State University, and the Medicaid Data Analyst. The team will be linking Medicaid claims data to SD PRAMS data from the years 2018-2020 in hopes of learning more about how experiences before and during pregnancy relate to outcomes, services, and access to care postpartum for women on Medicaid.
- The MCH Epidemiologist led a new OCFS team of staff focused on how to improve data reporting and quality. The team went through a gap analysis of current quality work in the department and made a recommendation to bring on a full-time contracted quality improvement specialist. The MCH Epidemiologist will be writing a request for proposal for this position.

Ongoing Efforts Supported by MCH for Cross-Cutting/Systems Building Domain

- PRAMS: MCH continued to conduct CDC Pregnancy Risk Assessment Monitoring System (PRAMS) through a contract with South Dakota State University. 2020 PRAMS data was weighted and sent to South Dakota. SD PRAMS produced multiple reports from this data including the following:
  - 2020 Data summary report by maternal race, December 2021
  - 2020 Data summary report by WIC participation, December 2021
  - 2018-2020 Data summary report among WIC participants by public health service region, December 2021
  - 2019 Data report and summary report for American Indian mothers by reservation counties, PRAMS

data report booklet, December 2021
- 2020 Opioid Supplement Summary, December 2021
- 2020 Disability Supplement Summary, December 2021

Cross-Cutting/Systems Building - Application Year

Priority: Data sharing and collaboration

SPM 3: The extent to which data equity principles have been implemented in SD MCH data projects

2021-2025 Objectives and Strategies:
Objective: Increase the extent to which data equity principles have been implemented in SD MCH data projects from 54.2% in 2021 to 59.6% in 2025.

Proposed strategies

3.1 Provide access to *timely* data to internal partners and policy makers to support evidence-based decision making

- Maternal and Child Health Indicators Monitoring (OCFS Internal Dashboard)
  The Office of Child and Family Services developed an internal data dashboard with indicators of Maternal and Child Health in South Dakota, with the purpose of carrying out the Strategic Community Outreach and Outcomes Plan (SCOOP)[1]. The dashboard was last updated in March 2022; findings displayed in the dashboard are most likely outdated and need review.
  During the next reporting period, the MCH epi team will update to the dashboard. After dashboard is updated, the MCH epi team will work to advertise the dashboard to our internal partners and SD policy makers. The MCH epi team will also identify items of dashboard that may be automatically updated based on real-time data, develop, and implement automation. The goal is to maintain the internal dashboard as current as possible, to serve as a source for evidence-based decisions.

- Bright Start Report Indicators
  A report of Bright Start Indicators will be produced. The report will be designed with the primary goal of providing nursing teams with regular feedback for their annual Continuous Quality Improvement projects. Additionally, it will be used to identify data quality issues, particularly those that impact program outcome measures reported to funders. While data quality improvement and monitoring comprise the primary goal, the data will include all clients in the program— both those within the Nurse Family Partnership (NFP) model, and those served within the Bright Start Program, but outside of the NFP model. Previously, data was only available for NFP clients, but with the inclusion of non-NFP client data in the report, contents of the report will be used to inform Medicaid and support their policy making process.

3.2 Provide access to *relevant* data to external partners and communities to support community-level initiatives for prevention.

- Maternal mortality report
  The number of maternal deaths in South Dakota is relatively small (less than 10 cases a year); because of that, it is challenging to produce county-level data without risking identification of the decedent. On the other hand, county-level data is necessary in order to identify priorities for preventive interventions at community-level. To address that need and the challenge, a report about Maternal Mortality in South Dakota will be produced covering a longer span of time (10 years).

- Infant mortality report
  The number of infants deaths reviewed by the Child Death Review (CDR) committee in South Dakota is also relatively small (less than 30 cases a year). Our goal is to produce an infant mortality report that covers the same period as that of the maternal mortality for the reasons discussed above.

- PedNSS/PNSS report
  WIC collects health and nutrition data on its participants through the Pediatric Nutrition Surveillance System (PedNSS) and Pregnancy Nutrition Surveillance System (PNSS). For example, PedNSS indicators include rates on breastfeeding and obesity for infant and child participants, along with Pregnancy BMI, frequency of smoking, and multivitamin consumption for PNSS indicators. This data has not been consistently disseminated internally nor externally.

- Dissemination of data
  Once completed, both the maternal and infant mortality reports will be presented together to communities and external partners in all regions of SD. We also plan to disseminate the findings from PedNSS and PNSS report with communities and external partners.

3.3 Make the application of data equity principles a required element of epidemiologic reports produced by OCFS so that communities, internal and external partners can use it in their own efforts to advance equity.

- Standardize data requests
  The Office of Child and Family Services is the steward of a wealth of data that could be used by both internal and external partners as evidence for well-informed decision making. Currently, we don't have a standard process in place that those partners can use to request the aforementioned data, so a lot of the access depends upon contact via e-mail. We want to implement a standardized electronic form for data requests, so that both external and internal partners can communicate with us about their data needs in a fast, efficient way, and we can keep track of the requests, to make sure that they are attended to in a timely manner. We aim to ensure data integrity by implementing that form.

- Qualitative data analysis of risk factors, social determinants of health, and preventive measures of maternal and infant mortality
  The Maternal Mortality Review Committee (MMRC) has completed the review of three years of cases of maternal deaths. Those reviews contain a wealth of information about risk factors, social determinants of health and possible preventive interventions. The Maternal Mortality Report will also include a qualitative analysis of those items from MMRC reviews. In going through the cases analyzed by the Child Death Review (CDR) Committee, we noticed that some of the underlying risk factors and recommendations were similar to the cases reviewed by MMRC. We will also produce a qualitative data analysis of the risk factors, social determinants of health, and preventive interventions of the CDR committees' reviews. Our final objective is to compare findings from both reports, identify overlapping items, and prioritize those overlapping items (risk factors, social determinants of health, preventive interventions) for action in South Dakota.

- Pregnancy Care Risk Assessment Data
  OCFS launched a new electronic health record for all the services in its community health offices across the state, including the pregnancy care program. A new risk assessment was added that captures a variety of data on social determinants of health. During the next reporting period the OCFS data team plans to analyze this data by race and geography to understand the main factors affecting OCFS clients.

- Update MCH data briefs
  The MCH epidemiologist will continue to submit MCH data such as new PRAMS reports to the SD Department of Health (SDDOH) Newsletter and SDDOH Public Health Bulletin. The MCH epidemiologist will identify other possible sources of data (e.g.: Federal Available Data, Maternity Care Desert) that can be used to identify inequities in South Dakota and include data from those sources in the next data briefs.

3.4 Increase collaboration around American Indian data between state and tribal partners

Over the past reporting period, the SPM 2 workgroup decided to be more intentional about data collaboration and sharing with Tribal partners cross South Dakota. A new strategy was added to address this need.

- Engage with Tribal Leaders
  The team of OCFS epidemiologists will meet monthly with epidemiologists who work for Tribes and Indian Health Services. During those meetings, data produced by OCFS epidemiologists will be shared and discussed. Moreover, we
  will work on engagement with tribal leaders to learn their preferred method of sharing county level data from Tribal land (i.e., PRAMS tribal reports). We will work through existing partnerships and outreach through our health equity coordinator who has frequent meetings with the Tribal Health Directors.

- Tribal data to action
  We will work with Great Plains Tribal Leaders Health Board to understand what tools the Tribes need to put data into action and how we can partner with them in their efforts.

3.5 Improve internal capacity to share data via referrals between different OCFS programs

Referrals of clients between different OCFS projects and programs are a pivotal element of the service we provide to South Dakota residents. At the moment, we don't have a uniform process in place to regulate the referrals; moreover, data from the referrals themselves is available for analysis for some, but not all programs, because many of them are done informally or via printed forms. Our goal is to identify the referrals we use and establish a process that facilitates making referrals electronically and allows for data analysis across the board.

- Gather key representatives
  Identify key representatives of OCFS programs (WIC, pregnancy care, Bright Start, family planning, and other CHS services) who write referrals as part of their regular work and gather them in a work group.

- Landscape of referrals
  The work group will collect information about referrals used between different OCFS programs, for instance: type of referral (internal or external), objective, direction (from which program to which program) whether referral is done in a paper formulary, electronic formulary, or via verbal communication. The objective is to

understand the landscape of the referrals used by the different OCFS programs as a grounding step for the standardization of referral process within OCFS.

3.6 Increase Internal capacity for big data linkage

- ASTHO Data Linkage Project
  In 2022, SD DOH was awarded funding and accepted into the ASTHO PRAMS data linkage community cohort. Over the past year, a team of data experts from DOH, Medicaid, South Dakota State University, and Dakota State University worked together to complete the linkage of SD PRAMS to Medicaid claims data for the years 2018-2020. The Health Informatics Analyst will continue this work, with plans to add 2021 data to the dataset and continue the analysis to further explore topics such as the intersection of substance use disorders (SUD) and mental health; access to preconception, prenatal, and postpartum care; access to SUD treatment; and postpartum birth control for the Medicaid population.

- Enhanced maternal death surveillance project
  In South Dakota, the identification of maternal deaths is a responsibility of the Office of Vital Records. Currently, pregnancy-associated deaths of South Dakota residents are identified based on the selection of specific options in the pregnancy status checkbox section of the death certificate only. Other recommended methods of identification of pregnancy-associated deaths are not currently in use in South Dakota, for instance:
  - Performing data linkage of women who died (as recorded in death certificate) to women who gave birth a year before (as recorded in birth certificates or fetal death certificates) on a regular basis
  - Identifying maternal deaths based on specific causes of death (search for key words).

  OCFS recently met with the Office of Vital Records and initiated a project to implement those enhanced surveillance methods in South Dakota. Our goal is to the data linkage piece implemented by the end of the next reporting year.

Completed Efforts:
Several activities from the previous state action plan were completed and have been removed from this year's plan and associated plan for application. These are mentioned below.

Women's Health Report.

The MCH epidemiologist worked with an MPH student to complete a Women's Health Report card that will be finished during the next reporting period. It highlighted a variety of women's health indicators.

MCH interns

The MCH Director and MCH epidemiologist advised three MCH student interns this summer. One intern is through the GSEP and the other two through the MCH/Title V program. These interns supported the SCOOP process, specifically in the priority of outreach and evaluation. They completed projects such as qualitative analyses, surveys, literature reviews, process evaluation, tool kits, and training tools.

SCOOP

A Strategic Community Outreach and Outcomes Plan (SCOOP) was completed. It focuses on four main goal areas of breastfeeding, nutrition, outreach and infant mortality.

New Efforts
Medicaid Pregnancy Health Home

The South Dakota State Legislature approved appropriations for a Medicaid Pregnancy Health Home to support increased care coordination for Medicaid eligible women. South Dakota Medicaid and South Dakota Department of Health will collaborate to create and implement this health home. Medicaid clients will be referred to DOH services such as WIC, Bright Start Home Visiting, and Pregnancy Care. The OCFS data team will be working on a referral and data sharing process between health care providers, Medicaid, and DOH programs.

Avera RMOMS grant

Avera hospital system in South Dakota received a HRSA funded Rural Maternity Obstetrics Management System grant that was supported by both South Dakota Medicaid and South Dakota Department of Health. This grant will increase care coordination between all Avera providers and DOH programs. Based on a social determinants of health screening, Avera providers will refer their patients to DOH programs, increasing the utilization of OCFS services. The OCFS data team is working with Avera on data sharing and referral processes, with the long-term goal of system interfaces.

Ongoing Efforts Supported by MCH for Cross-Cutting/Systems Building Domain

PRAMS

SDDOH continues to conduct CDC Pregnancy Risk Assessment Monitoring System (PRAMS) through a contract with South Dakota State University. During the next reporting period SD PRAMS will collect supplemental data on social determinants of health. SD PRAMS will also add a stratum for ethnicity and look at the possibility of calculating county level estimates.

OCFS Electronic Health Record

The Office of Child and Family Services launched a new electronic health record in January 2022. The Health Informatics Analyst continues to oversee the EHR development and launch, deliver technical assistance to staff, create and run reports, and analyze data coming from the EHR. This EHR has data from family planning, nurse visiting, and community health services.

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[1] SCOOP is a county level needs assessment and action planning process for all community health offices in South Dakota

III.F. Public Input

The Department of Health (DOH) made the FY 2024 MCH block grant priorities and action plans available for public review and comment via an email blast to internal and external stakeholders. MCH Team members were asked to share with any additional partners that would be involved in MCH activities and initiatives, and stakeholders were asked to share the notice widely among the populations they serve. Due to the ongoing DOH website redesign, the link was unable to be posted on the DOH website this year. The circulated public comment link can be found here:

https://drive.google.com/drive/folders/1DgU6Gg3-OUL-4HZZ-B6BQfmxImAUlvCN?usp=sharing

The DOH received one request from South Dakota Parent Connection for a printed copy of the completed application, one media inquiry to clarify a data point found in one of the domain objectives, and one public comment provided by South Dakota Parent Connection. The MCH Program responded to these requests and comment.

South Dakota Parent Connection is a longstanding partner with the MCH Program. Parent Connection staff have served on MCH workgroups, MCH staff serve on Parent Connection workgroups, and families of CYSHCN are regularly referred to SD Parent Connection for resources. The comment provided a list of strengths by domain as well as suggestions to enhance services in the infant, child, adolescent, and CYSHCN domains. The comment was shared with domain leads.

The MCH Team meets regularly to discuss methods of improving communication with partners and the public to foster a greater understanding of Title V activities and collaborations as well as to further promote community involvement in these activities.

Although we did not receive any additional comments or feedback this year, the MCH program's daily interactions with the MCH population and partners is an effective means for the MCH program to respond to any identified areas of need and build those recommendations into the annual plan. The DOH also utilizes various task forces and workgroups to gather input from partners regarding MCH activities and potential needs including the MCH domain workgroups, immunization workgroup, WIC participant surveys, and the Newborn Screening Advisory Council. The program also utilizes social media, radio ads, and printed materials to communicate messages to the public and educate on current priorities.

The MCH program works throughout the year with many different programs and stakeholders around the state on projects and activities that impact the MCH population. Through participation in these many different projects, meetings and workgroups, the MCH program consistently receives informal public input on additional opportunities to collaborate and improve efforts to serve the MCH population in South Dakota.

III.G. Technical Assistance

In the last year, the MCH Director, CYSHCN Director, domain leaders, Family Planning, and Bright Start Home Visiting staff participated in a couple MCH funded trainings. The first was Strengths, Opportunities, Aspirations, and Results provided by a local public health consultant. This training was an introspective look at our program strengths and how we can utilize those strengths to take on aspirations and new opportunities. Staff also attended a two part training on Collaborating Across Differences provided by Wilder Research. This training focused on mindfulness of biased systems and structures, power dynamics, and reaching across differences to work with communities and build relationships. This year, the team will attend a training on community engagement best practices and utilization of a community engagement toolkit. Over the next year, the SD MCH program would like to request TA assistance for peer to peer learning focused on strategies for utilizing infant, child, and maternal mortality data for program development and service outreach.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Medicaid-DOH amended MOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - 2022FamilySurvey Report.pdf

Supporting Document #02 - NBS_Pamphlet.pdf

Supporting Document #03 - SDDOH_NewbornHearingScreening_Brochure.pdf

Supporting Document #04 - YourBabysHearing_Poster.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Organizational Charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: South Dakota

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,630,392	
A. Preventive and Primary Care for Children	$ 1,070,303	(40.6%)
B. Children with Special Health Care Needs	$ 1,111,265	(42.2%)
C. Title V Administrative Costs	$ 101,917	(3.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 2,283,485	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,048,236	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 16,261	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 919,834	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 1,984,331	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,553,050		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 4,614,723	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 22,613,738	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 27,228,461	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 129,484
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 155,758
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 19,994,744
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 224,794
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 151,552
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 186,769
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 746,626
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,024,011

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,319,160 (FY 22 Federal Award: $ 2,229,569)		$ 1,763,580	
A. Preventive and Primary Care for Children	$ 702,573	(30.3%)	$ 552,917	(31.3%)
B. Children with Special Health Care Needs	$ 729,458	(31.5%)	$ 605,144	(34.3%)
C. Title V Administrative Costs	$ 120,432	(5.2%)	$ 45,324	(2.6%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,552,463		$ 1,203,385	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,035,794		$ 1,553,467	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 13,485		$ 15,197	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 700,263		$ 867,768	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 1,749,542		$ 2,436,432	
A. Your State's FY 1989 Maintenance of Effort Amount $ 1,553,050				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 4,068,702		$ 4,200,012	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 20,895,980		$ 22,083,730	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 24,964,682		$ 26,283,742	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 112,740	$ 126,450
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 140,116	$ 152,108
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 18,019,367	$ 19,526,117
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 204,231	$ 219,526
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 151,264	$ 148,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 220,425	$ 182,391
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 981,560	$ 729,127
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 0	$ 0
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,023,389	$ 1,000,011
Department of Justice > Office of Violence Against Women > DOJ Sexual Assault Training	$ 42,888	$ 0

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: The amount expended this year is significantly less than the amount budgeted. This reporting year was budgeted with the expectation that MCH work would resume to full capacity right away following the Covid 19 pandemic, however, staff time was still going to Covid efforts the first several months of this reporting period. Additional factors include staffing shortages and vacancies as well as increased lag time receiving invoices from some field offices.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: The amount expended this year is significantly less than the amount budgeted. This reporting year was budgeted with the expectation that MCH work would resume to full capacity right away following the Covid 19 pandemic, however, staff time was still going to Covid efforts the first several months of this reporting period. Additional factors include staffing shortages and vacancies as well as increased lag time receiving invoices from some field offices.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: The amount expended this year is significantly less than the amount budgeted. This reporting year was budgeted with the expectation that MCH work would resume to full capacity right away following the Covid 19 pandemic, however, staff time was still going to Covid efforts the first several months of this reporting period. Additional factors include staffing shortages and vacancies as well as increased lag time receiving invoices from some field offices.	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

	Field Note: The amount expended this year is significantly less than the amount budgeted. This reporting year was budgeted with the expectation that MCH work would resume to full capacity right away following the Covid 19 pandemic, however, staff time was still going to Covid efforts the first several months of this reporting period. Additional factors include staffing shortages and vacancies as well as increased lag time receiving invoices from some field offices.	
5.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: The amount expended this year is significantly less than the amount budgeted. This reporting year was budgeted with the expectation that MCH work would resume to full capacity right away following the Covid 19 pandemic, however, staff time was still going to Covid efforts the first several months of this reporting period. Additional factors include staffing shortages and vacancies as well as increased lag time receiving invoices from some field offices.	
6.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: The amount expended this year is significantly less than the amount budgeted. This reporting year was budgeted with the expectation that MCH work would resume to full capacity right away following the Covid 19 pandemic, however, staff time was still going to Covid efforts the first several months of this reporting period. Additional factors include staffing shortages and vacancies as well as increased lag time receiving invoices from some field offices.	
7.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: The amount expended this year is significantly less than the amount budgeted. This reporting year was budgeted with the expectation that MCH work would resume to full capacity right away following the Covid 19 pandemic, however, staff time was still going to Covid efforts the first several months of this reporting period. Additional factors include staffing shortages and vacancies as well as increased lag time receiving invoices from some field offices.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: South Dakota

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 173,959	$ 223,886
2. Infants < 1 year	$ 172,948	$ 320,451
3. Children 1 through 21 Years	$ 1,070,303	$ 552,917
4. CSHCN	$ 1,111,265	$ 605,144
5. All Others	$ 0	$ 15,858
Federal Total of Individuals Served	$ 2,528,475	$ 1,718,256

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 836,890	$ 503,691
2. Infants < 1 year	$ 834,986	$ 938,664
3. Children 1 through 21 Years	$ 1,030,073	$ 664,489
4. CSHCN	$ 341,330	$ 317,617
5. All Others	$ 92,990	$ 11,972
Non-Federal Total of Individuals Served	$ 3,136,269	$ 2,436,433
Federal State MCH Block Grant Partnership Total	$ 5,664,744	$ 4,154,689

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: South Dakota

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 45,880	$ 30,762
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 45,880	$ 30,762
2. Enabling Services	$ 1,832,326	$ 1,228,506
3. Public Health Services and Systems	$ 752,186	$ 504,312
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 20,062
Physician/Office Services		$ 1,520
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 1,379
Laboratory Services		$ 7,567
Other		
Targeted Case Management		$ 234
Direct Services Line 4 Expended Total		$ 30,762
Federal Total	$ 2,630,392	$ 1,763,580

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 987,091	$ 1,211,986
3. Public Health Services and Systems	$ 997,240	$ 1,224,446
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 1,984,331	$ 2,436,432

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: South Dakota

Total Births by Occurrence: 12,045 **Data Source Year: 2022**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	11,861 (98.5%)	363	21	21 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia
S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency
Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency		

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Infant Hearing Screening	11,774 (97.8%)	297	27	7 (25.9%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Long-term follow up was discontinued July1, 2015 and South Daktoa does not currently monitor infants post confirmed diagnosis. Plans are underway to restart long-term follow up in 2023.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Infant Hearing Screening - Total Number Referred For Treatment**
	Fiscal Year:	**2022**
	Column Name:	**Other Newborn**

Field Note:
The number referred for treatment is less than the number of confirmed cases. This is due to the 2021 data not yet being complete. Additionally, referral to early intervention service data is not available to the DOH.

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: South Dakota

Annual Report Year 2022

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	2,309	28.0	0.0	68.0	3.0	1.0
2. Infants < 1 Year of Age	5,317	28.0	0.0	68.0	3.0	1.0
3. Children 1 through 21 Years of Age	13,518	27.0	0.0	67.0	6.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	755	44.0	0.0	53.0	3.0	0.0
4. Others	5,194	9.0	0.0	84.0	7.0	0.0
Total	26,338					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	11,369	Yes	11,369	53.0	6,026	2,309
2. Infants < 1 Year of Age	12,210	No	12,045	100.0	12,045	5,317
3. Children 1 through 21 Years of Age	257,970	Yes	257,970	72.0	185,738	13,518
3a. Children with Special Health Care Needs 0 through 21 years of age^	49,206	Yes	49,206	69.0	33,952	755
4. Others	626,489	Yes	626,489	59.0	369,629	5,194

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2022**
	Field Note: Prenatal Health Review clients + MCH case managed clients + post-partum visits to women not risk assessed during pregnancy = 1397 Cribs for Kids Safe Sleep kits distributed (with education provided) = 912 1397 + 912 = 2309	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2022**
	Field Note: 363 infants receiving follow up after a positive newborn screen + 769 infants vaccinated at Community Health Offices* + 912 Cribs for Kids safe sleep kits distributed (with education provided) + 3273 infants inrolled in WIC whose parents received safe sleep education = 5317** *Count is significantly higher than previous year. This is likely attributed to an increase in client visits to community health offices post pandemic and improved reporting using electronic health record. **New Community Health Electronic Health Record (EHR) went into effect January 31, 2022. Community Health data from February 2022-September 2022 was pulled from the new EHR. Data from October 2021-January 2022 was pulled using previous reporting methods.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: 6502 individuals vaccinated in community health and PHA offices + 4610 suicide hotline calls + 1981 ASQ and ASQ SE screenings at community health and PHA sites (all screenings billed to MCH except those billed to Medicaid) + 425 attendees to 13 Teen Mental Health Class ** 6502 + 4610 + 1981 + 425 = 13,518* *Data from community health offices has increased this year due to an increase in client visits to offices post pandemic as well as improved reporting methods using new EHR. **Attendees to Teen Mental Health Class signifcantly increased from previous year due to more classes offered.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2022**

	Field Note: 9 clients served in Health KiCC program* + 661 clients served through repsite program + 56 clients served in Sanford Patient Navigation Program + 29 special needs car seats purchased = 755. *Health KiCC number decreased from last year due to program being phased out.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2022**
	Field Note: Adults vaccinated in Community Health and PHA offices.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2022**
	Field Note: 3701 SD Strong Families kids distributed to first-time mothers + 5a count 2309 = 6010 6010/11369 = 53% Not included in count due to possible duplication: For Baby Sake (FBS) website: 48,716 views, FBS Paid Facebook reach: 5,089,658, FBS Instagram reach: 634,580, FBS Snapchat impressions: 1,151,253 Also not included in count: 8 mini grants provided to breastfeedling friendly businesses to create or improve worksite lactation rooms	
2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2022**
	Field Note: Newborn screening is a service available to 100% of infants in South Dakota. During annual report year 2022, 11,861 infants were screened out of 12,045 total births. Total count from 5a is 5317 and is not included due to duplication.	
3.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2022**
	Field Note: 12,045 total live births in South Dakota in 2022	
4.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**

	Field Note: 18,443 student contact at schools + 163,142 immunizations provided through statewide immunization program + 22 individuals served through Sanford genetics outreach + 5a suicide hotline count 4610 = 186,217 Not included due to duplication: 5a individuals vaccinated in community health and PHA offices Also not included: hotline youth mental health and QPR (suicide prevention) trainings to teachers and agencies that provide services to children- 15 trainings with 355 total participants; 18 Harvest of the Month mini grants awarded to youth programs to promote healthy food choices	
5.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: NSCH data shows 18.3% of SD children are CYSHCN Form 5b 3a count: 186,217 186,217 x .183 = 34,077.71/49,206= 69%	
6.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**
	Field Note: Number of adults vaccinated through Immunization Program. Numerator includes both men and women.	

Data Alerts:

1.	Reported percentage for Others on Form 5b is greater than or equal to 50%. The Others denominator includes both women and men ages 22 and over. Please double check and justify with a field note.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: South Dakota

Annual Report Year 2022

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	10,977	7,825	350	715	1,428	186	20	426	27
Title V Served	3,656	1,765	193	471	871	129	12	215	0
Eligible for Title XIX	3,493	1,445	215	268	1,433	97	34	0	1
2. Total Infants in State	10,917	7,555	359	888	1,313	207	9	586	0
Title V Served	10,917	7,555	359	888	1,313	207	9	586	0
Eligible for Title XIX	4,479	2,034	294	306	1,688	110	47	0	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: South Dakota

A. State MCH Toll-Free Telephone Lines	2024 Application Year	2022 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 305-3064	(800) 305-3064
2. State MCH Toll-Free "Hotline" Name	Bright Start	Bright Start
3. Name of Contact Person for State MCH "Hotline"	Whitney Brunner	Jennifer Folliard
4. Contact Person's Telephone Number	(605) 773-4749	(605) 367-5374
5. Number of Calls Received on the State MCH "Hotline"		828

B. Other Appropriate Methods	2024 Application Year	2022 Annual Report Year
1. Other Toll-Free "Hotline" Names	National Suicide Prevention Lifeline; Text4Hope	National Suicide Prevention Lifeline; Text4Hope
2. Number of Calls on Other Toll-Free "Hotlines"		4,610
3. State Title V Program Website Address	doh.sd.gov/family	doh.sd.gov/family
4. Number of Hits to the State Title V Program Website		75,652
5. State Title V Social Media Websites	See note 1b for list	See note 1a for list
6. Number of Hits to the State Title V Program Social Media Websites		5,381,485

Form Notes for Form 7:

Due to shifting data collection methods with social media, the total "hits" reported in Form 7.B.6 looks much higher than previous years due to measuring reach, rather than clicks. Paid promotion of posts was increased during the reporting year resulting in much higher numbers reached. The social media sites utilized vary somewhat from year to year and may not reflect what was reported in previous years.

1a. Social Media usage in Annual Report Year 2022:
www.Facebook.com/ForBabySakeSD 536,036 reached
www.instagram.com/ForBabySakeSD 634,580 reached
www.Facebook.com/SouthDakotaWIC 881,491 reached
www.instagram.com/corhealthsd 2,687,746 reached
www.facebook.com/corhealthsd 641,632 reached

Snapchat is also used for For Baby's Sake and Corhealth. Snapchat is measured in impressions and not included in the count.
For Baby Sake Snapchat: 1,151,253 impressions
Corhealth Snapchat: 1,104,329 impressions

1b. Social Media for Application Year 2024
www.facebook.com/ForBabySakeSD
www.instagram.com/ForBabySakeSD
www.facebook.com/SouthDakotaWIC
www.instagram.com/corhealthsd
www.facebook.com/corhealthsd
For Baby Sake Snapchat
Corhealth Snapchat

Additional websites/pages used by Title V and WIC in annual report year 2022 (not included in Form 7.B.6 count):
doh.sd.gov/family/wic 1572 views
doh.sd.gov/family/pregnancy/family-planning 2426 views
doh.sd.gov/statistics/infant-mortality 919 views
doh.sd.gov/family/pregnancy/perinatal 162 views
doh.sd.gov/statistics/maternalmortality 794 views
doh.sd.gov/family/youth 7072 views
doh.sd.gov/statistics/prams 880 views
www.ForBabySakeSD.com 48,716 views
www.SDWIC.org - page views not available due to change in site management

Form 8
State MCH and CSHCN Directors Contact Information

State: South Dakota

1. Title V Maternal and Child Health (MCH) Director	
Name	Samantha Hynes
Title	MCH Director
Address 1	615 E 4th St.
Address 2	
City/State/Zip	Pierre / SD / 57501
Telephone	(605) 910-4546
Extension	
Email	samantha.hynes@state.sd.us

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Whitney Brunner
Title	CYSHCN Director
Address 1	615 E 4th St.
Address 2	
City/State/Zip	Pierre / SD / 57501
Telephone	(605) 773-4749
Extension	
Email	whitney.brunner@state.sd.us

3. State Family Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: South Dakota

Application Year 2024

No.	Priority Need
1.	Mental Health/Substance Misuse
2.	Safe Sleep
3.	Parenting Education and Support
4.	Mental Health/Suicide Prevention
5.	Access to Care and Services
6.	Healthy Relationships
7.	Data Sharing and Collaboration

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Mental Health/Substance Abuse	New
2.	Safe Sleep	Revised
3.	Parenting Education and Support	New
4.	Mental Health/Suicide Prevention	New
5.	Access to Care and Services	Revised
6.	Healthy Relationships	New
7.	Data Sharing and Collaboration	New

Form 10
National Outcome Measures (NOMs)

State: South Dakota

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	77.9 %	0.4 %	8,768	11,257
2020	77.9 %	0.4 %	8,475	10,873
2019	77.7 %	0.4 %	8,816	11,341
2018	77.5 %	0.4 %	9,118	11,769
2017	76.0 %	0.4 %	9,103	11,978
2016	76.8 %	0.4 %	9,326	12,149
2015	76.6 %	0.4 %	9,301	12,144
2014	76.4 %	0.4 %	9,248	12,103
2013	72.3 %	0.4 %	8,693	12,021
2012	70.6 %	0.4 %	8,367	11,843
2011	69.9 %	0.4 %	8,120	11,622
2010	71.2 %	0.4 %	8,255	11,596
2009	67.3 %	0.4 %	7,919	11,760

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020	44.5	6.6	46	10,326
2019	52.5	7.0	57	10,854
2018	57.1	7.2	64	11,207
2017	47.0	6.5	53	11,286
2016	40.4	6.0	46	11,399
2015	39.4	6.9	33	8,385
2014	47.7	6.6	53	11,122
2013	45.5	6.5	50	10,987
2012	33.1	5.5	36	10,873
2011	35.4	5.8	38	10,743
2010	40.7	6.2	43	10,555
2009	56.5	7.3	61	10,796
2008	40.8	6.2	44	10,780

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2021	25.9	6.7	15	57,805
2016_2020	18.7	5.7	11	58,711
2015_2019	16.6	5.3	10	60,087
2014_2018	16.4	5.2	10	60,921

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	7.1 %	0.2 %	810	11,360
2020	6.9 %	0.2 %	753	10,955
2019	7.0 %	0.2 %	802	11,444
2018	6.6 %	0.2 %	789	11,886
2017	6.9 %	0.2 %	835	12,126
2016	6.8 %	0.2 %	830	12,275
2015	6.1 %	0.2 %	754	12,328
2014	6.5 %	0.2 %	804	12,280
2013	6.3 %	0.2 %	766	12,237
2012	6.2 %	0.2 %	748	12,098
2011	6.3 %	0.2 %	744	11,839
2010	6.8 %	0.2 %	806	11,801
2009	5.8 %	0.2 %	696	11,929

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	10.5 %	0.3 %	1,197	11,365
2020	9.4 %	0.3 %	1,030	10,945
2019	9.6 %	0.3 %	1,093	11,444
2018	9.4 %	0.3 %	1,122	11,882
2017	9.3 %	0.3 %	1,125	12,121
2016	9.0 %	0.3 %	1,098	12,268
2015	8.5 %	0.3 %	1,053	12,325
2014	8.5 %	0.3 %	1,040	12,268
2013	8.1 %	0.3 %	993	12,221
2012	7.8 %	0.2 %	946	12,084
2011	7.9 %	0.3 %	940	11,832
2010	8.6 %	0.3 %	1,013	11,788
2009	7.9 %	0.3 %	944	11,912

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	29.4 %	0.4 %	3,346	11,365
2020	28.3 %	0.4 %	3,100	10,945
2019	27.8 %	0.4 %	3,177	11,444
2018	25.6 %	0.4 %	3,046	11,882
2017	25.3 %	0.4 %	3,063	12,121
2016	24.6 %	0.4 %	3,023	12,268
2015	23.7 %	0.4 %	2,917	12,325
2014	24.0 %	0.4 %	2,948	12,268
2013	22.9 %	0.4 %	2,795	12,221
2012	22.3 %	0.4 %	2,696	12,084
2011	23.5 %	0.4 %	2,781	11,832
2010	24.7 %	0.4 %	2,906	11,788
2009	26.1 %	0.4 %	3,106	11,912

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021/Q1-2021/Q4	2.0 %			
2020/Q4-2021/Q3	2.0 %			
2020/Q3-2021/Q1	2.0 %			
2019/Q4-2020/Q3	3.0 %			
2019/Q1-2019/Q4	3.0 %			
2018/Q4-2019/Q3	3.0 %			
2018/Q3-2019/Q2	3.0 %			
2018/Q2-2019/Q1	3.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	3.0 %			
2016/Q4-2017/Q3	3.0 %			
2016/Q3-2017/Q2	3.0 %			
2016/Q2-2017/Q1	3.0 %			
2016/Q1-2016/Q4	3.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	3.0 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	7.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	6.7	0.8	74	10,998
2019	6.2	0.7	71	11,478
2018	4.6	0.6	55	11,919
2017	7.8	0.8	95	12,177
2016	5.7	0.7	70	12,319
2015	6.8	0.7	84	12,374
2014	6.3	0.7	78	12,326
2013	6.4	0.7	79	12,292
2012	8.8	0.9	107	12,147
2011	6.3	0.7	75	11,882
2010	8.4	0.9	100	11,864
2009	5.8	0.7	69	11,962

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	7.3	0.8	80	10,960
2019	7.0	0.8	80	11,449
2018	5.9	0.7	70	11,893
2017	7.7	0.8	94	12,134
2016	4.9	0.6	60	12,275
2015	7.3	0.8	90	12,336
2014	5.7	0.7	70	12,283
2013	6.5	0.7	79	12,248
2012	8.3	0.8	101	12,104
2011	6.1	0.7	72	11,846
2010	7.1	0.8	84	11,811
2009	6.7	0.8	80	11,934

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	3.9	0.6	43	10,960
2019	4.1	0.6	47	11,449
2018	2.9	0.5	35	11,893
2017	5.5	0.7	67	12,134
2016	2.5	0.5	31	12,275
2015	4.8	0.6	59	12,336
2014	3.3	0.5	41	12,283
2013	3.9	0.6	48	12,248
2012	5.5	0.7	67	12,104
2011	3.6	0.6	43	11,846
2010	4.8	0.6	57	11,811
2009	3.8	0.6	45	11,934

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020	3.4	0.6	37	10,960
2019	2.9	0.5	33	11,449
2018	2.9	0.5	35	11,893
2017	2.2	0.4	27	12,134
2016	2.4	0.4	29	12,275
2015	2.5	0.5	31	12,336
2014	2.4	0.4	29	12,283
2013	2.5	0.5	31	12,248
2012	2.8	0.5	34	12,104
2011	2.4	0.5	29	11,846
2010	2.3	0.4	27	11,811
2009	2.9	0.5	35	11,934

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020	200.7	42.8	22	10,960
2019	148.5 ϟ	36.0 ϟ	17 ϟ	11,449 ϟ
2018	92.5 ϟ	27.9 ϟ	11 ϟ	11,893 ϟ
2017	255.5	45.9	31	12,134
2016	97.8 ϟ	28.2 ϟ	12 ϟ	12,275 ϟ
2015	178.3	38.1	22	12,336
2014	138.4 ϟ	33.6 ϟ	17 ϟ	12,283 ϟ
2013	212.3	41.7	26	12,248
2012	214.8	42.2	26	12,104
2011	168.8	37.8	20	11,846
2010	211.7	42.4	25	11,811
2009	167.6	37.5	20	11,934

Legends:

⚑ Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	209.9	43.8	23	10,960
2019	139.8	35.0	16	11,449
2018	168.2	37.6	20	11,893
2017	115.4	30.9	14	12,134
2016	122.2	31.6	15	12,275
2015	218.9	42.2	27	12,336
2014	114.0	30.5	14	12,283
2013	130.6	32.7	16	12,248
2012	90.9	27.4	11	12,104
2011	92.9	28.0	11	11,846
2010	118.5	31.7	14	11,811
2009	134.1	33.5	16	11,934

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	11.8 %	1.2 %	1,264	10,720
2020	13.3 %	1.3 %	1,380	10,345
2019	10.8 %	1.1 %	1,156	10,715
2018	8.2 %	1.0 %	913	11,086
2017	8.3 %	1.0 %	919	11,073

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	2.5	0.5	26	10,391
2019	1.6	0.4	17	10,798
2018	1.4	0.4	15	11,024
2017	1.7	0.4	19	11,354
2016	1.8	0.4	21	11,528
2015	1.6	0.4	14	8,555
2014	1.6	0.4	18	11,255
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	1.3	0.4	14	10,849
2010	NR	NR	NR	NR
2009	NR	NR	NR	NR
2008	NR	NR	NR	NR

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	10.2 %	1.0 %	20,630	202,573
2019_2020	8.2 %	1.1 %	16,357	199,763
2018_2019	8.6 %	1.2 %	16,737	195,087
2017_2018	8.4 %	1.3 %	16,330	193,439
2016_2017	8.7 %	1.2 %	16,828	193,935
2016	9.6 %	1.4 %	18,332	191,693

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	28.4	5.1	31	109,270
2020	19.1	4.2	21	110,041
2019	22.7	4.5	25	110,116
2018	20.8	4.3	23	110,785
2017	29.1	5.2	32	109,874
2016	29.2	5.2	32	109,629
2015	24.7	4.8	27	109,091
2014	26.7	5.0	29	108,445
2013	25.1	4.8	27	107,646
2012	31.3	5.4	33	105,530
2011	21.1	4.5	22	104,150
2010	20.3	4.4	21	103,502
2009	24.6	4.9	25	101,525

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	52.4	6.5	65	124,160
2020	42.5	6.0	51	120,111
2019	52.3	6.7	62	118,466
2018	54.8	6.8	65	118,556
2017	51.7	6.7	60	115,978
2016	63.7	7.5	73	114,680
2015	56.6	7.1	64	113,106
2014	37.0	5.7	42	113,630
2013	44.5	6.3	50	112,318
2012	44.0	6.3	49	111,395
2011	43.7	6.3	49	112,012
2010	56.5	7.1	63	111,588
2009	65.2	7.6	73	111,893

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019_2021	20.8	3.4	37	177,492
2018_2020	23.0	3.6	40	174,234
2017_2019	26.7	3.9	46	172,083
2016_2018	29.8	4.2	51	171,187
2015_2017	24.1	3.8	41	170,094
2014_2016	23.4	3.7	40	171,242
2013_2015	14.5	2.9	25	171,823
2012_2014	19.1	3.3	33	172,681
2011_2013	17.4	3.2	30	172,774
2010_2012	24.3	3.8	42	172,983
2009_2011	29.3	4.1	51	173,766
2008_2010	33.2	4.4	58	174,643
2007_2009	35.1	4.5	62	176,399

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2021	37.2	4.6	66	177,492
2018_2020	34.4	4.5	60	174,234
2017_2019	33.1	4.4	57	172,083
2016_2018	29.2	4.1	50	171,187
2015_2017	30.0	4.2	51	170,094
2014_2016	28.0	4.1	48	171,242
2013_2015	29.1	4.1	50	171,823
2012_2014	22.6	3.6	39	172,681
2011_2013	22.0	3.6	38	172,774
2010_2012	20.8	3.5	36	172,983
2009_2011	24.2	3.7	42	173,766
2008_2010	28.6	4.1	50	174,643
2007_2009	24.9	3.8	44	176,399

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	18.3 %	1.2 %	39,317	215,230
2019_2020	17.8 %	1.4 %	37,957	213,159
2018_2019	17.2 %	1.5 %	36,404	211,616
2017_2018	16.6 %	1.5 %	35,046	211,653
2016_2017	16.1 %	1.3 %	33,876	210,513
2016	15.7 %	1.4 %	32,704	208,339

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	19.5 %	2.8 %	7,649	39,317
2019_2020	20.9 %	3.5 %	7,950	37,957
2018_2019	15.7 %	3.3 %	5,705	36,404
2017_2018	16.3 %	3.9 %	5,708	35,046
2016_2017	15.6 %	3.8 %	5,296	33,876
2016	9.6 %	1.9 %	3,144	32,704

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	1.8 %	0.4 %	3,145	176,064
2019_2020	2.4 %	0.8 %	4,183	173,989
2018_2019	2.2 %	0.8 %	3,863	172,694
2017_2018	1.3 %	0.4 %	2,259	173,786
2016_2017	1.5 %	0.5 %	2,649	171,841
2016	2.0 %	0.8 %	3,263	166,826

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	9.7 %	1.0 %	17,024	176,237
2019_2020	8.4 %	1.0 %	14,432	172,440
2018_2019	7.0 %	1.0 %	11,981	170,586
2017_2018	6.5 %	1.1 %	11,164	172,611
2016_2017	6.5 %	1.0 %	10,997	170,388
2016	7.0 %	0.9 %	11,719	166,311

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	51.2 %	4.8 %	13,289	25,963
2019_2020	55.8 %	5.4 %	13,171	23,621
2018_2019	58.3 %	6.2 %	11,586	19,858
2017_2018	66.8 %	6.6 %	12,005	17,965
2016_2017	60.9 %	5.9 %	10,629	17,449
2016	51.8 %	7.0 %	8,075	15,596

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	93.1 %	0.8 %	199,821	214,659
2019_2020	92.0 %	1.0 %	195,399	212,305
2018_2019	91.6 %	1.1 %	192,700	210,359
2017_2018	93.7 %	1.0 %	197,336	210,705
2016_2017	93.7 %	0.9 %	196,224	209,466
2016	92.7 %	1.1 %	191,296	206,419

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	15.8 %	0.6 %	662	4,194
2018	16.0 %	0.5 %	1,004	6,269
2016	17.1 %	0.5 %	1,156	6,771
2014	17.1 %	0.5 %	884	5,179
2012	14.8 %	0.4 %	1,190	8,020
2010	17.3 %	0.4 %	1,363	7,884
2008	16.1 %	0.4 %	1,121	6,946

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	16.6 %	2.6 %	6,294	37,847
2019	14.1 %	0.9 %	5,256	37,324
2015	14.7 %	1.3 %	5,550	37,746
2013	11.9 %	1.1 %	4,509	37,874
2011	9.8 %	1.0 %	3,812	38,957
2009	9.5 %	1.0 %	3,662	38,353
2007	9.0 %	1.2 %	3,680	40,789
2005	10.4 %	1.1 %	4,285	41,028

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	18.9 %	2.0 %	18,067	95,581
2019_2020	15.2 %	2.1 %	13,488	88,834
2018_2019	11.7 %	2.0 %	10,480	89,317
2017_2018	11.9 %	2.3 %	10,969	91,796
2016_2017	13.6 %	2.3 %	11,680	86,126
2016	13.0 %	2.2 %	10,488	80,613

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	8.4 %	1.1 %	18,378	219,070
2019	5.7 %	0.9 %	12,368	215,236
2018	5.2 %	0.7 %	11,133	214,180
2017	6.1 %	1.0 %	12,936	212,391
2016	4.3 %	0.8 %	9,120	213,902
2015	7.4 %	1.3 %	15,401	209,556
2014	7.3 %	1.2 %	15,285	209,494
2013	7.3 %	1.0 %	14,974	205,982
2012	3.9 %	0.8 %	7,869	204,137
2011	5.7 %	0.8 %	11,454	202,877
2010	7.1 %	1.2 %	14,562	204,414
2009	6.7 %	0.9 %	13,342	199,435

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	75.3 %	2.9 %	9,000	12,000
2017	69.7 %	3.5 %	9,000	12,000
2016	68.9 %	3.8 %	9,000	12,000
2015	72.2 %	3.9 %	9,000	13,000
2014	73.4 %	3.3 %	9,000	13,000
2013	64.7 %	4.1 %	8,000	13,000
2012	73.6 %	4.2 %	9,000	12,000
2011	68.7 %	4.8 %	8,000	12,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	57.8 %	2.4 %	120,137	207,892
2020_2021	64.4 %	2.4 %	131,809	204,673
2019_2020	70.3 %	1.9 %	145,068	206,356
2018_2019	67.2 %	2.2 %	136,681	203,394
2017_2018	64.4 %	2.0 %	128,145	198,957
2016_2017	63.2 %	2.4 %	125,737	199,014
2015_2016	70.8 %	2.0 %	139,014	196,236
2014_2015	64.4 %	2.4 %	124,290	192,937
2013_2014	68.5 %	2.1 %	131,211	191,596
2012_2013	73.2 %	3.3 %	140,455	192,009
2011_2012	58.2 %	2.6 %	107,634	184,949
2010_2011	53.7 %	4.6 %	100,976	188,037
2009_2010	56.5 %	2.6 %	95,462	168,959

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	87.4 %	2.1 %	52,206	59,732
2020	84.5 %	2.2 %	50,137	59,310
2019	73.6 %	3.0 %	43,186	58,689
2018	68.7 %	2.9 %	39,413	57,365
2017	63.2 %	3.2 %	35,462	56,124
2016	55.9 %	3.4 %	30,966	55,423
2015	46.0 %	3.2 %	25,628	55,733

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	95.6 %	1.3 %	57,076	59,732
2020	91.5 %	2.0 %	54,257	59,310
2019	90.0 %	2.1 %	52,846	58,689
2018	86.6 %	2.2 %	49,689	57,365
2017	79.5 %	2.8 %	44,628	56,124
2016	79.4 %	2.9 %	43,986	55,423
2015	72.4 %	2.9 %	40,325	55,733
2014	75.0 %	3.0 %	41,570	55,439
2013	70.0 %	3.3 %	38,650	55,198
2012	65.9 %	3.3 %	35,845	54,368
2011	54.4 %	5.2 %	29,467	54,183
2010	52.5 %	3.2 %	29,225	55,702
2009	39.6 %	3.4 %	22,002	55,527

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	96.6 %	0.9 %	57,723	59,732
2020	94.2 %	1.5 %	55,888	59,310
2019	86.2 %	2.4 %	50,619	58,689
2018	85.3 %	2.2 %	48,920	57,365
2017	74.5 %	2.9 %	41,838	56,124
2016	65.7 %	3.2 %	36,400	55,423
2015	55.5 %	3.2 %	30,918	55,733
2014	57.0 %	3.4 %	31,618	55,439
2013	51.7 %	3.4 %	28,523	55,198
2012	40.0 %	3.5 %	21,743	54,368
2011	37.4 %	4.8 %	20,280	54,183
2010	30.9 %	3.0 %	17,198	55,702
2009	24.9 %	2.9 %	13,838	55,527

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	17.0	0.8	501	29,505
2020	18.7	0.8	533	28,486
2019	19.2	0.8	536	27,955
2018	20.4	0.9	565	27,707
2017	22.6	0.9	614	27,226
2016	25.1	1.0	681	27,149
2015	26.5	1.0	720	27,214
2014	26.7	1.0	735	27,483
2013	29.4	1.0	812	27,650
2012	33.5	1.1	929	27,747
2011	34.3	1.1	964	28,066
2010	34.8	1.1	975	28,045
2009	38.7	1.2	1,092	28,228

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	11.1 %	1.0 %	1,176	10,622
2020	12.6 %	1.2 %	1,299	10,272
2019	12.6 %	1.1 %	1,338	10,618
2018	13.0 %	1.2 %	1,435	11,037
2017	14.3 %	1.2 %	1,604	11,203

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	3.5 %	0.6 %	7,616	214,627
2019_2020	2.9 %	0.7 %	6,164	212,838
2018_2019	2.4 %	0.7 %	5,106	211,616
2017_2018	2.9 %	0.7 %	6,216	211,542
2016_2017	3.1 %	0.7 %	6,559	210,083
2016	2.3 %	0.7 %	4,772	207,703

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: South Dakota

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			79.6	73.1	78.9
Annual Indicator		77.6	70.4	77.3	77.4
Numerator		110,174	101,908	110,595	112,934
Denominator		141,888	144,765	143,127	145,872
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	81.4	83.4	85.4

Field Level Notes for Form 10 NPMs:

None

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	92.4	89.3	89.1	87	88
Annual Indicator	87.6	87.0	86.6	87.8	89.4
Numerator	9,793	9,485	9,150	8,964	9,349
Denominator	11,174	10,900	10,566	10,213	10,456
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	88.5	88.7	88.9

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		39.2	41.8	41.5	41.2
Annual Indicator	38.4	41.6	40.5	40.1	43.9
Numerator	4,014	4,380	4,136	3,932	4,422
Denominator	10,466	10,533	10,223	9,810	10,070
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	43.5	44.7	45.8

Field Level Notes for Form 10 NPMs:

None

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		48.4	48.4	52.9	56.1
Annual Indicator	48.2	46.9	52.0	55.8	60.3
Numerator	5,069	4,923	5,339	5,404	6,039
Denominator	10,516	10,495	10,267	9,676	10,020
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	56.6	56.9	57.2

Field Level Notes for Form 10 NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	41.2	42.8	41.4	40.3	38.1
Annual Indicator	42.4	40.4	39.4	36.5	32.9
Numerator	10,542	8,655	9,910	9,949	9,000
Denominator	24,884	21,429	25,131	27,272	27,376
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	38.6	41.5	44.4

Field Level Notes for Form 10 NPMs:

None

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Federally Available Data				
Data Source: HCUP - State Inpatient Databases (SID)				
	2019	**2020**	**2021**	**2022**
Annual Objective			312.1	274.2
Annual Indicator	313.0	318.8	281.9	316.4
Numerator	363	378	334	380
Denominator	115,978	118,556	118,466	120,111
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2017	2018	2019	2020

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	278.8	266.3	253.8

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	46.1	50.8	53.4	49.7	49.4
Annual Indicator	49.6	53.0	48.8	48.4	49.4
Numerator	16,789	18,568	17,763	18,368	19,423
Denominator	33,876	35,046	36,404	37,957	39,317
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	51.5	52.6	53.6

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: South Dakota

SPM 1 - Increase the percentage of 10-19 year olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 58% in 2022 to 60.74% in 2025.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			46.1	52
Annual Indicator			50.9	58
Numerator			199	307
Denominator			391	529
Data Source			SRAE and PREP survey	SRAE and PREP survey
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	58.9	59.8	60.7

Field Level Notes for Form 10 SPMs:

None

SPM 3 - Percent of data equity principles implemented in South Dakota MCH projects

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator		50.7
Numerator		73
Denominator		144
Data Source		South Dakota Data Equity Tool
Data Source Year		2022
Provisional or Final ?		Final

Annual Objectives			
	2023	2024	2025
Annual Objective	56.0	57.8	59.6

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: South Dakota

ESM 1.1 - % of WIC clients with a positive response to Whooley questions that received a PHQ 9 screening

Measure Status:	**Inactive - Replaced**			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			100	100
Annual Indicator			0	60.3
Numerator			0	295
Denominator			100	489
Data Source			DOH EMR	DOH EMR
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Final

Field Level Notes for Form 10 ESMs:

None

ESM 1.2 - % of WIC clients whose PHQ 9 score met criteria for a referral and were referred

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			100	100
Annual Indicator			0	78.2
Numerator			0	86
Denominator			100	110
Data Source			2021	2022
Data Source Year			DOH EMR	DOH EMR
Provisional or Final ?			Provisional	Final

Field Level Notes for Form 10 ESMs:

None

ESM 1.3 - # of messages posted promoting well women care

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	12	9
Numerator		
Denominator		
Data Source	SD Media Services	SD Media Services
Data Source Year	2021	2022
Provisional or Final ?	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	13.0	14.0	15.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.4 - % of women with positive depression screen who are referred to their PCP within OCFS field offices

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator		57.4
Numerator		109
Denominator		190
Data Source		DOH EMR
Data Source Year		2022
Provisional or Final ?		Final

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.1 - % of Child Death Review (CDR) team members who scored above 80% on a post-test

Measure Status:	Inactive - Completed			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			100	100
Annual Indicator			100	100
Numerator			10	15
Denominator			10	15
Data Source			Post test results	Post test results
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Final

Field Level Notes for Form 10 ESMs:

None

ESM 5.3 - % of birthing hospitals that receive information on certification process that become safe sleep certified

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			100
Annual Indicator		0	25
Numerator		0	2
Denominator		7	8
Data Source		Manual count	Manual count
Data Source Year		2021	2022
Provisional or Final ?		Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 6.1 - % of Community Health Offices that distribute tracking cards

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			100	100
Annual Indicator	100	100	100	100
Numerator	76	76	76	74
Denominator	76	76	76	74
Data Source	OCFS Community Health Offices	OCFS Community Health Offices	OCFS Community Health Offices	OCFS Community Health Offices
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 6.2 - Percentage of children enrolled in Bright Start Home Visiting that receive a developmental screen by 18 months of age.

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	92	64.9
Numerator	23	24
Denominator	25	37
Data Source	Bright Start Home Visiting program data records	Bright Start Home Visiting program data records
Data Source Year	2021	2022
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.2.1 - # of students trained in teen Mental Health First Aid

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			60	120
Annual Indicator			38	425
Numerator				
Denominator				
Data Source			class training facilitator	class training facilitator
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 7.2.2 - Number trained in Youth Mental Health First Aid

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	6
Numerator	
Denominator	
Data Source	Report from training facilitator
Data Source Year	2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	12.0	24.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - % of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			100	100
Annual Indicator			18.2	53.7
Numerator			4	22
Denominator			22	41
Data Source			SDSU Population Health	SDSU Population Health
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: South Dakota

SPM 1 - Increase the percentage of 10-19 year olds who would talk to a trusted adult if someone they were dating or going out with makes them uncomfortable, hurts them, or pressures them to do things they don't want to do from 58% in 2022 to 60.74% in 2025.
Population Domain(s) – Adolescent Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Improve young peoples' (10 to 24 years) relationships by increasing education and support, STI prevention, and pregnancy prevention.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td># of individuals answering “very true” to the entry survey question: “I would talk to a trusted adult (for example, a family member, teacher, counselor, coach, etc.) if someone I am dating or going out with makes me uncomfortable, hurts me, or.....</td></tr>
<tr><td>Denominator:</td><td>total # of individuals who completed the above question on the entry survey</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>SRAE and PREP entry survey</td></tr>
<tr><td>Significance:</td><td>Relationships are an important part of adolescent development. Adolescence is a time for young people to explore and develop relationships by connecting with peers, parents, teachers, or a romantic partner. These relationships might be healthy or unhealthy, and can be emotional, physical, or sexual. A comprehensive approach of covering education and support for healthy relationships, STI prevention, and teen pregnancy prevention is key to achieving healthy relationships in adolescence.</td></tr>
</table>

SPM 3 - Percent of data equity principles implemented in South Dakota MCH projects
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Understand our strengths and weaknesses in collecting, analyzing, and sharing data equitably. This measurement promotes communication about equity principles among the workgroup members with the goal of improving our data sharing and collaboration.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Combined score of each principle for all data projects using the SD data equity tool **Denominator:** highest possible score of each principle for all data projects using the SD data equity tool
Data Sources and Data Issues:	South Dakota data equity tool
Significance:	Data can be a powerful, evidence-based approach to addressing health equity. Disaggregated data and data on social determinants of health can help identify and understand health inequities. Using community-based participatory research or qualitative methods lifts community voices and supplements quantitative data. Working across sectors to link and analyze data creates more robust data sets and parallel approaches to reporting. In South Dakota, honoring Indigenous data sovereignty is an especially important data principle to advance equity in data sharing and collaboration. This measure not only helps the group identify weaknesses in this area but offers an avenue to communicate about the ways that Indigenous data sovereignty can be observed in future data projects. South Dakota Maternal Child Health strives for meaningful partnership with American Indian Tribes and wants to honor their perspective on the ways in which data should be analyzed and interpreted to represent their communities.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: South Dakota

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: South Dakota

ESM 1.1 - % of WIC clients with a positive response to Whooley questions that received a PHQ 9 screening
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Inactive - Replaced</td></tr>
<tr><td>Goal:</td><td>Address mental health in women by measuring the percentage of WIC clients with a positive response to Whooley questions that received a PHQ 9 screening.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td># of WIC clients with a positive response to Whooley questions that received a PHQ 9 screening</td></tr>
<tr><td>Denominator:</td><td># of positive PHQ 2 generated from the WIC assessment</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>code added to the state's Time Keeping System for a PHQ 9 screening</td></tr>
<tr><td>Significance:</td><td>A Pregnancy and Postpartum WIC Assessment provides a critical opportunity to identify mental health needs and improve subsequent maternal and infant outcomes by providing appropriate referrals to address mental health issues.</td></tr>
</table>

ESM 1.2 - % of WIC clients whose PHQ 9 score met criteria for a referral and were referred
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Inactive - Replaced
Goal:	Address mental health in women by measuring the percentage of WIC clients whose PHQ 9 score met criteria for a referral and were referred
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of WIC clients whose PHQ 9 score met criteria for a referral and were referred **Denominator:** # of WIC clients whose PHQ 9 score met criteria for a referral
Data Sources and Data Issues:	Statistics kept by Community Health Offices
Significance:	A Pregnancy and Postpartum WIC Assessment provides a critical opportunity to identify mental health needs and improve subsequent maternal and infant outcomes by providing appropriate referrals to address mental health issues.

ESM 1.3 - # of messages posted promoting well women care
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	This measure is tracking the number of our posts on social media to childbearing people in SD that seek well care.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** The number of social media posts to childbearing people in SD that seek well care **Denominator:**
Data Sources and Data Issues:	South Dakota media services data from Facebook, Instagram, and snapchat.
Evidence-based/informed strategy:	The evidence for this strategy falls under “Community, other media, population-based systems”. There is moderate evidence to support this strategy to be effective. The use of media to facilitate and support healthy behaviors is found throughout the literature. Anderson et al (2009) developed and broadcast a mass media campaign that targeted women 40-69 across all socioeconomic groups. Cervical screening increased 27% during the campaign over a 52-week period. Other studies have looked at the influence of social media on the ability to increase knowledge and change behavior. A study by Bonnevie et al (2020) used a pre- and post- campaign surveys to measure the impact of flu vaccination rates using social media influencers. The 117 influencers generated over 69,000 engagements showing significant increases in positivity about the flu vaccine. Another study aimed to describe the use of social media by young adults aged 18-24 years to motivate and engage with health information. Participants completed profiling surveys and web-based registration to be part of the study. They completed discussion forums on a web-based community. They found that young adults used Facebook, You Tube, and Instagram for health and wellness information. Twitter, Tumblr, and Snapchat were rarely used for health information (Lim, Molenaar, Brennan, Reid & McCaffrey, 2022). Anderson JO, Mullins RM, Siahpush M, Spittal MJ, Wakefield M. (2009). Mass media campaign improves cervical screening across all socio-economic groups. Health Educ Res: 24(5):867-75. https://www.ncbi.nlm.nih.gov/pubmed/19342422 Bonnevie E, Rosenberg SD, Kummeth C, Goldbarg J, Wartella E, Smyser J (2020) Using social media influencers to increase knowledge and positive attitudes toward the flu vaccine. PLoS ONE 15(10): e0240828. https://doi.org/10.1371/journal. pone.0240828 Lim, M., Molenaar, A., Brennan, L., Reid, M., and McCaffrey, T. (2022). Young adults’ use of different social media platforms for
Significance:	Social media provides an outlet to reach a broader audience to disseminate health related information. Messages posted related to well woman promotes communication by informing women of childbearing age the importance of preventative care for overall health.

ESM 1.4 - % of women with positive depression screen who are referred to their PCP within OCFS field offices
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>This measure will determine if our process for screening is effective in identifying women with symptoms of depression and getting them referred to their PCP.</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>number of women with a positive screen who were referred to PCP</td></tr>
<tr><td>Denominator:</td><td>total number of women with a positive PHQ-9</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Netsmart EHR screens and documented referrals</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The evidence for this strategy falls under emerging evidence. The Association of Maternal & Child Programs (AMCHP) supports strategies to build capacity to support pregnant people and women of reproductive age with mental health and substance use disorders (https://amchp.org/mental-health-sud/). It aligns with Innovation Hub’s Perinatal Depression Screening and Referral Project example in Connecticut (https://amchp.org/wp-content/uploads/2021/05/Perinatal-Depression-Screening-Referral_2015.pdf). The Agency for Healthcare Research and Quality states on their fact sheet for depression screening that screening pregnant women for depression enables health professionals to initiate services that can prevent later problems for both the mother and baby. (https://www.ahrq.gov/ncepcr/tools/healthier-pregnancy/fact-sheets/depression.html)

Further support comes from the American College of Obstetricians and Gynecologists (ACOG) in their ACOG committee opinion: Screening for Perinatal Depression (ACOG, No. 757, 2018) and Optimizing postpartum care (ACOG No. 736, 2018). It is recommended that “obstetric care providers complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive visit for each patient”, (ACOG, No. 757,2018). Postpartum support international (PSI) recommends universal screening for the presence of prenatal or postpartum mood and anxiety disorders, using an evidence-based tool (https://www.postpartum.net/professionals/screening/). The US Preventative Services Task Force (USPSTF) recommendation statement (2016) calls for screening for depression in the general adult population, including pregnant and postpartum women.

Optimizing postpartum care. ACOG Committee Opinion No. 736. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018: 131: e140-50

Post-Partum Support International (PSI) https://www.postpartum.net/professional</td></tr>
<tr><td>Significance:</td><td>Screening women for depression during routine, prenatal, and postpartum WIC visits allows health professionals to refer and initiate services with a primary care provider. This screening to initiate primary care can prevent later problems for mom and baby.</td></tr>
</table>

ESM 5.1 - % of Child Death Review (CDR) team members who scored above 80% on a post-test
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Inactive - Completed
Goal:	Determine the effectiveness of training provided to CDR team members by measuring the % of team members who scored above 80% on a training post-test.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of CDR team members who scored above 80% on a post-test **Denominator:** # of CDR team members who took post-test
Data Sources and Data Issues:	Manual tally of post-test scores
Significance:	By measuring the effectiveness of training on upstream root causes of infant death, we have more confidence in a review team's ability to recommend ways to prevent deaths from occurring instead of responding to the deaths.

ESM 5.3 - % of birthing hospitals that receive information on certification process that become safe sleep certified NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Increase the % of birthing hospitals that become safe sleep certified after receiving information on the certification process
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of birthing hospitals in SD that receive information on Cribs for Kids safe sleep certification process that become safe sleep certified **Denominator:** # of birthing hospitals in SD that receive information on Cribs for Kids safe sleep certification process
Data Sources and Data Issues:	Manual count of SD birthing hospitals that become safe sleep certified after receiving information on Cribs for Kids safe sleep certification process.
Evidence-based/informed strategy:	The evidence for this strategy falls under “Caregiver+Provider+Hospital without Quality Improvement (Moderate Evidence) “appear to be effective as the majority of the studies had favorable results” in the National Performance Measure 5 Safe Sleep Evidence Review from the Women’s and Children’s Health Policy Center at John Hopkins University (2017). NICHQ’s study states “Statewide implementation of hospital policy intervention to increase knowledge among health care professionals has resulted in significant reductions in infants found in unsafe sleep situations while in the hospital. (Infant Safe Sleep Interventions, 1990 -2015: A Review. J community Health. 2016) Cribs for Kids National Safe Sleep Hospital Certification Program includes: • Developing safe sleep policy statement incorporating the AAP’s Infant Safe Sleep guidelines • Training staff on safe sleep guidelines, hospital safe sleep policy, and the importance of modeling safe sleep for parents • Educating parents on the importance of safe sleep practices and implementing these practices in the hospital setting.
Significance:	This measure is significant because it demonstrates that hospital systems (who become safe sleep certified) have met Cribs for Kids standards of providing evidence based strategies in their policies, in safe sleep training for staff and with their education provided to new families.

ESM 6.1 - % of Community Health Offices that distribute tracking cards
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Inactive - Replaced
Goal:	Provide parenting education on developmental screening by providing trifold developmental screening tracking cards at Community Health Offices
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of Community Health Offices that distribute tracking cards **Denominator:** # of Community Health Offices
Data Sources and Data Issues:	Reporting from Community Health Offices
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. There are many electronic options available for parents and caregivers to track a child's development, however, not every family has access to the required technology to utilize these apps. It is important that community health offices continue to distribute developmental screening tracking cards and other hard copy resources to ensure all populations have an effective means to track the development of the children in their care.

ESM 6.2 - Percentage of children enrolled in Bright Start Home Visiting that receive a developmental screen by 18 months of age.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Track the percentage of children enrolled in Bright Start Home Visiting that receive a developmental screen by 18 months of age to measure the impact of the program on improving developmental screening rates.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of children served in Bright Start Home Visiting aged 18 months that have received a developmental screen **Denominator:** Total # of children aged 18 months that have been served by Bright Start Home Visiting
Data Sources and Data Issues:	Bright Start Home Visiting program data records
Evidence-based/informed strategy:	There is moderate and growing evidence that using home visiting sessions to encourage parents to use the Ages and Stages tool may increase developmental screening rates. Green et al. looked at whether home visiting services were effective for families with different social, demographic, and other differing characteristics by conducting a randomized study of the Healthy Families Oregon home visiting program. The study was carried out through a telephone survey with a randomly selected group of mothers to assess the program's early outcomes at children's 1-year birthday. Out of 803 randomly selected mothers, 402 were assigned to receive the Healthy Families Oregon program. Results found that mothers assigned to the Healthy Families program read more frequently to their young children and provided more developmentally supportive activities. Children of these mothers were more likely to have received developmental screenings and were somewhat less likely to have been identified as having a developmental challenge. Green B, Tarte JM, Harrison PM, Nygren M, Sanders M. Results from a randomized trial of the Healthy Families Oregon accredited statewide program: early program impacts on parenting. Child Youth Serv Rev. 2014; 44:288-298. https://www.sciencedirect.com/science/article/pii/S0190740914002175
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. As the Home Visiting program expands, it provides an opportunity to improve the state's developmental screening rates.

ESM 7.2.1 - # of students trained in teen Mental Health First Aid
NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Inactive - Replaced
Goal:	Address suicide prevention and mental health in adolescents by promoting evidence-based programs and practices that increase protection from suicide risk
Definition:	**Unit Type:** Count **Unit Number:** 500 **Numerator:** # of students trained in teen Mental Health First Aid **Denominator:**
Data Sources and Data Issues:	# of class participants reported by training facilitator to have completed the teen mental health first aid curriculum
Significance:	New evidence-based curriculum for youth that teaches high school students how to identify, understand and respond to signs and symptoms of mental health or substance abuse. Education is important in this area because during Adolescence 1 in 5 youth has had a serious mental health disorder at some point in their life and 50% of all mental illnesses begins by age 14 and 75% by the mid-20s(Mental Health First Aid). This training gives students the skills to have supportive conversations with their friends and get a responsible and trusted adult to take over as necessary.

ESM 7.2.2 - Number trained in Youth Mental Health First Aid
NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	Address suicide prevention and mental health inadolescents by promoting evidence-based programs and practices that increase protection from suicide risk.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of individuals trained in Youth Mental Health First Aid **Denominator:**
Data Sources and Data Issues:	Number of class participants reported by training facilitator to have completed the Youth Mental Health First Aid curriculum
Evidence-based/informed strategy:	Promote evidence-based programs and practices that increase protection from suicide risk - Available evidence is strongest for universal school-based interventions that target multiple-risk behaviours, demonstrating that they may be effective in preventing engagement in tobacco use, alcohol use, illicit drug use, and antisocial behaviour, and in improving physical activity among young people. MacArthur et al., 2018.
Significance:	Evidence based curriculum for professionals who work with youth that teaches how to identify, understand, and respond to signs and symptoms of mental health or substance abuse issues. Education is important in this area because during adolescence 1 in 5 youth has had a serious mental health disorder at some point in their life and 50% of all mental illnesses begin by age 14 and 75% by mid-20s.

ESM 11.1 - % of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Improve access to care and services for CYSHCN by measuring the effectiveness of the Sanford Care Coordination Program.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services **Denominator:** # of families enrolled in care coordination services
Data Sources and Data Issues:	pre-care coordination and post-care coordination surveys of clients provided by South Dakota State University Population Health
Significance:	The AAP specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. By measuring the effectiveness of the Sanford Care Coordination Program, the CYSHCN program can tailor services provided to close gaps in care and increase the percentage of families that experience an improvement in obtaining needed referrals to care and/or services. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

Form 11
Other State Data

State: South Dakota

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: South Dakota

Annual Report Year 2022

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Monthly	1		
2) Vital Records Death	Yes	Yes	Monthly	1	Yes	• Infant Birth
3) Medicaid	Yes	No	Annually	12	No	
4) WIC	Yes	Yes	More often than monthly	6	No	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	6	Yes	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	6	Yes	
7) Hospital Discharge	Yes	Yes	Semi-Annually	6	No	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	12	Yes	

Other Data Source(s) (Optional)

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) Pregnancy Mortality Surveillance System	Yes	Yes	Annually	36	Yes	
10) Fatality Review Case Reporting System	Yes	Yes	More often than monthly	0	No	
11) OCFS Electronic Health Record	Yes	Yes	More often than monthly	0	No	
12) Maternal Mortalitity Review Information App	Yes	Yes	Daily	18	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None